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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 64LU
Facility ID: 00775

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245361**
2. STATE VENDOR OR MEDICAID NO. (L2) **134543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEEKER MANOR REHABILITATION CENTER, LLC**
(L4) **600 SOUTH DAVIS AVENUE**
(L5) **LITCHFIELD, MN** (L6) **55355**

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) **07/14/2016**
6. DATE OF SURVEY **05/07/2021** (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 **75** (L18)
13. Total Certified Beds **75** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(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 :
Susie Haben, Unit Supervisor 05/12/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 05/12/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1986** (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. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **04/30/2021** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
May 12, 2021

CMS Certification Number (CCN): 245361

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

Dear Administrator:

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 April 28, 2021 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
May 12, 2021

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: CCN: 245361
Cycle Start Date: March 25, 2021

Dear Administrator:

On April 16, 2021, we notified you a remedy was imposed. On May 7, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 28, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective May 31, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 16, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 29, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 28, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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2 AOA 3 Other

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And/Or Approved Waivers Of The Following Requirements:
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___ 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)

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 04/28/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 04/30/2021 (L20)

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

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____ 2. Facility is not Eligible
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04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE: (L27)

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

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
April 14, 2021

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: CCN: 245361
Cycle Start Date: March 25, 2021

Dear Administrator:

On March 25, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 31, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 31, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 31, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 31, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Meeker Manor Rehabilitation Center, Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 31 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 September 25, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/22/21 to 3/25/21, a survey for compliance with the Centers for Medicare and Medicaid (CMS) Appendix Z Emergency Preparedness requirements was conducted during a recertification survey. Meeker Manor Rehabilitation Center was found to be in full compliance.	E 000		
F 000	INITIAL COMMENTS On 3/22/21 to 3/25/21, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Meeker Manor Rehabilitation Center was found to be not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. In addition, multiple complaint investigations were completed at the time of the recertification survey. The following complaint(s) were found to be substantiated: H5361051C; with deficiencies issued at F580 and F689. The following complaint(s) were found to be unsubstantiated: H5361049C, H5361050C, H5361052C, H5361053C 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	F 000		

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

Electronically Signed | 04/22/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

(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	Continued From page 1 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light or device to alert staff was present and accessible for 1 of 1 residents (R25) observed to not have a way to call for staff help and/or assistance while in their room. Findings include: R25's admission Minimum Data Set (MDS), dated 1/28/21, identified R25 had moderately impaired cognition, required supervision with locomotion in his room, and had sustained a fall with major injury since his admission to the nursing home. R25's care plan, dated 2/20/21, identified R25 was at risk for falls and injury due to impaired cognition and seizure activity. The care plan outlined several interventions to help reduce his risk of falls which included, "Keep call-light within reach." On 3/22/21, at 2:21 p.m. R25 was observed laying in his bed inside his room. A white-colored	F 558	§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Resident 25 call light has been replaced on 3/22/2021. Resident 25 discharged on 4/22/2021. To ensure other residents have reasonable accommodation of needs a call light audit was performed on 3/22/2021 to ensure all residents have call lights. Staff were inserviced on 4/20/2021 to ensure the importance of call lights being in place and accessible to residents. Monitoring will be accomplished through an audit by center administration x1 daily for 1 week, weekly for 4 weeks, and monthly or as indicated by QA committee to ensure call lights are in place. Results will be reported to the facility QAPI	4/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

(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 558	Continued From page 2 hard plastic receiver box was present on the wall adjacent to R25's bed which had two visible ports to insert an electronic call light; however, there was no call light plugged into these ports, nor was there any other call light(s) or devices present inside R25's room which could be used to signal the need for assistance from staff, if R25 needed. When questioned on how he would alert staff if he needed help R25 responded only with, "Yea, they help." On 3/22/21, at 2:34 p.m. nursing assistant (NA)-D was alerted by the surveyor to R25 being a fall risk and not having a call light in reach as outlined by his care plan. NA-D observed R25's room and verified it lacked a call light or any audible devices to alert staff to a need for assistance. NA-D voiced she was unaware R25 had been without a call light device in his room prior to being found without one on 3/22/21; however, she expressed he "absolutely" should have a bell or call light to alert staff if he needed assistance. R25's progress note, dated 1/28/21, identified R25 had previously voiced comments about wanting to harm himself and, as a result, the staff outlined " ... continue to keep bell in room vs call light cord at this time." When interviewed on 3/23/21, at 1:48 p.m. nursing assistant (NA)-C voiced R25 was fairly independent with his cares but required supervision and cues to ensure he completed them. NA-C stated R25 was "a fall risk" though and had, in the past, used his call light to get staff' attention when he needed something. NA-C voiced she had heard R25 was found without a call light or bell in his room on 3/22/21; however, she voiced she was unaware why he did not have	F 558	committee for review and follow-up. Deficient practices will be corrected upon identification Allegation of compliance is 4/28/2021.	

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	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

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F 558	Continued From page 3 one. On 3/23/21, at 2:39 p.m. registered nurse manager (RN)-A was interviewed. R25 admitted from the acute hospital where he had previously voiced he wanted to harm himself by wrapping the call light around his neck. As a result, the nursing home had decided to remove the call light cord and provide a bell so he could alert staff if he needed help. However, RN-A voiced the threat of self-harm had since passed and R25 was no longer considered at risk for such behavior so his call light should have been replaced so he had it accessible. RN-A expressed she was unsure how long R25 had went without a call light or device to alert staff while in hi room and added, "I missed it." Further, RN-A voiced all residents should have a call light or some audible alert device available to them to help prevent falls and ensure staff can respond to their needs. A facility' policy on call light(s) was requested, however, was not received.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		4/28/21

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F 580	Continued From page 4 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the medical provider was notified	F 580	Notification of Changes. i. A facility must immediately inform the	

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F 580

Continued From page 5

of a change in condition for 1 of 1 residents (R55) reviewed that had documented increased periods of low oxygen (O2) saturations (sats) and an unresponsive episode which lasted approximately one minute whom was sent the following day to a routine renal dialysis appointment. R55 had required a hospital admission directly from the dialysis appointment related to low O2 sats and low blood pressure (BP), who subsequently passed two days later.

Findings include:

R55's quarterly Minimum Data Set (MDS), dated 10/14/20, identified R55 had intact cognition and communication abilities. The MDS identified R55 had been free of falls since the prior MDS assessment and had diagnosis of orthostatic hypotension (abnormal decrease in BP when standing), congestive heart failure (impaired heart pumping), end stage renal disease which required dialysis management, and chronic respiratory failure (failure of lungs to function properly) with O2 used at that time; however, R55 was not considered to have a life-limiting prognosis.

R55's alteration in oxygen/gas exchange respiratory status care plan, dated 6/24/20, identified R55 had periods of low blood O2 sats in which he would refuse to wear the O2 at times. Interventions to assist R55 with the goal of "adequate gas exchange" included the following: monitor and document respiratory status, monitor O2 sats as ordered and as needed, keep medical provider informed of changes. R55' care plan failed to identify R55 had history of unresponsive episodes or low BP.

F 580

resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is—

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is—

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

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F 580	Continued From page 6 R55's treatment administration record (TAR), dated 11/1/20 - 11/30/20 directed staff to monitor R55's O2 sats during the day and evening shifts. The TAR identified R55 had an order for O2 at 0-4 liters (L) via nasal cannula (N/C) to maintain O2 sats of 90% or greater at rest and 0-5L with exertion for low O2 sats. Further, the TAR identified R55 had two O2 sat readings of 89% on 11/3/20 and 11/5/20 where the remainder of the O2 sats ranged from 90 to 98% and consistently required 4L of O2 daily. The TAR lacked evidence of documentation responses for the day shift O2 monitoring from 11/26/20 - 11/30/20. In addition, the TAR directed staff to monitor R55's BP after dialysis on Monday, Wednesday, and Fridays. R55's BP ranged from 103/64 to 108/60. The TAR lacked evidence a BP reading after dialysis on 11/27/20. On 11/26/20, R55's rapid COVID-19 rapid test had been negative. On 11/27/20, time stamped 6:53 p.m. a nursing assistant (NA) had updated registered nurse (RN)-A that "[R55's] BP was low." R55 had been asleep in his wheelchair when RN-A entered R55's room. R55 had responded to verbal command but had "quickly fell asleep." R55's O2 nasal cannula had been in his nares; however, the portable O2 machine had been "off." R55 was switched to a standard O2 machine and assisted back to bed with a two person pivot transfer. R55 had stated he "just didn't feel good." RN-A had instructed the trained medication aide (TMA) to administer R55 Midodrine (medication used to manage low BP when standing) if he had not received Midodrine that day. The note indicated, "Will continue to watch and reassess resident." The progress note lacked documentation of BP or	F 580	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Resident 55 passed away on 12/2/2020. To ensure that current residents experiencing change of condition have appropriate notifications to self, physician and representative's facility staff were inserviced on 4/20/2021. Licensed nurses were educated on 3/30/2021 to the change of condition policy to include notification. A facility wide audit was conducted on 4/15/2021 to ensure that all change of conditions and accidents include appropriate notifications in the past 30 days. Monitoring will be accomplished by daily audits of incidents and accidents and change of condition for 1 week. 5 residents audits of incidents and accidents and change of condition weekly for 2 weeks. Then 10 audits of incidents and accidents and change of condition monthly for 2 months. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification Allegation of compliance 4/28/2021.	

F 580 Continued From page 7 F 580

O2 sats readings at the time of the entry or that the medical provider had been contacted on status.

R55 lacked evidence of documented progress note entries from 11/27/20, at 6:53 p.m. to 11/28/20, at 4:11 p.m.

On 11/28/20, time stamped 4:11 p.m. R55 had fallen to the floor at approximately 2:45 p.m. after he had attempted to pick up a dropped fork while he sat in his wheelchair. R55 had sustained a left elbow skin tear that measured 2.6 inches by 3 inches wide. R55 had been alert and oriented to person, place, and time. R55's blood pressure had been reported to be "up and down but has seemed to level out within normal range as of now." The progress note lacked documentation the medical provider had been contacted on status.

R55 lacked documented progress note entries from 11/28/20, at 4:11 p.m. to 11/30/20, at 5:30 a.m.

On 11/30/20, time stamped 5:30 a.m. R55 had "went limp and did not respond to staff for approximately one minute" when two staff had assisted him into bed with a mechanical stand lift during cares the evening prior. R55, once he again responded to staff, had O2 sats at 89% on 3.5L of O2. R55 had stated he had felt cold in which he also felt cold to touch. The progress note indicated R55 had been checked on throughout the night and he had rested "quietly without complaint." That morning, R55 had stated he had felt "tired and foggy." He had been afebrile; however, his O2 sats had been 85% which required the nurse to increase the O2 flow

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F 580	Continued From page 8	F 580		

to 4L. The progress note lacked documentation the medical provider or dialysis had been contacted and/or updated on status.

On 11/30/20, time stamped 11:13 a.m. R55 had been sent to the emergency room (ER) from the dialysis center due to low blood oxygen saturations; however, the ER had transferred R55 to the St. Cloud Hospital due to elevated tropin levels and a positive ER COVID-10 test. Staff had updated dialysis on R55's condition; however, the progress note lacked documentation R55's facility medical provider had been contacted on status.

On 12/2/21, the facility had received a call from the St. Cloud Hospital which indicated R55 had passed away that day.

An Inpatient Discharge Death Summary, dated 12/2/20, indicated R55 had arrived to dialysis on 11/30/20 with O2 sats "in the 60's" and a BP of 80/40. Due to R55's low O2 sats and initial low BP, R55 had been sent to the local ER for evaluation and subsequently admitted to a transfer hospital. R55's principle hospital discharge diagnosis had been acute on chronic hypoxic respiratory failure secondary to COVID-19, with additional diagnosis of acute on chronic systolic heart failure and type II myocardial infarction (heart attack).

During interview on 3/25/21, at 9:25 a.m. licensed practical nurse (LPN)-C explained her mode of physician communication for resident changes in status would depend on the nature of the change. If the change was "severe" she would "contact the doctor right away" and if it was "less significant" she would fax the medical provider. In either situation LPN-A stated she would

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F 580	Continued From page 9	F 580		

document the medical provider follow-up in the resident's record. LPN-C explained if a resident were to present as unresponsive or have abnormally low O2 sats she would contact the physician "right away" due to these being changes in condition.

When interviewed on 3/25/21, at 10:11 a.m. care coordinator LPN-B stated if a resident were to present with abnormally low O2 sats and/or had an unresponsive episode she "would call the doctor" and would put monitoring in place due to these being changes in a resident's condition.

During interview on 3/25/21, at 10:40 a.m. case manager registered nurse (RN)-A confirmed R55's O2 sats "would drop on occasion but not too bad" and that R55's O2 sats on 11/16/20, of 69% had not been normal for him. RN-A explained staff had educated R55 on the need to keep his O2 N/C in place as ordered as he would remove the N/C independently; however, he had not been known to turn the O2 machine off. RN-A felt R55 had typically been free of adverse consequences when he removed his O2. RN-A acknowledged she had been unaware of R55's 11/29/20 evening unresponsive episode. After RN-A reviewed R55's 11/30/20 progress note, she stated she "would have sent him in." RN-A confirmed she would have expected staff "at a minimum" to contact the medical provider after R55's unresponsive episode and then again after the abnormal O2 sats on 11/30/20 for follow-up. Further, RN-A stated then if R55 would have refused any medical provider orders and/or directions she would have expected documentation to support the follow-up. RN-A explained she would have also initiated increased vitals monitoring as her biggest concern would

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F 580	Continued From page 10	F 580		

have been COVID-19. RN-A stated "something was brewing" for R55. RN-A explained the risk of staff not updating medical providers on residents' changes in conditions was "this [death]."

When interviewed on 3/25/20, at 11:07 a.m. the director of nursing (DON) stated she would have expected staff to update R55's medical provider on his unresponsive episode and increased periods of lower O2 sats as these would be considered a change in condition for R55. Further, the DON explained she would have expected to see supporting documentation that staff had followed up with the medical provider. The DON confirmed R55 had not had COVID-19 testing on 11/29/20 after the unresponsive episode or on 11/30/20 before going to dialysis despite the DON's explanation the facility's "primary focus" of "resident care delivery" around the time of R55's unresponsive episode had been COVID-19 and "infection control."

During interview on 3/25/21, at 11:58 a.m. nurse practitioner (NP)-A stated R55 had been "stable" and "doing fairly well" after his gastrointestinal (GI) bleed in September. NP-A reviewed available R55 clinic notes during the interview and confirmed the only notes present past 11/16/20 had been related to negative COVID-19 test results. NP-A voiced she had last examined R55 on 11/9/20 for a "regulatory visit." NP-A acknowledged she had not been provided any updates which concerned R55's 11/28/20 fall, the unresponsive episode on 11/29/20, or his abnormal O2 sats. NP-A denied any recollection of R55 having had unresponsive episodes in the past and she further explained R55 typically had not experienced issues with lower O2 sats despite R55's having not wanted to wear the O2

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F 580	Continued From page 11 at all times as prescribed. NP-A stated she would have expected staff to contact the clinic about R55's changes in condition as she "would have done more of a workup" which would have included a COVID-19 test. In addition, NP-A explained, "We would have been fairly aggressive to monitor him due to COVID running rampant at that time [in the facility]." During a telephone interview on 3/25/21, at 12:20 p.m. LPN-F stated on the evening of 11/29/20, R55 had "went limp" when staff "had him in the lift." LPN-F believed he had similar episodes of this in the past "but not too frequent." LPN-F had been unable to provide further details about other unresponsive episodes R55 may have had. LPN-F acknowledged R55's O2 sats were typically "in the 90's;" however, they would drop to about 85 - 88% but only with exertion. LPN-F had been unable to remember if R55 had signs or symptoms of respiratory distress on 11/29/20 or 11/30/20. LPN-F confirmed she had not contacted the medical provider about R55's unresponsive episode or overall status and further confirmed she had also not updated dialysis on 11/30/20 regarding R55's status that morning. LPN-F stated she had felt R55's unresponsive episode had been a concern; however, due to her belief he had this type of episode in the past she only monitored R55. LPN-F explained if a resident's condition were to change she would take "the proper steps" of monitoring their vitals and calling the medical provider. A policy Change in Resident Condition, dated 6/2019, directed staff to notify the resident's physician/healthcare provider when there had been an accident or incident which involved the resident, a significant change in the resident's	F 580		

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F 580	Continued From page 12 mental physical or mental condition, and/or a need to transfer the resident to a hospital.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		4/28/21

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F 656	Continued From page 13 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to include assessed dental concerns and subsequent interventions to ensure good oral hygiene was maintained for 1 of 2 residents (R37) reviewed for dental hygiene care. Findings include: R37's admission Minimum Data Set (MDS), dated 2/18/21, identified R37 had intact cognition and required extensive assistance to complete her activities of daily living (ADLs). Further, the MDS outlined R37 had no broken teeth and/or likely cavities present. R37's MHM (Monarch Health Management) Oral/Dental Evaluation, dated 2/11/21, identified R37 had observed plaque or debris on her teeth along with, " ... several missing teeth." R37 was recorded as not wearing dentures and required set-up for oral cares. When interviewed on 3/22/21, at 3:33 p.m. R37 voiced she needed dental care as "they're [her teeth] falling out." R37 expressed she had numerous missing teeth which made her self-conscious of her smile and, as a result, she tried to "hide it as much as possible." R37	F 656	Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Resident 37’s care plan was revised to include alteration in dental care. A full house audit was conducted for all facility residents and completed on 4/13/2021 to ensure that oral assessments are completed and accurate. A facility wide audit of care plans was completed on 4/25/2021. Facility regional nurse consultant educated clinical leadership on 4/1/2021 to completion of comprehensive care plans and timing and revision. Facility staff inserviced on 4/20/2021. Audit of the comprehensive care plans will be completed within one week after the care plan due date per the MDS schedule by the DON or designee for 30 days. Results will be reported to the facility	

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	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

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F 656	Continued From page 14 proceeded to show her teeth to the surveyor, and was observed to have several missing teeth on both the top and lower palate. However, R37's care plan, printed 3/23/21, was reviewed and lacked any identified problem statements, goal(s), or interventions to ensure R37 maintained good oral hygiene despite being assessed as needing oversight and/or assistance to ensure dental care was completed and having numerous missing teeth. When interviewed on 3/23/21, at 1:50 p.m. nursing assistant (NA)-C stated she noticed R37 had several missing teeth and, as a result, "tries to keep her mouth closed" as she "hates her smile." NA-C explained they attempt to help R37 clean her teeth but she often refuses or will verbalize she would do it later on her own. However, NA-C added, she was unsure if it was actually getting done or not then. On 3/24/21, at 9:56 a.m. registered nurse manager (RN)-A was interviewed and verified the care plan lacked any problem statements, goals or interventions regarding R37's dental care or needs. RN-A explained since there had been no issues recorded on R37's MDS, dated 2/18/21, she "wouldn't think to care plan it." However, RN-A voiced she was aware R37 had numerous missing teeth and stated it should have been added to the care plan to ensure staff were "looking at the whole person" and getting care completed. A provided Care Planning policy, dated 6/2019, outlined the interdisciplinary team (IDT) would develop and implement a comprehensive care plan no later than 21 days after admission for	F 656	QAPI committee for review and follow-up. Deficient practices will be corrected upon identification. Allegation of compliance 4/28/2021.	

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F 656	Continued From page 15 each resident. The policy continued, "The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 657	Comprehensive Care Plans Timing and	4/28/21

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F 657	Continued From page 16 review, the facility failed to revise and follow the care plan for 2 of 3 resident (R4 and R26) reviewed for provisions of care. Findings include: R4's annual minimum data set (MDS) dated 3/17/21, indicated severe cognitive impairment along with needing extensive assistance with bed mobility and transfers. R4's face sheet dated 3/24/21, indicated diagnosis included: unspecified dementia with behavioral disturbances (brain impairment in memory and judgement), peripheral vascular disease, insomnia (difficulty with sleeping), Alzheimer disease with late onset (a progressive disease that destroys memory and other important mental functions). R4's provider orders dated 12/23/20, indicated use foot cradle under blanket when resident is in bed to reduce pressure on feet/toes. R4's tissue tolerance evaluation and skin risk factors dated 3/16/21, indicated moderate risk for skin breakdown. R4's Care plan, revised 3/4/21, indicated ADL's extensive assistance with dressing, showering, bed mobility and personal hygiene. R4's care plan indicated vulnerable with mobility limitation, communications, staff will provide daily cares as per care plan and will notify nursing when plan needs updating for accuracy. R4's care plan indicated risk for skin integrity which lacked any information about the foot cradle. R4's had a high risk for falls and interventions of use of a concave mattress to help remind where the edge of the	F 657	Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be—(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-¬ (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Resident 4's care plan was reviewed and updated. Resident 4's plan of care no longer requires the concave mattress or foot cradle. Resident 26's plan of care was reviewed	

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F 657	Continued From page 17 bed was. During observation on 3/22/21, at 1:15 p.m. R4 laying on left side in bed with blankets on top of feet covering entire body. Foot cradle was observed sitting on the floor next to the wall under the tray table. During observation on 3/23/21, at 1:59 p.m. R4 laying on left side with blankets covering body from neck to below toes, foot cradle was again observed sitting on the floor, next to the wall under the tray table. No concave mattress observed in use. During interview on 3/23/21, at 2:35 p.m. nursing assistant (NA)-A stated being unaware of R4 should be using the foot cradle while in bed but would assume the cradle should be kept on her bed and utilized to prevent further break down of her toes. NA-A stated R4 had scabs on her toes that the nurses are monitoring. NA-A stated she has never seen the foot cradle on R4's bed. NA-A further stated she follows the Kardex which tells her how to care for the residents and did not see this listed on there. Immediately following interview, at 2:42 p.m. NA-A left R4's room, without implementing foot cradle, and walked down the hallway into another residents room, R4 continues to lay on left side with blankets on her feet/toes and foot cradle on the floor. During observation on 3/24/21, at 7:24 a.m. R4 lying in bed toes/feet have blankets on them and foot cradle sitting on floor, next to wall and under the tray table.	F 657	and updated. Resident 26 no longer requires the foot cradle or use of Gerri Sleeves. A full house audit was conducted for all facility residents and completed on 3/26/2021 to ensure that interventions for skin integrity and falls are in place and appropriate. Facility regional nurse consultant educated clinical leadership on 3/31/2021 to completion of comprehensive care plans and timing and revision. Facility staff inserviced on 4/20/2021. A facility wide audit of care plans was completed on 4/25/2021. Audit of the comprehensive care plans will be completed within one week after the care plan due date per the MDS schedule by the DON or designee for 30 days. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification. Allegation of compliance 4/28/2021.	

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F 657	Continued From page 18 During interview on 3/24/21, at 7:24 a.m. NA-B stated R4 has sores on her right great toe and second toe of the right foot which the trained medication aid or nurse will treat before getting R4 up for the day. NA-B stated since she has been employed she has never seen the foot cradle being used which has been for approximately 7-8 months and would look to the Kardex for interventions for the residents. During interview on 3/24/21, at 9:19 a.m. Licensed practical nurse (LPN)-A stated R4 should have the foot cradle on the bed if there was an order for it along with a concave mattress as she is a high falls risk. LPN-A further stated the staff look to the care plan/Kardex when caring for residents and would think that those interventions should be on there. During interview on 3/24/21, at 9:21 a.m. LPN-B stated that R4 should have a concave mattress on her bed and should be using the foot cradle due to her sores on her toes. Not sure if the beds got switched when moved rooms due to covid. LPN-B stated it is important to have the concave mattress on her bed due to high falls risk and the use of the foot cradle to prevent further break down and relieving pressure to her toes. LPN-B stated all interventions should be on the care plan for staff to follow as this indicated how to care for the resident. LPN-B stated she would look at this and get items added or discontinued after talking with hospice. During interview on 3/25/21, at 9:56 a.m. Director of nursing (DON) stated R4's foot cradle should be on her bed to prevent pressure on her feet and to prevent further breakdown and would expect that it would be listed on the Care plan. DON	F 657		

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F 657	Continued From page 19 further stated the concave mattress should be on R4's bed as the care plan indicated which is used to help residents are aware of the edge of the bed. DON stated that staff look to the Kardex/care plan when providing cares to the client and should be updated. R26's face sheet dated 3/24/21, indicated diagnosis include: Parkinson's disease (disorder that affects movement), major depressive disorder, anxiety disorder, post traumatic stress disorder, dementia in other diseases classified elsewhere with behavioral disturbances (impairment of memory and functioning), and muscle weakness. R26's MDS dated 2/3/21, indicated severe cognitive impairment and required extensive two assist with transfers and bed mobility. R26's required extensive assistance with activities of daily living. R26's order summary report dated 3/24/21, indicated Left (L) heel- remove pressure by floating heel with a pillow under calf and applying a heel cushion boot. R26's care plan revised on 2/10/21, indicated a risk for alteration in skin integrity interventions to include turn and reposition every 2-2.5 hours. Elevate heels off the bed, foot cradle added to foot of bed to keep blankets off resident's toes, place pillow under legs as tolerated. Heel protectors when not wearing shoes. Notify hospice of any skin concerns. Care plan lacked any interventions or risk for pain. Care plan lacked interventions of Gerri sleeves to bilateral arm, which was indicated on treatment plan.	F 657		

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F 657	Continued From page 20 During observation on 3/23/21, at 2:06 p.m. R26 laying in bed, blankets are tucked under mattress and resting on residents feet, no elevation of bilateral feet on a pillow, R26 was wearing a short sleeve shirt. Did not view any Gerri sleeves on resident's arms. During observation on 3/23/21, at 3:20 p.m. R26 sitting in Broda chair in short sleeves has blanket covering his lap, right arm is resting on arm rest of chair. R26 reported pain in right foot. NA-A came in room and asked if R26 was having pain, R26 replied yes. NA-A repositioned right foot and heel protector. NA-A asked if that was better and R26 replied no. NA-A stated would let someone know. During interview on 3/24/21, at 7:24 a.m. NA-B stated staff know how to care for residents by their care plan/Kardex. NA-B stated these list out the interventions to follow and how to transfer the resident. During interview on 3/24/21, at 9:28 a.m. NA-E stated R26 should have pressure boots on at all times, but unsure if legs are to be elevated. NA-E stated she has not seen the foot cradle in a long time, but thinks it was removed due to the air mattress and R26 bumping his feet. NA-E stated he likes a blanket on him and use to wear Gerri sleeves but would remove them. NA-E stated she has not seen the Gerri sleeves in a long time and he should have a blanket on him in place of the sleeves. NA-E stated she uses the Kardex to know how to care for the residents. NA-E stated nurses updates the Kardex. During interview on 3/24/21, at 12:54 p.m. hospice registered nurse (RN)-B stated R26 was	F 657		

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F 657	Continued From page 21	F 657		

kicking the foot cradle so they got that discontinue and he should be having feet up on a pillow as he allows to prevent further breakdown of skin. RN-B further stated R26 should be monitored for pain as he does have nonverbal cues of wincing during dressing changes. RN-B stated important to keep R26 comfortable and free of pain.

During observation on 3/24/21, at 1:02 p.m. R26 lying in bed with blankets over bedrail and bilateral feet elevated on a pillow.

During interview on 3/24/21, at 1:08 p.m. LPN-A stated R26 does have PRN pain medication and should be given if he was having pain. LPN-A further stated the foot cradle was removed from his care plan by the care manager since being aware that it was still in place by state agency. LPN-A further stated pain management and pressure reducing interventions should be in the treatment plan and in the care plan for staff to monitor and know how to care for the residents. LPN-A stated she reviewed the treatment plan which indicated Gerri sleeves are to be on and verified staff are checking this off, however stated he does refuse these and staff should be making sure that feet are elevated and sleeve are on but if not using these interventions they should be removed from the plan of care. LPN-A further stated staff should be following provider orders to elevate R26's feet to prevent further breakdown. LPN-A stated she updates the care plan/Kardex and this should reflect the plan of care for each resident.

During interview on 3/25/21, at 9:24 a.m. LPN-B stated R26 doesn't wear the Gerri sleeves but, rather using a blanket which he should be care

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F 657	Continued From page 22 planned for (care plan lacked evidence of blanket use in place of Gerri sleeves) and doesn't really need them any longer as he is not wheeling himself around in wheelchair. LPN-B stated she does not see pain management listed on R26 care plan and this should be fixed right away. LPN-B stated R26 should have his heels elevated on pillow as ordered to prevent further break down and further stated R26 wears heel protectors as well. LPN-B stated blankets should be folded over the rail of the bed to relieve pressure and prevent further break down to resident's skin. During observation on 3/25/21, at 9:36 a.m. R26 sitting in chair with blanket covering bilateral arms and had both heel protectors on his feet. During interview on 3/25/21, at 9:52 a.m. DON stated R26 is vulnerable and the staff watch him carefully for pain. DON further stated it looked like the care plan for pain is missing and should be part of R26's plan to help keep him comfortable. DON further stated it was surprising to her as she goes through the care plans. DON further stated their care plans/Kardex are a work in progress over the last month as they are transitioning to using the Kardex system. DON stated the importance of care plans to be revised/updated as it is the actual plan of care for staff to follow when caring for residents. DON stated if there were any changes in a residents care is should be update as well to notify other staff of the change. Care planning revised on 6/2019, indicated "In accordance with state and federal regulations, each resident will have a person-centered care plan developed by the interdisciplinary team for	F 657		

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F 657	Continued From page 23 the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The interdisciplinary team, in conjunction with the resident and the resident representative will develop and implement a comprehensive individualized care plan no later than the 21st day of the admission of the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes."	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine grooming to 2 of 2 residents (R26 and R31) reviewed for activities of daily living (ADLs) and who were dependent on staff for their cares. Findings include: R26's face sheet, dated 3/24/21, indicated R26 had Parkinson's disease (disorder that affects movement), major depressive disorder, anxiety disorder, post traumatic stress disorder, dementia in other diseases classified elsewhere with behavioral disturbances (impairment of memory and functioning), and muscle weakness. R26's MDS dated 2/3/21, indicated severe cognitive impairment and required extensive assistance with activities of daily living.	F 677	ADL's §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Resident 26 shaving preferences and plan of care have been updated to meet his needs. Resident 31 oral care preferences have been updated to meet her needs. Resident is scheduled to see the dental provider on 7/30/2021. Resident 31 agreeable to this date for service. To ensure other residents shaving and oral care preferences are adhered to, a facility wide audit was conducted on 4/12/2021. A facility wide audit on shaving preferences was completed on 4/21/2021.	4/28/21

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F 677	Continued From page 24 R26's care plan revised on 2/10/21, indicated limited physical mobility related to weakness and required 2 staff at times for cares. R26 has self care performance deficit with activities of daily living related to Parkinson's, post traumatic stress disorder, confusion at time, personal hygiene requires 2 assist total dependence with all personal hygiene when he refuses care allow time and reproach. Review of R26's tasked dated 3/2021, indicated personal hygiene was signed off at least daily from march 1st through March 25th. Review of Weekly Skin Inspection dated 3/19/21, indicated R26 had a bedbath and was not shaved. During observation on 3/22/21, at 1:27 p.m. R26 had scruffy chin/cheek. During observation on 3/23/21, at 8:48 a.m. R26 seated in Broda chair in day room. Mask in place and had long hairs under chin and on cheeks. Unable to see under mask or upper lip due to mask being in place. During observation on 3/23/21, at 9:04 a.m. R26's mask was removed by staff and noted 1/4-3/4 inch coarse, gray and white hairs on chin, under chin, and cheeks. R26 stated staff shave him but further stated not "for a while". During observation on 3/23/21, at 2:06 p.m. hospice nurse in R26's room. R26 continues to have long facial hair 1/4-3/4 inch remains in place. R26 appeared calm and cooperative with hospice nurse.	F 677	Staff were inserviced on 4/20/2021 to the facility practice for shaving and oral care preferences. Facility CNAs were educated on 3/30/2021 to ADL cares and following resident preference to shave and oral care. Monitoring will be accomplished through an audit by center administration x1 daily for 1 week, weekly for 4 weeks, and monthly or as indicated by QA committee to ensure resident bathing preferences are maintained. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification. Alleged date of compliance 4/28/2021.	

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F 677	Continued From page 25 During observation on 3/23/21, at 3:20 p.m. R26 sitting up in Broda chair and still has not been shaved. 1/4-3/4 inch coarse, gray and white hairs on chin, under chin, and cheeks. During observation on 3/24/21, at 8:52 a.m. R26 sitting up in Broada chair, continues to be unshaved. During interview on 3/24/21, at 9:28 a.m. nursing assistant (NA)-E stated she tried to shave R26 this morning but his razor is broken. NA-E stated she tries to shave the resident every day if possible. NA-E stated she is not sure how long his razor has not been working, but appears he hasn't been shaved in a while. NA-E stated she will bring the razor to the social worker and try to find another razor to shave him. During interview on 3/24/21, at 12:54 p.m. registered nurse (RN)-B stated she was only made aware of the broken shaver today and family will not supply a new one as they just got him one. RN-B stated as long as he wishes to be shaved he should be. RN-B stated that she already is working on getting him a new one. During interview on 3/24/21, at 1:04 p.m. NA-E stated that R26 was now shaved and she applied some oil to his face as it was rough. NA-E stated R26 tolerated being shaved well. NA-E further stated that she found out that someone lost the head to the razor and that is why it is not working, but not sure how long it hasn't been working for. NA-E stated if a residents razor is not working there is a spare on the North end that they can used and clean and that they should also bring the broken razor to the social worker.	F 677		

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F 677	Continued From page 26 During observation on 3/24/21, at 1:05 p.m. R26 face appears smooth and without scruffy hair on face or neck. During interview on 3/24/21, at 1:44 p.m. NA-B stated she shaves residents every week or so, but some need to be shaved daily if there hair grows fast. NA-B stated R26's razor has been broken for about a week or so and that there is a universal one on North side that staff can use. NA-B further stated that if a resident looked scruffy and hair was growing out they should go to the North end to get the universal razor. NA-B stated R26 use to have really long facial hair, however, now prefers it to be shaved. During interview on 3/25/21, at 9:24 a.m. licensed practical nurse (LPN)-B stated R26 requires staff assistance for being shaved and the head of the razor is broken, but staff should still be able to use the side piece for shaving him or using the universal razor on the North end. LPN-B stated R26 does have behaviors and sometimes will hit out at staff when being shaved, however they should attempt it at a later time. During interview on 3/25/21, at 9:52 a.m. Director of nursing (DON) stated men should be shaved according to the care plan and each resident is different in this expectations. DON stated if someone's razor is broken they should use the one at the facility until their razor is replaced and should be reported to the unit manager. DON stated it would not be acceptable to leave them unshaved. DON stated they do a periodic walk through to make sure that residents are being shaved. DON further stated shaving should be under personal hygiene which is done daily and with R26 should be reproached if he had	F 677		

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F 677	Continued From page 27 behaviors during first attempt. Shaving the resident policy revised 2/2018, indicated "The purpose of this procedure is to promote cleanliness and to provide skin care. The following information should be recorded in the resident's medical record: the date and time that the procedure was performed, the name and title of the individual who performed the procedure, If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. Any problems or complaints made by the resident related to the procedure, if the resident refused the treatment, the reason(s) why and the intervention taken. The signature and title of the person recording the data. Reporting:notify the supervisor if the resident refuses the procedure. report other information in accordance what facility policy and professional standards of practice." R31's quarterly MDS, dated 2/5/21, indicated R31 was cognitively intact, was able to make herself understood and required physical assistance to complete personal hygiene. Further, R31's care plan, dated 12/28/20, indicated R31 required assistance from staff to set up for oral cares twice daily. On 3/22/21, at 1:51 p.m. R31 indicated staff had not set her up or provided assistance with oral for three weeks. R31 stated she had communicated this to staff and requested staff set her up so she could brush her teeth, but it did not happen.	F 677		

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F 677	Continued From page 28	F 677		

During the interview, R31's teeth were observed to have a thick, white substance on her upper and lower teeth across the front of her mouth. This substance started at the gum line and extended halfway to the end of each tooth.

On 3/23/21, at 8:38 a.m. R31 stated she did not receive help from staff to set up her toothbrush or to assist with oral care before going to bed on 3/22/21 or that morning after breakfast and voiced she did not know where her toothbrush or toothpaste even were. At this time, the same thick white colored substance observed the day prior, on 3/22/21, remained on R31's upper and lower teeth across the front of her mouth.

On 3/24/21, at 7:28 a.m. nursing assistant (NA)-E was observed assisting R31 with morning cares. However, R31 was not set up to complete oral cares. NA-E commented to R31 that she would set her up to brush her teeth after breakfast, but she must of have brushed her teeth the evening before because the toothbrush was wet. R31's toothbrush was noted to have a drop of water on the bristles, but the bristles had dried toothpaste on them, the bristles were dry and did not move when light pressure was applied.

On 3/24/21, at 8:55 a.m. R31 stated, "No, I didn't get them brushed last night. That is why I want them brushed this morning." R31 continued with the observed thick, white substance on R31's upper and lower teeth across the front of her mouth.

On 3/24/21, at 9:31 a.m. licensed practical nurse clinical coordinator (LPN)-B stated personal hygiene included brushing the resident's teeth or setting up the resident to brush their own teeth.

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F 677	Continued From page 29 LPN-B confirmed R31's care plan indicated R31 required staff assistance for personal hygiene, if R31 is able to brush her teeth, then staff should set her up. LPN-B expected this to be complete twice a day, or more often if the resident requested it. LPN-B looked in R31's mouth, then confirmed there was thick, white substance on R31's upper and lower teeth across the front of her mouth. LPN-B looked at R31's toothbrush and confirmed it had been, "a while," since the toothbrush was used as she threw the toothbrush, toothpaste and emesis basin these items were in, into the garbage can. On 3/25/21, at 9:55 a.m. R31 was observed in her bathroom, brushing her teeth. R31 stated she was not set up to brush her teeth prior to bed on 3/24/21. The previously noted thick, white substance was no longer noted on R31's teeth. On 3/25/21, at 10:49 a.m. the director of nursing (DON) stated she expected oral care to be completed according to each resident's care plan. If the assigned staff was not able to complete oral care, the assigned staff should have asked if another staff was able to assist or let the nurse know so the care can be completed. A provided Activities of Daily Living (ADLs), Supporting, policy, revised March 2018, indicated, "Appropriate care and services will be provided for residents who are unable to carry out ADLs independently." Oral care was included in this section. A facility policy regarding oral care was requested, however, none was received.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident	F 679		4/28/21

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F 679	Continued From page 30 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to promote activities of interest for 1 of 2 residents (R37) reviewed who complained about a lack of meaningful activities in the facility on weekend and evening hours. In addition, the facility failed to ensure activities of interest were consistently provided to promote quality of life for 1 of 1 resident (R7) observed to not attend activities. Findings include: LACK OF ASSESSMENT R37's admission Minimum Data Set (MDS), dated 2/18/21, identified R37 had intact cognition and required extensive assistance with her activities of daily living (ADLs). Further, the MDS outlined it was, "Very important," to R37 to do her favorite activities while in the nursing home. The MDS recorded R37 considered having music to listen to, being around animals, and doing activities with groups of people also as, "Very important."	F 679	Activities Meet Interest/Needs of each Resident §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community Resident 37 was reassessed for therapeutic recreation needs and plan of care updated. Resident 7 was reassessed for therapeutic recreation needs and plan of care updated. To ensure other residents have an accurate therapeutic recreation	

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F 679	Continued From page 31 When interviewed on 3/22/21, at 3:16 p.m. R37 voiced she enjoyed going to the activity programs in the nursing home and attended "every one of them" offered. However, R37 expressed there was not enough activities to do on the weekend or evening hours adding, "There's nothing." R37 stated she just sits in her room and watches television then. Further, R37 stated she had mentioned to the staff before about needing more activities on the weekends and evenings but is just told "we're working on it." R37's most recent MHM (Monarch Health Management) Therapeutic Recreation Evaluation, dated 2/15/21, identified R37 was alert and oriented to person, place and time with dictation reading, "wants to attend all activities." The assessment outlined R37's activity preferences which included cards, other games, crafts or art, walking or wheeling outdoors, trips or shopping, gardening or plants, and, "would like all the activities, besides reading." R37 was listed as being enthusiastic and willing to try the activities at the nursing home; and needed minimal cues or prompts to engage in group-based activities. A section labeled, "Program Plan," outlined R37 enjoyed bingo, music, church, crafts, and games; along with one-to-one activities and cards. A final section item labeled, "Resources / Interventions required," had written dictation which outlined, "no comment." R37's care plan, dated 3/4/21, identified R37 was independent to choose the activities she wanted to attend and listed a goal which read, "To encourage to attend activities for socialization, for something to do, and or a little busy work." The care plan listed two interventions to help R37	F 679	assessment a facility wide audit was completed on 3/25/2021. Facility therapeutic recreation staff were educated to proper documentation requirements on 3/26/2021 by therapeutic recreation director. Therapeutic recreation director as part of the QAPI process completed a survey of resident preferences related to therapeutic recreation on 3/5/2021 to ensure that preferences are being met and determine needs for future programming requests. Therapeutic recreation director evaluated programming for nights and weekends and facility offers programming per resident preferences. Staff inserviced on 4/20/2021 to the facility practice for therapeutic recreation programming. Monitoring of assessments will be completed through an audit by therapeutic recreation director x1 daily for 1 week, weekly for 4 weeks, and monthly or as indicated by QA committee to ensure resident bathing preferences are maintained. Allegation of compliance is 4/28/2021.	

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F 679	Continued From page 32 meet this goal which read, "Keep a current activity calendar in room for their viewing and choosing pleasure ..." and, "Respect the residents right to refuse the offer of activities, but make all we have available if they would like to." During interview on 3/23/21, at 1:50 p.m. nursing assistant (NA)-C stated R37 attended activities "once in awhile" she recalled; however, had repeatedly heard R37 voice there was "nothing to do in this damn place." NA-C explained R37 had last complained of such over this past weekend and expressed she didn't want to remain in the nursing home due to there was "nothing to do." NA-C stated R37 was frequently observed to be "pretty much just in her room" and looking out the window or rummaging through her belongings. When interviewed on 3/23/21, at 2:02 p.m. NA-G stated R37's activity involvement seemed to "depend on her mood" but acknowledged she did witness her attend various group-based activities such as bingo. NA-G stated she had heard R37 complain in the past of a lack of things to do in the nursing home and ask staff repeatedly, "What can I do[?]" or, "What is there to do?" NA-G stated she felt R37 was offered activities throughout the day but added she "can't say 100%." R37's medical record was reviewed and lacked any evidence R37 had been comprehensively reassessed for her activity desire and/or involvement needs despite repeated complaints to the staff about a lack of activities of being bored. There was no evidence the facility had reviewed what, if any, options were available to include or provide R37 with additional activities involvement to ensure her quality of life while	F 679		

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F 679	Continued From page 33 residing in the nursing home. On 3/23/21, at 2:53 p.m. therapeutic recreation assistant (TR)-A was interviewed and verified she had worked with R37 throughout her stay at the nursing home. TR-A explained R37 did attend the activity programs and would often "share her thoughts" on them which were "both good and bad." R37 routinely attended activities such as bingo, Jingo and "Fancy Fingers" which TR-A voiced R37 as being typically receptive to most activities programs offered to her. TR-A stated she was aware R37 had voiced there "could be more activities" on the weekends and in the evenings and added R37 made these comments to her "everyday I work." As a result, TR-A stated she brought R37 down to her supervisor, therapeutic recreation director (TRD), and had them discuss the issue. When questioned on actions or the assessment of R37 since she's been making such comments, TR-A voiced she had approached the issue with more just directing her to "come to what we have" as she has no ability to change the activity programs. R37's POC (Point of Care) Response History - Activity flowsheet, dated 3/10/21 to 3/23/21, identified all the activities R37 had attended during the period. This identified only four (4) days (3/11/21, 3/12/21, 3/16/21, and 3/18/21) R37 was recorded as having an activity completed during the evening hours (after 5:00 p.m.). The sheet recorded R37 as attending the provided table game and group movie on 3/13/21 (Saturday), and the religious service and table game on 3/13/21 (Sunday). Further, on 3/20/21 (Saturday) R37 attended the table game and food event, and the religious service and a 1:1 visit on 3/21/21 (Sunday). There was no other evidence	F 679		

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F 679	Continued From page 34	F 679		

provided demonstrating what, if any, other personal or group activities had been offered or attempted with R37 on these weekend days.

On 3/23/21, at 3:03 p.m. TRD was interviewed and verified knowledge R37 had voiced concerns with a lack of activities on the weekends and evening hours. TRD voiced she provided R37 with an activities calendar and explained to her there was "something every single day" for her to do" adding these programs were what they had been able to offer "at this time" given the low census and staffing needs of the department. TRD acknowledged she had not comprehensively reassessed R37 to determine what, if any, individual or other group activities could be provided to her; nor had she started a formal grievance process to ensure R37's concerns were addressed. TRD voiced it was important to ensure residents were assessed and their activities needs' met to ensure their quality of life at the nursing home.

A provided "Documentation, Activities" policy, dated 6/2018, identified TRD was responsible to ensure appropriate departmental documentation was maintained, and any completed activity assessments would be recorded in the medical record. However, the provided policy lacked any steps or procedures on ensuring voiced issues or concerns with the activity department were addressed and/or assessed to ensure resident' quality of life.

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F 679	Continued From page 35	F 679		

Surveyor: Elhard, Kathy
R7's admission minimum data set (MDS) dated 12/24/21, identified severely impaired cognition, required total assistance with transfers, and extensive assistance with her activities of daily living (ADLs). The MDS also identified R7 considered listening to music, the news, and religious services also as very important.

Review of R7's Moments Hospice document identified activities: Keep a current calendar in her room for her viewing and choosing pleasure of the activities we offer. Respect her right to refuse this offer of activities.

R7's care plan last revised 1/11/21, identified R7 independent to choose the activities she would like to attend while here. We will encourage, once she is feeling up to it if she would like to participate or receive the 1:1 activities that we offer. The care plan listed two interventions to help R7 meet this goal: "Keep a current activity calendar in room for their viewing and choosing pleasure ..." and, "Respect the residents right to refuse the offer of activities, but make all we have available if they would like to."

R7's medical record was reviewed from admission 12/16/20 through 3/23/21 lacked any evidence R7 had been comprehensively reassessed for her activity interest and/or involvement in the facility offered activities

R7's activity assessment was requested however, not received.

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F 679	Continued From page 36	F 679		

During observations on 3/23/21, at 1:41 p.m., 2:44 p.m., 3:34 p.m., and 3:52 p.m. R7 sat in the Broda chair awake while watching the television game show "password puzzle." When asked at 3:52 p.m., R7 stated, "I like talk shows."

Review of the Meeker Manor March activity events calendar for 3/23/21, indicated 8:15 a.m. to 9:30 a.m. spa hand massages, 9:30 a.m. to 11:15 a.m. devotional readings, room to room 1:1 visiting with everyone, 9:30 a.m. to 11:15 a.m., 2 p.m. matching game chapel, and 6:45 p.m. to 7:30 p.m. Dominoes. The POC response history - activity flow sheet dated 3/23/21, identified R7 at 11:09 a.m. and 3:16 p.m. as unavailable.

R7's POC response history - activity flow sheet, dated 3/11/21 to 3/23/21 (13 days), identified all the activities R7 had attended during the period. The flowsheet identified only three days (3/12/21, 3/18/21, and 3/21/21) R7 was recorded as having an activity completed. The sheet recorded R7 as attending the group movie on 3/12/21 (Friday), reading/local paper/library cart/book club 3/18/21 (Thursday), and religious service 3/21/21 (Sunday). Further, on 3/11/21 R7 was recorded for the scheduled activity ([Manicure/painting fingernails) as not applicable. Additionally, the activity flowchart identified twenty-one (21) times R7 was not available out of twenty-nine (29) times approached.

During an interview on 3/24/21, at 11:33 a.m. licensed practical nurse (LPN)-F indicated R7's activities included reading to her in the room. LPN-F also indicated the hospice aids spends a lot of time interacting with R7. LPN-F also identified R7 really enjoys a manicure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

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F 679	Continued From page 37	F 679		

During an interview on 3/24/21, at 12:09 p.m. recreation director (RD) identified the documentation titled POC Response History identified R7 was unavailable. RD verified unavailable indicated R7 maybe in the bathroom, hospice was with her, or sleeping in her room. RD indicated we do not wake residentis up when we see they are sleeping. RD also identified R7 played bingo with staff assistance and was very happy to get to play.

During a follow-up interview on 3/25/21, at 9:47 a.m. with RD verified R7 attended only three activities in a 14 day period of time. RD indicated when activity staff prepared for a large group activity they did not have time to complete one-to-one time with R7. RD also verified R7 did not receive one-to-one time activity on the POC Response History in a 13 day period of time (3/11/21 - 3/23/21). RD stated we certainly could improve on the one-to-one time with R7. RD also stated printed articles from the newspaper had been given to R7 to read however RD was not sure if R7 was able to read them independently. RD indicated activity staff checked with R7 once and then if not available, they moved on to check with other residents; they are unable to check more than once. RD identified R7 did not have any one-to-one activity visits and needed to be assessed to determine what changes could have been made to spend more time with her. At 10:45 a.m. RD-B approached surveyor and identified the POC Response History Document did not identify why one-on-one activities were not being completed and why R7 resident was unavailable. RD-B stated this document will be changed to better assess each resident's situation and provide more individualized care.

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to comprehensively assess, develop appropriate interventions, and adequately monitor efficacy of the interventions to promote resident sanitary food practices for 1 of 1 residents (R39) reviewed for personal food storage. Findings include: R39's annual Minimum Data Set (MDS), dated 2/12/21, identified R39 had intact cognition with a diagnosis of depression who had been on a physician-prescribed weight loss regimen. On 3/22/21, at 2:46 p.m. during an interview with R39 in his room, it had been observed R39 had dirty dishes and multiple containers sitting around his room that contained uneaten food, along with numerous empty containers with food remnants remaining in them. R39's room had an unpleasant odor to it. On the spare bed, there had been an unburied larger clear plastic container, approximately four liters in size, which contained a spoon and an unidentified item. All sides and lid of the container, along with the	F 684	Quality of Care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices Resident 39 has been educated on food handling policy on 4/20/2021. Resident 39 has been informed of risks and benefits in improper food storage. Resident 39's care plan has been updated to ensure interventions are placed for proper food storage and intervention when resident refuses interventions. An audit of all residents with personal refrigerators was conducted by infection control nurse on 3/26/2021. A care plan review of all presidents was completed on 4/25/2021. There are no other resident with food hoarding behaviors.	4/28/21

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F 684	Continued From page 39 spoon and the unidentified item, had been covered with darker colored mold. R39 stated he had felt the container held ribs in which the container "got buried" and had "been there a week." On the same bed, there had been a 950 milliliter shallow rectangular clear plastic container with sauerkraut in it. R39 explained he had taken it out of the fridge "yesterday [3/21/21]" and "will take it down [to the kitchen]" when he had a chance. On the room's television stand, there had been two clear smaller square plastic containers; one contained cheese sauce and the other contained chicken. R39 stated the chicken container had been there since 11:00 a.m. that morning and he would put it back in the fridge when he had finished eating it. R39 voiced, "Staff help with the dishes when they have time;" however, he explained, "They could do it [take the dishes to the kitchen] if there were enough staff to do it, but I could get it done before them." R39 stated when he accumulated a "bunch of dishes together" he brought them down to the kitchen to be washed, in which he explained, "I take them on Tuesdays." When R39 had been questioned on staffs' response to the dirty dishes, he stated, "They just leave it." R39 voiced he preferred to obtain his own food items which he heated up by himself as he had not cared for many of the facility provided meals delivered to him. On 3/23/21, at 2:50 p.m. during a subsequent interview with R39, all the containers observed on 3/22/21 remained in the exact same locations. R39 denied he had talked to staff about the dirty dishes and containers. When R39 had been questioned about his plan for the dirty dishes and eight plastic containers located around his room, he stated, "I will get it all." In addition, R39 explained that in about an hour from that time he	F 684	Monitoring will be accomplished through an audit by DON or designee x1 daily for 1 week, weekly for 4 weeks, and monthly or as indicated by QA committee to ensure proper food storage is maintained by infection control nurse or designee. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification. Allegation of compliance is 4/28/2021.	

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F 684	Continued From page 40 would have the chicken container placed back in his refrigerator as "that's good" and voiced he had ate "a little bit of the chicken for breakfast." R39 denied gastrointestinal concerns. R39's alteration in mood and behavior care plan, dated 2/27/20, indicated R39 had a history of throwing food away in the garbage, past statements of his having wished to die, and refusal of medications which directed staff to "be alert to mood and behavioral changes" and to offer "foods/fluids" as one of the multiple non-medication approaches when behaviors observed. R39's morbidly obese care plan, dated 2/28/20, indicated R39 had a history of energy intakes greater than his energy expenditures which directed staff to encourage low sugar items when R39 had been seen at the vending machines. Prior to 3/25/21, the care plan lacked documentation of R39's trips to Walmart with his having brought back high calorie food items, potential food hoarding tendencies, or food sanitation concerns. R39's Clinical Nutritional Assessment, dated 2/10/21, identified R39 had a weight of 287 pounds with a meal intake which ranged from 50 -75%. R39's diabetes had been controlled with diet and medication usage and that R39 had been meeting his estimated nutritional needs. The assessment identified R39 had been independent at meals with as needed setup assist. The assessment lacked documentation of R39 having been non-compliant with following his diet orders or potential food hoarding tendencies. An interdisciplinary team (IDT) care conference form, dated 2/12/21, indicated R39 had a history of going out to Walmart for shopping purposes	F 684		

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F 684	Continued From page 41	F 684		

and kept high calorie/sugar items in his room.

A regulatory medical provider visit, dated 2/19/21, identified R39 had morbid (severe) obesity due to excess calories with a weight of 290; however, the dictation indicated R39's weight had been "trending down." Further, the dictation indicated R39 had a history of cognitive impairment and major depression that had led to issues of non-compliance. The dictation lacked documentation R39 had potential food hoarding tendencies.

A progress note, dated 3/1/21, indicated R39's weight had begun "to trend back up in past month." R39 had continued on a consistent carbohydrate diet with meal intakes approximately 75%. Per the note, the medical provider had been updated on 2/14/21 and staff were to continue to encourage R39's diet compliance while praising healthy food choices. R39's weight gain had been reported as possibly having been related to diuretic use. The note lacked documentation R39 had diet non-compliance or potential food hoarding tendencies.

R39's Kardex (nursing assistant care plan), dated 3/23/21, identified under the heading "Behavior" that staff had been directed to "Be alert to mood and behavioral changes." Under the "Activities" heading, R39 "Independently goes to Walmart on his own." The Kardex heading "Eating/Weight Loss" directed staff to encourage low sugar items when he had been seen at the vending machines and identified R39 had a "diabetic diet." The Kardex lacked interventions related to R39's potential food hoarding tendencies or staff directions to monitor and/or assist with food

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F 684	Continued From page 42 sanitary concerns. R39's Order Summary Report, dated 3/25/21, indicated R39 had been prescribed a consistent carbohydrate diet. The report lacked medical provider and/or nursing orders to monitor R39's room for sanitary food practices. During interview on 3/23/21, at 3:24 p.m. nursing assistant (NA)-J stated R39 enjoyed "a lot of the outside food" in which R39 would eat the facility provided meal but would get hungry and then "snack." NA-J acknowledged he had assisted R39 with food prep and denied he provided R39 with his personal fridge management. NA-J explained he had in the past asked R39 if he could help R39 clean up the food containers to which R39 has had periods of declined assist; however, NA-J has emptied the garbage when food items had been disposed of. NA-J voiced if R39 would decline to allow assist to dispose of old food he would update the nurse. NA-J denied having ever observed containers with mold. NA-J confirmed he had been in R39's room on 3/22/21 to administer medications and then again that day to supply R39 with fresh water. NA-J stated he had never seen R39 cleaning any of the used containers in his room; however, he voiced, "He might use the sink in the bathroom." When NA-J visualized the containers on the spare bed, he stated, "Oh, this is not good. There is some mold in there." NA-J stated he had been surprised he had not seen the containers on 3/22/21. NA-J had asked R39 if he could put the sauerkraut container back in the fridge; however, R39 stated to throw it away. When NA-J questioned R39 on the chicken container, R39 rolled his eyes and stated in an annoyed voice, "Go ahead." NA-J	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 43	F 684		

explained to R39, "You cannot eat food that has been out that long." R39 had initially wanted the cheese sauce container left alone; however, when NA-J read the label of an unopened can of cheese sauce to R39, which directed to refrigerate after opening, R39 voiced, "Well then you are going to have to throw that." NA-J obtained R39's approval to look for additional container issues in R39's room in which NA-J had found a total of 11 dirty containers. NA-J stated, "This is an eye opening thing there." NA-J explained he definitely had to talk to the nurse to make sure that things were being refrigerated and that R39 was getting the help he needed with the containers. NA-J explained, "We are aware he is hoarding food, but not aware he was keeping chicken out." NA-J stated R39 could get diarrhea from eating spoiled food with an additional statement of, "That is very bad."

When interviewed on 3/24/21, at 12:55 p.m. trained medication aide (TMA)-B stated she typically had been in R39's room two to three times a day when she passed medications and about every two to two and a half hours when she worked as a nursing assistant. TMA-B acknowledged R39 had "a lot of food in his room" and she explained, "[R39] goes out to Walmart quite frequently and buys and abundance." She stated several weeks ago she had found "soggy lettuce," "spoiled stuff," and "moldy cheese" in R39's fridge. TMA-B explained around that same time R39 had asked her to warm up something that had been "sitting out for a while;" however, she had encouraged him not to eat it, in which he had been okay with her disposing of it at that time. Further, TMA-B explained she had previous conversations with R39 about not eating food that had been left out. TMA-A acknowledged she had

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F 684	Continued From page 44	F 684		

not conversed with the nurse manager or the nurse when these conversations with R39 had occurred. TMA-B denied a process had been in place to check R39's room for spoiled food or other food concerns. She voiced she had thought housekeeping handled it.

During interview on 3/24/21, at 1:19 p.m. NA-B stated she had been aware that R39 hoarded food and that R39 had food that sat out that should have been refrigerated. NA-B explained during the "last month or two" R39 had been going out to Walmart in which she would help him put food in his fridge. She has observed expired food items in R39's fridge and explained she had had conversations with R39 about not keeping expired items in his fridge. NA-B acknowledged she took dirty containers down to the kitchen about two weeks ago; however, she lacked knowledge of who had been responsible to assist R39 with container management and denied staff had been directed to monitor R39's room for food concerns. NA-B explained she had felt housekeeping may have managed it. She denied she had told other staff about any food issues she had observed.

When interviewed on 3/24/21, at 1:36 p.m. housekeeper (H)-A acknowledged she had cleaned R39's room; however, she denied she had ever seen dirty food containers or unrefrigerated food sitting out for multiple days. H-A denied knowledge of a process in place to monitor R39's room for spoiled food or to assist with dirty dishes or container management.

During interview on 3/24/21, at 1:43 p.m. dietary aide (DA)-A acknowledged the kitchen staff "wash containers [for R39] all the time...

F 684 Continued From page 45 F 684

whenever he feels he wants them washed." DA-A explained "Nursing brings them [containers] down or whoever feels comfortable with them." She denied there had been a schedule in place for checking his room for dirty dishes or containers.

When interviewed on 3/25/21, at 9:25 a.m. licensed practical nurse (LPN)-C stated R39 had a behavior of keeping food in his room. LPN-C explained, "We have to keep going in there [R39's room] and throw things away." Further, LPN-C explained R39 will verbalize to staff that food items are still good when staff question him on food that has been observed to be laying out in which R39 "will normally let us throw things away." LPN-C denied having personally seen moldy food items; however, she stated other staff have informed her they have and have thrown the food away. LPN-C denied knowledge of R39 having been assessed for hoarding behavior or sanitary food processes. Further, she denied there had not been a process or plan in place to monitor R39's room for food concerns. LPN-C stated she had not communicated R39's food hoarding tendencies or food sanitary concerns to other staff due to her having assumed everyone had already been aware of it.

During interview on 3/25/21, at 10:11 a.m. care coordinator/LPN-B stated R39 "absolutely" had hoarding behaviors. She explained R39 had been happy when he had been informed he could resume his ventures out into the community. LPN-B voiced when R39 comes back from his shopping trips he "brings back a lot of things." LPN-B explained she has had conversations with R39 about "things getting icky on occasion;" however, she stated R39 had not appeared to be concerned at the time. LPN-B stated R39 had

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F 684	Continued From page 46 tried to stick to more canned food items versus perishable items; however, "we have to respect his wishes but do not want him to get sick either." She denied R39's hoarding and food sanitation concerns had been assessed, monitored, or care planned. LPN-B explained she would work on these steps so that "we could help manage how he does things so that he can be safe...They are in our care so we should keep him safe with his food. He could get sick." LPN-B acknowledged she expected staff to inform her about any food issues. A policy Handling Food Brought in for Resident's Individual Consumption, dated 1/2017, directed food brought into the facility for particular residents would be assessed by facility staff on an individual basis and any outside refrigerated food intended for resident consumption would be kept in a refrigerator except when being consumed. Further, the policy indicated if food does not require refrigeration and it can be stored in a sanitary manner in the resident's room then staff were to monitor the use.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		4/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 47 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed follow pressure ulcer interventions for 2 of 2 residents (R4 and R26) identified at risk for pressure ulcers. Findings include: R4's annual minimum data set (MDS) dated 3/17/21, indicated severe cognitive impairment along with needed extensive assistance with bed mobility and transfers. R4's face sheet dated 3/24/21, indicated diagnosis included: unspecified dementia with behavioral disturbances (Brain impairment in memory and judgement), peripheral vascular disease, insomnia (difficulty with sleeping), Alzheimer disease with late onset (a progressive disease that destroys memory and other important mental functions). R4's provider orders dated 12/23/20, indicated use foot cradle under blanket when resident is in bed to reduce pressure on feet/toes. Monitor scabs on right/left toes every shift discontinue when they heal. Betadine swab sticks swab 10% apply to first and second toes topically every morning and at bedtime for wound care. R4's tissue tolerance evaluation and skin risk factors dated 3/16/21, indicated moderate risk for skin breakdown. R4's Care plan, revised 3/4/21, indicated ADL's	F 686	Treatments to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that— i. A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and ii. A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Resident 4 plan of care was reviewed on 3/26/2021 to ensure skin interventions are in place and appropriate. Resident 26 plan of care was reviewed on 3/26/2021 to ensure skin interventions are in place and appropriate. To ensure other residents skin interventions are active and appropriate, a house wide audit was completed on 3/26/2021. Facility nurses and CNA's were educated to the expectation of ensuing appropriate skin interventions are in place at all times for all residents on 3/20/2021. Facility staff	

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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 686	Continued From page 48 extensive assistance with dressing, showering, bed mobility and personal hygiene. R4's care plan further indicated vulnerable with mobility limitation, communications, staff will provide daily cares as per care plan and will notify nursing when plan needs updating for accuracy. Risk for skin integrity with interventions of monitoring skin integrity every shift with cares and on bath days, apply lotion to dry skin, and reposition approximately every 2-3 hours and as needed (prn). R4's care plan indicated risk for skin integrity which lacked any information about the foot cradle. R4's weekly skin assessment dated 3/17/21, indicated right toes remains discolored ongoing. Review of skin assessment dated 3/10/2, indicated right foot great toe and second digit scabbed areas ongoing. During observation on 3/22/21, 1:15 p.m. R4 laying on left side in bed with blankets on top of feet covering entire body. Foot cradle was observed sitting on the floor next to the wall under the tray table. During observation on 3/23/21, at 1:59 p.m. R4 laying on left side with blankets covering body from neck to below toes, foot cradle was again observed sitting on the floor, next to the wall under the tray table. No concave mattress was observed in use. During interview on 3/23/21, at 2:35 p.m. nursing assistant (NA)-A stated being unaware of R4 should be using the foot cradle while in bed but would assume the cradle should be kept on her bed and utilized to prevent further break down of	F 686	were inserviced on the need to ensure skin interventions are in place and appropriate on 4/20/2021. Audits of 3 pressure ulcer interventions will be completed weekly x 4 then monthly x2 months to ensure that residents are being assisted with their interventions per their individualized plan. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification Allegation of compliance is 4/28/2021.	

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F 686	Continued From page 49 her toes. NA-A stated R4 had scabs on her toes that the nurses are monitoring. NA-A stated she has never seen the foot cradle on R4's bed. NA-A further stated she follows the Kardex which tells her how to care for the residents and did not see this listed on there. Immediately following interview, at 2:42 p.m. NA-A left R4's room, without implementing foot cradle, and walked down the hallway into another residents room, R4 continues to lay on left side with blankets on her feet/toes and foot cradle on the floor. During observation on 3/24/21, at 7:24 a.m. R4 lying in bed toes/feet have blankets on them and foot cradle sitting on floor, next to wall and under the tray table. During interview on 3/24/21, at 7:24 a.m. NA-B stated R4 has sores on her right great toe and second toe of the right foot which the trained medication aid or nurse will treat before getting R4 up for the day. NA-B stated since she has been employed she has never seen the foot cradle being used which has been for approximately 7-8 months and would look to the Kardex for interventions for the residents. During interview on 3/24/21, at 9:19 a.m. Licensed practical nurse (LPN)-A stated R4 should have the foot cradle on the bed if there was an order for it. LPN-A stated R4 has scabs on her right toes that are being monitored and treatments done per order. LPN-A further stated the staff look to the care plan/Kardex when caring for residents and would think that those interventions should be on there.	F 686		

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F 686	Continued From page 50 During interview on 3/24/21, at 9:21 a.m. LPN-B stated that R4 should be using the foot cradle due to her sores on her toes. LPN-B stated it is important the foot cradle to prevent further break down and relieving pressure to her toes. LPN-B stated all interventions should be on the care plan for staff to follow as this indicated how to care for the resident. During interview on 3/25/21, at 9:56 a.m. Director of nursing (DON) stated R4's foot cradle should be on her bed to prevent pressure on her feet and to prevent further breakdown and would expect that it would be listed on the Care plan. DON stated she would expect staff to be following the residents care plan. R26's face sheet dated 3/24/21, indicated diagnosis include: Parkinson's disease (disorder that affects movement), major depressive disorder, anxiety disorder, post traumatic stress disorder, dementia in other diseases classified elsewhere with behavioral disturbances (impairment of memory and functioning), and muscle weakness. R26's MDS dated 2/3/21, indicated severe cognitive impairment and required extensive two assist with transfers and bed mobility. R26's required extensive assistance with activities of daily living. R26's order summary report dated 3/24/21, indicated Left (L) heel- remove pressure by floating heel with a pillow under calf and applying a heel cushion boot. Heel protectors to both feet. Offload heels in bed. Position blankets over bed frame. Monitor right lateral heel bruise non-blanchable as well as left heel and left toes	F 686		

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F 686	Continued From page 51 redness. Monitor bruise on top of right great toe every shift. Review of weekly pressure wound evaluation are as follows: -3/19/21, right heel pressure length 2.5 x 2.5 0 depth unstageable. -3/12/21, right heel pressure length 3.0 x 1.2 0 depth unstageable. -3/4/21, right heel pressure length 2.5 x 1.0 0 depth unstageable. R26's care plan revised on 2/10/21, Risk for alteration in skin integrity interventions to include turn and reposition every 2-2.5 hours. Elevate heels off the bed, foot cradle added to foot of bed to keep blankets off resident's toes, place pillow under legs as tolerated. Heal protectors when not wearing shoes. Notify hospice of any skin concerns. During observation on 3/23/21, at 2:06 p.m. R26 lying in bed, blankets are tucked under mattress and resting on residents feet, no elevation of bilateral feet on a pillow. During interview on 3/24/21, at 7:24 a.m. NA-B stated staff know how to care for residents by their care plan/Kardex. NA-B stated these (care plan/Kardex) list out the interventions to follow and how to transfer the resident. During observation on 3/24/21, at 8:52 a.m. R26 sitting up in Broda chair. LPN-A removed old dressing which had serosanguinous drainage noted scant amount, cleansed with wound cleanser and dried with gauze. Wound was noted to be eschar in the center with pink surrounding skin which was blanchable. LPN did not measure	F 686		

F 686 Continued From page 52 F 686

wound. Applied Mepilex with boarder. R26 tolerated well. LPN-A stated hospice measures and provides wound treatments.

During interview on 3/24/21, at 9:28 a.m. NA-E stated R26 should have pressure boots on at all times, unsure if legs are to be elevated, has not seen the foot cradle in a long time, but thinks it was removed due to the air mattress and bumping his feet. NA-E stated R26 has a sore on the right foot that has a dressing on it. NA-E added she uses the Kardex which is at the desk to know how to care for the residents.

During interview on 3/24/21, at 12:54 p.m. hospice registered nurse (RN)-B stated R26 was kicking the foot cradle so they got that discontinue and he should be having feet up on a pillow as he allows to prevent further breakdown of skin.

During observation on 3/24/21, at 1:02 p.m. R26 lying in bed with blankets over bedrail and bilateral feet elevated on a pillow. NA-E stated she placed R26 feet up on a pillow to reduce pressure now that she knows it needs to be done.

During interview on 3/24/21, at 1:08 p.m. LPN-A further stated the foot cradle was removed from his care plan by the care manager since being made aware that it was still in place by state agency. LPN-A further stated staff should be following provider orders to elevate R26's feet to prevent further breakdown. LPN-A stated care manager updates the care plan/Kardex and this should reflect the plan of care for each resident.

During interview on 3/25/21, at 9:24 a.m. LPN-B stated R26 should have his heels elevated on

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F 686	Continued From page 53 pillow as ordered to prevent further break down and further stated R26 wears heel protects as well. LPN-B stated blankets should be folded over the rail of the bed to relieve pressure and prevent further break down to resident's skin. LPN-B stated staff should be following R26 interventions that were ordered by the doctor. During observation on 3/25/21, at 9:36 a.m. R26 sitting in chair with blanket covering bilateral arms and had both heel protects on his feet. During interview on 3/25/21, at 9:52 a.m. DON stated R26's sheets should be pulled off of his feet to prevent pressure injury or add to skin break down. DON stated heel floating was important to reduce pressure of R26's heels. DON further stated it is expected for staff to follow the plan of care. Skin assessment and wound management policy dated 7/2018, indicated " Wound care will be provided per nursing or provider order. Procedure will be performed utilizing safe and sanitary methods in an effort to prevent contamination or the spread of infection. Document treatment or refusal of treatment in the resident's medical record."	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		4/28/21

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F 688	Continued From page 54 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned range of motion (ROM) exercises were consistently implemented to prevent decline and reduce the risk of contracture for 1 of 2 residents (R14) reviewed for mobility and ROM. Findings include: R14's annual Minimum Data Set (MDS), dated 10/16/20, identified R14 had intact cognition and demonstrated no delusions or other behaviors. Further, R14 required extensive assistance to complete most of her activities of daily living (ADLs); however, the section to record functional limitation(s) to her ROM were dashed and did not record if any impairment existed. R14's Therapy Recommendations sheet, dated 6/11/19, identified a Restorative Nursing Program for R14 which included, "U/E [upper extremity] ROM 6x/wk [six times a week] - 10 reps [repetitions]," and, "L/E [lower extremities] Ex's [exercises] 2x/wk - 15 reps." Further, R14's care plan, dated 3/5/21, identified R14 was alert and orientated to person, place and time. The care	F 688	§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Resident 14's range of motion (ROM) program was evaluated by DON on 4/20/2021 and is reflective of current needs. A facility wide audit of ROM programs was	

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F 688	Continued From page 55 plan outlined R14 had limited physical mobility and directed to provide gentle ROM daily with cares along with, "UE/LE ROM 7X/Week 10 Reps." On 3/22/21, at 2:10 p.m. R14 was observed in her room. R14 had visible contractures of the fingers of her left hand with an applied splint in place; along with a rolled up washcloth present in the slightly closed fist of her right hand. R14 stated she was supposed to be on a ROM program for her upper and lower extremities; however, it was not always getting completed due to poor staffing in the facility. R14 voiced she went to an offsite campus for other rehab exercises a couple times a week, however, still needed the ROM programs done at the nursing home to prevent further loss of her mobility. R14 expressed these concerns had been reported to the nurses but they just always tell her "we're working on it." Further, R14 voiced she felt her fingers and joints felt tighter in the past weeks and attributed it to the lack of her ROM programs being completed. When interviewed on 3/24/21, at 10:04 a.m. nursing assistant (NA)-C stated R14 had several exercises she was supposed to be doing including a NuStep and "standing frame" program; however, these would often be refused. NA-C voiced she was aware R14 wore braces on her upper extremities and acknowledged hearing R14 voice her ROM exercises weren't being completed adding, "She does a lot [complain about it]." NA-C stated R14's ROM was supposed to be done "when she wakes up," however, then voiced she was unaware a lower extremity ROM program was care planned adding, "As far as I [knew] we didn't have to [do the lower ROM]."	F 688	performed to ensure that residents with ROM programs are receiving their program on 4/19/2021. Facility Nursing staff and CNA's were educated on the need to completed ROM on 4/23/2021 by DON or designee. Facility staff were inserviced on 4/20/2021 in regards to expectations with ensuring completion of ROM programs. Monitoring will be accomplished through an audit by DON or Designee for 3 residents per week x4 weeks. Then 5 resident's per month for 2 months. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification Allegation of compliance is 4/28/2021.	

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F 688	Continued From page 56 NA-C expressed R14's exercises may not be getting done consistently as R14 favors certain staff members to care for her and others may not complete the programs "the way she wants," however, verified she was unsure. NA-C explained R14 had not really complained about increased pain, nor had NA-C observed more tightening or stiffening in R14's extremities in the past months. Further, NA-C stated any attempted or completed exercises, including ROM programs, would be recorded by the NA staff in the PointClickCare charting system. During interview on 3/24/21, at 10:25 a.m. NA-F stated she routinely worked with R14 and voiced she had heard R14 complain before that "her contraction" was "kind of stiff," however, NA-F did not feel R14 had sustained a decline in her overall ROM in the past months. NA-F voiced R14 had mentioned before her ROM programs to her upper and lower extremities were not being completed adding she last heard her voice such a complaint "maybe a week ago or so." Further, NA-F expressed she believed the night shift was responsible to complete R14's ROM exercises adding, "I want to say nights do [them]." R14's Documentation Survey Report(s) v2, dated 2/2021, identified tasks to be completed for R14. This included, "Floor Aides: L/E exercise 2x/wk 15 reps also Be [sic] sure do ROM daily on evening her hands, arms and legs, 7 days per week this needs to be done daily by the CNA's if there is no restorative aids [sic]." This was recorded as being completed only two times in February 2021, on 2/1/21 and 2/4/21. The remainder of the areas to record the exercise minutes and rep(s) were either left blank, or had "NA [not applicable]" dictated. In addition, the	F 688		

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F 688	Continued From page 57 report outlined another task which read, "Floor Aides: Passive ROM U/E ROM 5x/wk 10 reps." This was recorded as being completed only once in February 2021, on 2/1/21. The remainder of the areas to record the exercise minutes and rep(s) were either left blank, or had "NA [not applicable]." R14's Documentation Survey Report v2, dated 3/2021, identified tasks to be completed for R14. This included, "Floor Aides: L/E exercise 2x/wk 15 reps also Be sure do ROM daily on evening her hands, arms and legs, 7 days per week this needs to be done daily by the CNA's if there is no restorative aids [sic]." This was recorded as being completed only three times in March (so far) on 3/9/21, 3/10/21, and 3/15/21. R14 was recorded as refusing the exercises only three times, on 3/19/21, 3/20/21, and 3/24/21. The remainder of the areas to record the exercise minutes and rep(s) were either left blank, or had "NA [not applicable]" dictated. There was no evidence R14 had been provided or offered her LE ROM exercises the week of 3/1/21 to 3/6/21. In addition, the report outlined a task which read, "Floor Aides: Passive ROM U/E ROM 5x/wk 10 reps." This was also recorded as being completed only two times in March (so far) on 3/9/21 and 3/15/21. R14 was recorded as refusing the exercises only four times, on 3/10/21, 3/19/21, 3/20/21, and 3/24/21. The remainder of the areas to record the exercise minutes and rep(s) were either left blank, or had "NA [not applicable]" or "No" dictated. Further, R14's medical record was reviewed and lacked any other evidence demonstrating when R14's ROM exercises had been completed and/or refused. When interviewed on 3/24/21, at 1:29 p.m.	F 688		

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F 688	Continued From page 58 registered nurse manager (RN)-A voiced R14 had a previous spinal cord injury and required extensive assistance with her mobility and ADLs as a result. RN-A reviewed R14's medical record, including the recorded minutes and reps for each exercise, and verified the exercises were not being completed or documented as they should be; nor was there evidence to demonstrate the ROM exercises were offered and refused. RN-A expressed there was "room for improvement" and voiced she was not sure if the exercises were getting done or not. RN-A stated R14's ROM exercise programs should be completed and documented as care planned to help prevent further contracture and promote strengthening adding, "They need to be done." A provided Range of Motion Exercises policy, dated 10/2010, directed how to complete ROM for a resident which included ensuring a physician's order was in place for such procedure and reviewing the care plan prior to starting for any "special needs" of the resident. The policy then outlined specific physical step(s) on how to complete various ROM exercises and concluded with directing appropriate documentation was recorded in the medical record, and, "Report other information in accordance with facility policy and professional standards of practice."	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		4/28/21

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F 689	Continued From page 59 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure concerns related to potential burn hazards surrounding higher hot water temperatures in resident accessible locations were communicated and addressed by maintenance for 15 of 15 residents (R4, R8, R10, R19, R23, R29, R34, R37, R47, R48, R50, R52, R505, R555, R556) who communicated the hot water in their bathroom faucets were too hot. In addition, the facility failed to ensure assessed and care planned interventions were implemented immediately after a fall in order to minimize recurrent falls and/or injury for 1 of 1 residents (R55) reviewed for falls. Further the facility failed to ensure adequate supervision to prevent accidents for 1 of 1 residents (R40) reviewed for accidents. Findings include: HOT WATER On 3/22/21, from 1:10 p.m. to 6:57 p.m. several resident room bathroom sink faucets were tested amongst all four facility' units. 15 occupied resident rooms (R4, R8, R10, R19, R23, R29, R34, R37, R47, R48, R50, R52, R505, R555, R556) were found to have hot running water in the bathroom faucets which required surveyor to pull hand away after only a few seconds to avoid getting burned. When interviewed on 3/22/21, at 2:18 p.m. R47 had initially verbalized, "Look out, it [hot water in bathroom sink] can be hot," after the surveyor	F 689	Free of Accidents and Supervision The facility must ensure that – §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. R4, R8, R10, R19, R23, R29, R34, R37, R47, R556 all had room water temperature adjustments on 4/8/2021. R48, R50, R52, R505, R555 all have discharged from the facility. However, room water adjustments occurred on 4/8/2021. Resident 55 passed away on 12/2/2020. Resident 40's care plan was updated to reflect independent in room with transfers and mobility on 4/15/2021. Resident is expected to discharge home on 4/24/2021. Facility wide water temperatures were adjusted on 4/8/2021 and lowered by a contracted service provider. Maintenance director and assistant maintenance director were educated to proper water temperature regulation and ensuring that if a resident voices a concern that a grievance should be filed and investigation initiated on 4/21/2021. Facility wide audit of falls occurring in the last 30 days was completed by NHA on 4/15/2021 to ensure all fall's have an identified intervention and fall interventions are in place. Facility staff	

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	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 60 asked permission to check the bathroom sink water temperature. R47 denied having been burned by the hot water; however, R47 explained she does not put her hands directly under the water faucet stream as staff brought a basin of water to her for morning and evening cares. R47 confirmed staff had knowledge about the "water getting hot when it is running." R47 explained staff wet the washcloth from the basin and waited "a little bit" to ensure the washcloth was not too hot before they gave the washcloth to her. During interview on 3/22/21, at 2:57 p.m. R10 stated she had felt the hot water had been too hot. R10 explained due to this, "I have to use the cold [water] when I wash my hands." When interviewed on 3/22/21, at 3:28 p.m. R37 denied she had ever burned herself while she used the water; however, R27 stated she had noticed "it [the water temperature] was too hot" that day while she had been washing her hair. R37 explained 3/22/21 had been the first day she had noted the water to be "that hot; however, on 3/21/21 she stated she had witnessed a nurse using the water "and it was steaming." On 3/22/21, at 6:36 p.m. the director of maintenance (DOM) used an analog spike thermometer to assess the bathroom sink hot water temperatures in eight of the 15 resident rooms after he had been updated on the surveyors' findings. None were verified to be over 120 degrees Fahrenheit. During the hot water check, the DOM stated he had not been aware of any staff hot water concerns. During interview on 3/22/21, at 6:44 p.m. nursing assistant (NA)-A stated she had felt the bathroom	F 689	inserviced on 4/20/2021 on the need to report resident concerns of hot water, using gait belts when applicable for transfers and ensuring fall interventions are initiated timely. Monitoring of water temperatures will be completed through weekly audits of 15 rooms by the maintenance director or designee for 6 weeks. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification Monitoring of fall interventions will be completed by the DON or designee for 10 residents weekly for 4 weeks then 10 residents monthly for 1 month. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification Monitoring of staff assisted transfers will be completed through 3 transfer observations weekly for 4 weeks then 5 staff assisted transfer observations for 2 months. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification Allegation of compliance is 4/28/2021.	

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F 689	Continued From page 61	F 689		

water temperatures were hot and had periods where the temperature had been "uncomfortable" to her. Further, NA-A stated the water could burn residents' hands which prompted her to stay "close" to them when they used the water to make sure it was not too hot. NA-A explained she had concerns about the hot water temperatures since she started employment with the facility one and a half months ago; however, she voiced she had been unsure if she had communicated this concern to a nurse.

When interviewed on 3/22/21, at 6:47 p.m. NA-I stated when she worked with the residents and the hot water had been turned on by itself, without the cold, she had been unable to put her hands under the water stream. NA-I confirmed when she provided care to R47 she had to "shake" the wet washcloth out so it became cooler and not so hot on R47's body. NA-I stated she had felt there were concerns with the water since she had started employment at the facility approximately two months ago; however, she voiced she had not communicated this concern to anyone, in which she added "but most everybody knows [concerns with the hot water temperatures]."

During interview on 3/23/21, at 3:12 p.m. NA-J stated, "If you put it [hot water knob] all the way to the hottest setting it is going to burn." NA-J explained, "You have to play around until you get it (the water temperature knob] in the center...there is a trick to it." NA-J stated based on this concern he will usually adjust the water temperatures for the residents so "they do not burn themselves." NA-J denied he had communicated this concern to anyone.

When interviewed on 3/25/21, at 9:25 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 62 licensed practical nurse (LPN)-C denied knowledge of resident or staff hot water concerns prior to the interview; however, LPN-C explained the hot water in the "library area" had been "a little hot" that morning when she had turned on just the hot water. LPN-C had denied she felt this had been a concern at the time as she had added cold water to the hot and thus she had not communicated the initial hotness to other staff. On 3/25/21, at 9:50 a.m. the DOM and the maintenance assistant (MA)-A were interviewed and confirmed MA-A checked designated resident accessible water temperature locations weekly. The DOM stated acceptable hot water temperatures should be 115 degrees Fahrenheit or less to meet state regulations and 120 degrees Fahrenheit or less to meet federal regulations. The DOM explained he had adjusted the water temperature "about two months ago" due to higher water temperatures having been reported with showers, with a result of lower temperatures after follow up; however, the DOM and the MA-A denied they had knowledge of staffs' current hot water concerns. The DOM stated after he reviewed the weekly water temperature logs during the interview that he had not been previously made aware of the temperatures that had been greater then 115 degrees Fahrenheit. The DOM explained he would expect MA-A to update him on these elevated readings with an additional statement, "but with me running around, things slipped through the cracks." The DOM explained he expected all staff to bring hazard concerns to him or the MA-A "right away" as resident safety was a top priority and water temperature's outside the regulations had the potential to burn or injure the residents. The DOM and the MA-A denied knowledge of a facility	F 689		

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F 689	Continued From page 63 policy which directed them on how to check resident accessible water temperatures; however, a policy had been provided after the interview. During interview on 3/25/21, at 10:11 a.m. care coordinator (LPN)-B denied any knowledge that residents or staff had hot water concerns and had not experienced any concerns with the hot water personally. LPN-B explained she expected staff to report issues with hot water to the "maintenance supervisor right away" and alert other staff of the potential risks. A Logbook Documentation: Air Temps, Water Temps, Eye Washes temperature monitoring report, dated 2/23/21 through 3/23/21, identified designated facility locations for water temperature monitoring which included individual headings for Lane 1, Lane 2, Lane 3, and Lane 4 "Resident" and Lane 1, Lane 2, Lane 3, and Lane 4 "Resident 2". The report indicated water checks had been performed on 2/23/21, 3/1/21, 3/9/21, and 3/17/21 and identified all documented temperatures taken on these four days showed all Resident and Resident 2 Lane checks had temperatures which ranged from 116 and 119 degrees Fahrenheit. On 3/23/21, the hot water documentation for these same areas identified temperatures which ranged from 103 to 112 degrees Fahrenheit. An undated policy Water Temps: Test and Log the Hot Water Temperatures directed staff to "Ensure patient room water temperatures are between 105 [degrees] and 115 [degrees] Fahrenheit (or as specified by state requirements). Minnesota had not been identified in the list of differed requirements. Further, the policy directed staff to record the results in the water temperature log	F 689		

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F 689	Continued From page 64	F 689		

and "Note any discrepancies," "Adjust water heater settings as required," and "Retest as necessary." The policy instructs staff to use a "dial thermometer" to test water temperatures which should be calibrated on a regular basis.

FALL INTERVENTIONS

R55's quarterly Minimum Data Set (MDS), dated 10/14/20, identified R55 had intact cognition and communication abilities. Further, the MDS indicated R55 required limited physical assist for mobility and most activities of daily living (ADL's) in which R22 had instability during surface transitions and walking. The MDS identified R55 had been free of falls since the prior MDS assessment and had diagnosis of orthostatic hypotension (abnormal decrease in blood pressure when standing) and respiratory failure (failure of lungs to function properly) with oxygen used at that time.

R55's care plan, revised on 10/12/20, indicated R55 had been a fall risk related to history of falls, weakness, and assistance needed with transfers. R55's fall goal had been to be safe and free from falls. The care plan indicated a revision on 11/24/20 which identified call don't fall signs had been placed, along with anti-roll back brakes added to R55's wheelchair. The care plan failed to identify any further revisions after 11/24/20.

R55's Fall Review Evaluation, dated 1/15/20, identified R55 had multiple falls in the prior six months in which he took more than three fall risk medications and had fall risk diagnosis. The evaluation indicated R55 had been oriented and alert and had no issues with his memory. R55's

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F 689	Continued From page 65	F 689		

vision was impaired and required use of a device and hands-on assist to move from place to place in which he had been unable to independently come to a standing position. Care plan interventions at the time of the evaluation were as follows: proper footwear at all times; room to be kept clear of clutter and debris; personal items and call light within reach.

A progress note, entered on 11/16/20, at 12:44 p.m. indicated R55 had been found lying on the floor after he had been previously noted in his wheelchair with a small laceration on top of his head and a raised swollen area above the right eye. The progress note did not identify any new fall prevention interventions or documentation to support a reason for no new fall prevention interventions in response to the fall.

A Fall Scene Investigation Form, dated 11/17/20, indicated R55 had lost his strength and appeared to get weak after dialysis. The form identified R55 did not have his oxygen on prior to the fall and that R55 had been "sleepy." Further, the form identified weakness and low blood oxygen saturations had appeared to be the root cause of the fall and directed staff to lay R55 down in bed when his blood oxygen saturations were below 90%.

An Incident Review and Analysis V-3, dated 11/24/20, at 3:09 p.m. identified R55 had a fall on 11/16/20, at 12:10 p.m. The incident report indicated dietary staff had heard a crash in which R55 had been found on the floor in his room. R55 had not known what happened; however, the incident report identified R55 had returned from dialysis that day with his oxygen "off" and had oxygen blood saturations of 69% at that time.

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F 689	Continued From page 66 Staff had applied oxygen after they obtained the low oxygen saturation reading and "5 minutes later was on floor." Further, the incident report indicated R55 had not always been aware of his limitations and required assist of one. Call don't fall signs were placed on 11/24/20 in response to the fall. A progress note, entered on 11/28/20, at 4:11 p.m. indicated at approximately 2:45 p.m. R55 had been found lying on the floor with a sustained left elbow skin tear. The progress note identified R55 stated he fell after he reached for a fork he had dropped on the floor while seated in his wheelchair. A fork had been found under him when staff assisted him up off of the floor and he had been incontinent during the incident. The progress note did not identify any new fall prevention interventions or documentation to support a reason for no new fall prevention interventions in response to the fall. R55's electronic medical record (EMR) lacked evidence of a Fall Scene Investigation Form related to R55's 11/28/20 fall. R55's EMR lacked evidence of an Incident Review and Analysis V-3 related to R55's 11/28/20 fall. An Incident Review and Analysis V-3 had been requested related to R55's 11/28/20 fall; however, none had been provided. R55's record lacked evidence his physician was notified of the fall. On 3/24/21, information had been requested to support R55's 11/28/20 fall had been reviewed by the interdisciplinary team (IDT). An unnamed, undated piece of paper had been provided to the	F 689		

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F 689	Continued From page 67	F 689		

surveyor on 3/24/21, which indicated typed information R55 had been found on the floor on 11/28/20 at 4:11 p.m. Further, this indicated R55 had been free of injury and intervention(s) for the fall were "TBD [to be determined]." A hand written note on the piece of paper indicated, "This is pulled from daily clinical morning meeting report on 11/30/2020 (Monday) where falls/interventions, injuries are reviewed. (patient was admitted to hosp [hospital] on 11/30/20)."

When interviewed on 3/25/21, at 10:11 a.m. LPN-B stated staff were expected to put an "immediate intervention" in place after a resident fall which would help decrease further potential falls. The intervention(s) put into place after the fall would then be reviewed during the next IDT meeting for any needed adjustments. LPN-B stated staff always have a nurse who is on-call if they required assist with fall intervention decision making at the time of the fall. LPN-B explained staff were also expected to fill out an Incident Review and Analysis, along with a Risk Management report, after each resident fall.

During interview on 3/25/21, at 10:40 a.m. care manager registered nurse (RN)-A stated staff were expected to put "immediate interventions" in place after a resident fall. RN-A explained she would have looked to see if R55 had a grabber, "maybe Dycem (non-slip material)," or some other intervention as she "would have done something." RN-A reviewed R55's EMR and acknowledged R55's 11/28/20 fall progress note; however, she confirmed the EMR lacked information that identified immediate fall intervention(s) had been implemented or that the fall had been followed up on by facility management, to which RN-A voiced, "Does not

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F 689	Continued From page 68	F 689		

look like anything was done." RN-A explained staff should have communicated the fall to management for follow up as staff "should have been trained" on facility expected fall procedures.

When interviewed on 3/25/21, at 11:07 a.m. the director of nursing (DON) stated the nurse and the nursing assistants would talk after a fall and "initiate something." The DON explained fall interventions were "usually done immediately" and she would expect the interventions to be documented. Further, the DON explained IDT reviewed falls in which staff discussed the effectiveness of the fall interventions. The DON reviewed R55's EMR and confirmed the lack of documented interventions after his 11/28/20 fall.

A policy Fall Prevention and Management, revised 2/2021, indicated the purpose of the policy was to identify residents at risk for falls, to implement fall prevention interventions, and to provide guidelines for post-fall resident assessment and fall root cause identification. The policy directs staff post-fall to notify the resident's medical provider and family in an appropriate time frame, to complete an incident review and analysis, and record in the EMR "appropriate interventions taken to prevent future falls." In addition, the policy directs staff to re-evaluate fall interventions if a resident continues to fall, to evaluate the chain of events or circumstances preceding the fall, and that falls will be reviewed by the IDT daily.

ADEQUATE SUPERVISION AND GAIT BELT USE

R40's admission (MDS) dated 2/16/21, identified

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F 689	Continued From page 69 moderately impaired cognition, extensive assist needed for bed mobility, transfers, dressing, toilet use, and personal hygiene. R40 also required one person physical assistance to walk in room. R40's medical diagnoses included arthritis and cerebral vascular accident (CVA) (stroke) with an indwelling urinary catheter, and a fall within the last month. R40's Visual/Bedside Kardex Report document dated 2/19/21, identified R40 required assist of one and front wheeled walker (FWW) to ambulate short distances and to walk in room. R40's care plan dated 3/4/21 identified fall risk related to history of falls, weakness, CVA, heart failure, and DM2 (diabetes mellitus); follow PT (physical therapy) and OT (occupational therapy) instructions for mobility functional; alteration in mobility related to CVA polyarthritis, heart failure, DM2, CKD [chronic kidney disease], and weakness; follow PT instructions; assist with one and FWW ambulation; assist one to two with movement in bed and in/out of bed; assist one and FWW with transfers; self-care deficit related to CVA, polyarthritis, heart failure, DM2, CKD, and weakness; assist one with dressing and personal hygiene. R40's fall review evaluation dated 2/10/21, identified history of falls in the last six months one to two times; medication use and diagnoses that may contribute to falls: diuretics (water pills used to increase urine production in kidneys), NSAIDS (nonsteroidal anti-inflammatory drugs); gait while standing in one spot, walking straight forward and while make a turn exhibits loss of balance while standing and requires wide base support. Fall review summary identified R40 has the potential	F 689		

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F 689	Continued From page 70 risk for fall r/t (related to) age, decreased mobility, history of falls, medication listed above, and diagnosis of CVA; resident is continent of bowel and bladder and has indwelling Foley for neurogenic bladder; assist of one and FWW for transfers and currently does not self transfer. Review of R40's occupational therapy recertification, progress report & updated therapy plan dated 3/12/21, identified R40 needed SBA [stand by assistance] with FWW for standing balance, toileting transfer with SBA, and current assistance of one per PT. R40's progress note dated 3/23/21, at 10:55 a.m. identified R40 required daily skilled care for stroke, received PT and OT and transfers with assist of one. Review of R40's physical therapy treatment encounter notes dated 3/24/21, identified "discussed and instructed/educated pt [patient] [R40] that PT would like to to [sic] ask for assist with all transfers due to fall risks. Continue to stress to pt [R45] to use call light for assist with mobility, transfer training wheelchair with SBA. During an observation on 03/23/21, at 2:10 p.m. R40 sat on toilet in bathroom by herself with wheel chair placed next to her. At 2:13 p.m. R40 had gotten herself off the toilet, back into her wheelchair, and pushed her feet on the floor to wheel herself back to the bedside table for a drink of water. During an observation on 3/24/21, at 7:16 a.m. R40 sat on the edge of the bed completely dressed and bent over to tie her shoes. R40 stood up, held onto the bedside railing, and	F 689		

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	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

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MEEKER MANOR REHABILITATION CENTER, LLC	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

(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 689	Continued From page 71 pivoted herself into the wheel chair located in front of her without assistance. R40 bent down and unhooked indwelling urinary catheter bag and placed it on her lap. R40 pushed the call light on to request help with the indwelling urinary catheter bag. During an observation on 3/24/21, at 7:45 a.m. nursing assistant (NA)-G entered R40's bathroom and placed gloves on. R40, without a gait belt on, pushed herself up off the toilet to a standing position and took hold of the bar on the wall. NA-G provided perineal cares and pulled her pants up while R40 hung onto the bar on the bathroom wall. R40 pivoted herself into the wheelchair. The facility staff failed to transfer R40 with the use of a gait belt. During an observation on 03/25/21 08:18 a.m. a dietary aid knocked on R40's closed door and waited for a response and heard nothing, she knocked again and then opened door. R40 was observed to open the bathroom door and pushed herself in the wheelchair with her feet. R40 wore the same blue sweatshirt and tan slacks on she wore yesterday. R40 verified she had gotten herself dressed and stated "Yes, shoes and all by myself." During an interview with R40 on 3/23/21, at 1:56 p.m. stated she was headed to the bathroom right now. R40 stated, "I take myself and I don't know if I am supposed to." R40 indicated the staff must know it, as she is not asking them for help and is getting there somehow. R40 also stated "I try to be careful, wheel myself to the bathroom and use the bar on the wall to pull myself up. R40 also indicated therapy told her she was getting much stronger.	F 689		

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F 689	Continued From page 72	F 689		

Continued From page 72

During an interview on 03/23/21, at 3:07 p.m. trained medication aid (TMA)-C indicated R40 was toileted about every 2 hours and transferred with assist of one. TMA-C indicated R40 does not really transfer by herself. TMA-C identified a transfer belt is placed on R40 and assistance of one is needed to stand because she may lean backwards and we want to prevent a fall. TMA-C also indicated R40 sometimes needed cues to hang onto the bar on the wall.

During an interview on 03/23/21, at 3:19 p.m. NA-K identified R40 was one assist to go to the bathroom. NA-K also stated we have rarely had to help R40 to the bathroom, she has taken herself but I have not seen that. NA-K indicated she placed the wheelchair next to the bed at a forty-five degrees, R40 grabs the bed railing on her own, and I have also transferred her from the wheel chair to bed. NA-K verified she had helped boost R40 up more times than not to get her out of the wheelchair. NA-K also verified the charting on R40 indicated she should have assist of one to transfer.

During an interview on 03/24/21, at 8:04 a.m. NA-G indicated a gait belt was not used during the transfer with F40 in her bathroom today at 7:45 a.m. NA-G identified a gait belt should be used when R40 transferred and staff need to be in the room because she had fallen prior to coming to this facility. NA-G stated staff need to make sure R40 does not fall. NA-G also stated she is aware R40 transferred herself and she had told her coworkers and indicated they had also noted R40 self-transfer. NA-G identified she had also informed LPN-H.

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F 689	Continued From page 73 During an interview on 3/24/21, at 8:47 a.m. LPN-E identified R40 required assistance of one to transfer. LPN-E stated she had caught R40 self transfer regularly and going to the bathroom by herself. LPN-E indicated she reminded R40 to call for help. LPN-E also indicated she had informed PT so they are well aware of it. LPN-E indicated R40 should have on a gait belt during all transfers. LPN-E stated "I did not place a belt on her this morning" during a transfer R40 is too quick and does not like it. LPN-E identified the transfer gait belt is used for safety to help prevent falls. During an interview on 3/24/21, at 12:42 p.m. OT identified R40 should be provided with stand by assistance of one due to being unsteady with walking and transfers. OT also identified R40 should have supervision with transfers onto the toilet from the wheel chair. OT also verified a gait transfer belt should be used anytime you transfer R40. OT stated she heard R40 had been self transferring in the rehabilitation meeting today. During an interview on 03/24/21, at 01:45 p.m. PT identities every time physical therapy worked with R40 she would be assessed, then progress notes are entered every ten days or on tenth visit. PT stated R40 should not be self-transferred, should put on the call light, and wait for staff to arrive to help her. PT indicated she had not been made aware R40 had self transferred. Facility policy titled Monarch Healthcare Management [MHN] Safe Resident Handling Program last revised on 3/20/20, identified gait belts must be used for ambulatory residents when indicated in the patient care plan to allow employees to hold onto the belt to provide	F 689		

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F 689	Continued From page 74 support and stabilize the resident when walking. A gait belt must also be used during a stand pivot transfer to provide guidance to the resident, when indicated in the care plan.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide timely pain management for 1 of 1 residents (R26) who complained of foot pain and did not receive timely intervention. Findings include: R26's face sheet dated 3/24/21, indicated diagnosis include: Parkinson's disease (disorder that affects movement), major depressive disorder, anxiety disorder, post-traumatic stress disorder, dementia in other diseases classified elsewhere with behavioral disturbances (impairment of memory and functioning), and muscle weakness. R26's MDS dated 2/3/21, indicated severe cognitive impairment and required extensive two assist with transfers and bed mobility. R26's required extensive assistance with activities of daily living.	F 697	Pain Management The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person- centered care plan, and the residents' goals and preferences. Resident 26 was assessed for pain on 4/9/2021 and pain care plan was reviewed. To ensure other residents assessments related to pain are completed per the RAI, all facility residents were assessed for pain and interventions were placed within the plan of care and MD's updated as necessary with completion date of 4/25/2021. Staff education was initiated on 4/20/2021 to the facility practice for pain assessments to be completed timely per	4/28/21

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F 697	Continued From page 75 R26's care plan revised on 2/10/21, Risk for alteration in skin integrity interventions to include turn and reposition every 2-2.5 hours. Elevate heels off the bed, foot cradle added to foot of bed to keep blankets off resident's toes, place pillow under legs as tolerated. Heel protectors when not wearing shoes. Notify hospice of any skin concerns. Review of care plan lacked any interventions or idenified risk for pain despite R26's receiving daily pain management medications. Review of Medication Administration Record dated 3/1/21-3/31/21, indicated the following medications: -Gabapentin Capsule 100 mg give 300 millegram (mg) by mouth two times a day for anxiety/pain. -Acetaminophen Tablet 325 mg give 2 tablet by mouth every 4 hours as needed for general discomfort. -Morphine Sulfate (concentrate) (pain medication) solution 20mg/ML (milliliters). Give 5 mg by mouth every 4 hours as needed for pain/SOB (shortness of breath) 5mg=0.25 ml. R26's progress notes dated 3/9/2021, at 14:52 "Hospice Note Text: [R26] was lying in bed when I arrived. VS stable. No edema noted. Lung sound clear throughout. Bowel sounds present x 4. Dressing changed to wound on right heel. Patient denies pain initially, during dressing change shows nonverbal signs of discomfort, encouraged staff to use PRN (as needed) morphine (pain medication) for pain control and to notify Moments (hospice provider) if ineffective. Staff deny specific concerns at this time. No changes to POC (plan of care) today."	F 697	the RAI also on practice to treat pain, and notification when observed. Facility nurses were educated on 3/31/2021 on pain policy. Monitoring will be accomplished through an audit by center administration of effectiveness of current pain management interventions 5 residents per week for 4 weeks, then 10 residents monthly or as indicated by QA committee to ensure resident interventions for pain control are managed. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification Allegation of compliance is 4/28/2021.	

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F 697	Continued From page 76 During observation and interview on 3/23/21, at 3:20 p.m. R26 sitting in Broda chair with feet resting on foot rest of chair. R26 made a moaning sound. R26 was asked if he was having pain. R26 stated "right foot is killing him". Nursing assistant (NA)-A walked into room and notified of R26 reporting pain. NA-A adjusted R26's right foot and asked if it was better. R26 stated "No". NA-A stated she was going to notify the nurse. During continual observation on 3/23/21, at 3:24 p.m. NA-A walked down hallway into another room. -at 3:26 p.m. NA-A walked down hallway with linens in hand and dropped them off into another residents room, then proceeded to the nurses station passing license practical nurse (LPN)-C and walked into the room in back of nurses station. -at 3:28 p.m. NA-A left nurses station, walked down the hallway and answered another call light passing LPN-C. -3:30 p.m. NA-A walked back up 300 wing, NA-A standing at nurses station desk grabbing afternoon snacks and proceeded down the wing. LPN-C was sitting at nurses station on the computer. -3:34 p.m. NA-A sanitized hands, grabbed another snack, again passing LPN-C and proceeded to pass another residents snack. NA-A returned to nursing station. -3:37 p.m. LPN-C sitting at nurses station on computer. NA-A standing at nurses station grabbing another residents snack and proceeded	F 697		

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F 697	Continued From page 77	F 697		

to walk down the hallway.

-3/23/21, at 3:40 p.m. NA-A reported that another resident (not R26) was having pain to LPN-C.

During interview on 3/23/21, at 3:40 p.m. (20 minutes after R26 reported pain to NA-A) LPN-C stated no staff had reported R26 having any pain. LPN-A stated all staff should report if a resident is having pain immediately so they can assess why they are having pain and get the pain relief.

During observation on 3/23/21, at 3:49 p.m. LPN-C asked R26 if he was having pain. R26 stated yes. LPN-C gave R26 acetaminophen (Tylenol) for pain relief and told him she would be back to reassess the pain.

During interview on 3/24/21, at 12:54 p.m. hospice registered nurse (RN)-B stated R26 should be monitored for pain as he does have nonverbal cues of wincing during dressing changes. RN-B stated important to keep R26 comfortable and free of pain. RN-B stated their goal with hospice is to keep R26 as comfortable as possible. During interview on 3/24/21, at 1:08 p.m. LPN-A stated R26 does have as needed medication if he is having pain. LPN-A stated she would expect staff to report a residents pain within 5 minutes but should be right away so the nurse can assess the pain and treat it as soon as possible.

During interview on 3/25/21, at 9:24 a.m. LPN-B stated if a resident reports pain to a staff they should report it immediately to the nurse. LPN-B stated it is important to give residents relief of pain as soon as possible.

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F 697	Continued From page 78 During interview on 3/25/21, at 9:43 a.m. NA-A stated she forgot to report R26's pain to the nurse as she forgot. NA-A stated it was important to report this pain immediately to give the resident relief. During interview on 3/25/21, at 9:52 a.m. Director of nursing (DON) stated R26 is vulnerable and the staff watch him carefully for pain. DON further stated it looked like the care plan for pain is missing and should be part of R26's plan to help keep him comfortable. DON stated staff should either use the walkie talkie or tell a nurse immediately if a resident is having pain. Pain management protocol undated "Purpose: to ensure that resident's with pain or at risk for pain, have an effective pain management plan in place with individualized interventions that are consistent with the resident's goals for comfort. "Pain management" is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on her or her clinical condition and established treatment goals. The nursing staff will identify any situations of interventions where an increase in the resident's pain may be anticipated; for example, wound care, ambulation, or repositioning."	F 697		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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.	F 761		4/28/21

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F 761 Continued From page 79 F 761

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) 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.

§483.45(h)(2) 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 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 ensure stock medication were discarded after expiration on 2 of 4 medication carts, potentially affecting 26 of 26 residents on those units. In addition, the facility failed to ensure resident's personal medications were discarded after expiration for 2 of 26 residents (R2 and R14).

Findings include:

Review of the facility's Medication Room or Medication Cart Audits form dated 2/11/21, by trained medication aide (TMA)-B Lane 1 expired medication located in the cart: No was circled. Lane 2 No was circled. Lane 3 No was circled, and Lane 4 No was circled.

During the medication tour of the 300 Wing on

Label/Store Drugs Biologicals
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.
§483.45(h) Storage of Drugs and Biologicals
§483.45(h)(1) 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.
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F 761	Continued From page 80 3/22/21, at 5:20 p.m. with licensed practical nurse (LPN)-A multiple expired medication were observed in the medication cart. The following concerns were identified: R2's Phillips colon health (help promote bowel movement) take one capsule daily with expiration date of 2/2021. Stock medication one daily multivitamin (supplement) 100 tablets with expiration of 2/2021. During interview on 3/22/21, at 5:25 p.m. LPN-A stated the medications are expired and should not be given to residents as it could make them sick and they are not sure off the effectiveness of the medication after they expire. LPN-A stated all medications should be removed from cart after expiration. LPN-A stated medication carts are gone through on a monthly basis. During medication tour of the 200 Wing on 3/23/21, at 1:00 p.m. with TMA-A multiple expired medications were observed in the medication cart. The following concerns were identified: R14's Tylenol pm (help with sleep) 500-356 mg take one tablet by mouth at bedtime with expiration date of 1/30/21. Stock medication Prostate sugar free (supplement) open on 10/29/20 label stated expires 3 months after opening. 30 fluid ounce, 15 grams of protein and 100 kcal per 1 FL ounce, cherry flavor. During interview on 3/23/21, at 1:05 p.m. trained medication aid (TMA)-A stated all medications	F 761	Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. INTENT §483.45(g) Labeling of Drugs and Biologicals and §483.45(h) Storage of Drugs and Biologicals Resident 2 medications were audited on 3/31/2021 and no expired medications remain. Resident 24 medications were audited on 3/31/2021 and no expired medications remain. To ensure other residents are free from administration of expired medications all 4 facility medication carts were audited on 3/31/2021 and all expired medications (stock and resident specific) were removed. Staff were inserviced on 4/20/2021 to communicate the expectation that medication carts are audited and expired medications are removed. Clinical leadership was educated to the policy of medication storage and handling on 4/21/2021. Monitoring will be accomplished through an audit by center DON or designee weekly for 4 weeks, and monthly or as indicated by QA committee to ensure no expired medications are on the carts. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon	

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F 761	Continued From page 81 should be removed from cart immediately if they are expired as they are not effective. TMA-A stated medications have not been used on anyone on the unit. During interview on 3/23/21, at 1:54 p.m. registered nurse (RN)-A stated medication carts are gone through on a monthly bases usually on night shift. RN-A stated it is important not to give medications as they do not know the effectiveness of the medication past the expiration date. RN-A stated with the prostat there could be issues with bacteria and should not be used past 3 months from opening. RN-A stated it is a problem that the medications were expired and left on the cart. During interview on 3/25/21, LPN-B stated medication carts are gone through and an audit sheet is completed and there should not be any expired medications left in the carts. LPN-B stated if any resident did receive the medication they would notify the doctor and monitor for side effects. During interview on 3/25/21, at 9:52 a.m. director of nursing (DON) stated expired medications are gone through on a monthly basis and sometimes even twice a month. DON stated it is important not to give expired medications. DON stated the last time the medication carts were gone through on 2/10/21 or 2/11/21 and would be due again at the end of the month. During interview on 3/25/21, at 10:55 a.m. pharmacist stated the DON are having the nurses go through the medication carts and then she sends her the forms. However, in the next few months pharmacy will be back in and auditing	F 761	identification. Allegation of compliance is 4/28/2021.	

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F 761	Continued From page 82 these. Pharmacist stated it is important to not give medications past the expiration date as they have not been studied past that dated. Storage of medication policy revised 04/2019 indicated "Discontinue, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed."	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental	F 791		4/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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F 791

Continued From page 83

services and the extenuating circumstances that led to the delay;

§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure voiced dental concerns were addressed and acted upon for 1 of 2 residents (R37) reviewed for dental care.

Findings include:

R37's admission Minimum Data Set (MDS), dated 2/18/21, identified R37 had intact cognition and required extensive assistance with her activities of daily living (ADLs), and had no obviously broken teeth or likely cavities. Further, R37's Census list, printed 3/24/21, identified R37 resided at the nursing home and listed her payer source as Medicaid.

R37's MHM (Monarch Health Management) Oral/Dental Evaluation, dated 2/11/21, identified R37 had observed plaque or debris present on her teeth along with, " ... several missing teeth." R37 was recorded not wearing any dentures and required set-up for oral cares. Further, the assessment outlined, "Staff will assist resident to

F 791

Routine/Emergency/Dental Services
The facility must assist residents in obtaining routine and 24-hour emergency dental care.
§483.55(b) Nursing Facilities. The facility—
§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:
i. Routine dental services (to the extent covered under the State plan); and
ii. Emergency dental services;
§483.55(b)(2) Must, if necessary or if requested, assist the resident—
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services locations;

Resident 37 has a dental appointment on 9/22/2021 and resident is agreeable to date of service.

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F 791	Continued From page 84 set up dental appointments and transportation as needed." The completed assessment lacked any dictation regarding if R37 had been offered and/or refused a dental appointment at the time; nor any dictation on when R37's last dental appointment had been prior to her admission to the nursing home. When interviewed on 3/22/21, at 3:33 p.m. R37 voiced she had concerns with her dentition as "they're [her teeth] falling out." R37 showed her teeth to the surveyor and was observed to have several missing teeth on both the top and lower palate. R37 stated she needed to see a dentist to get them addressed; however, nobody had helped her arrange those services. R37 voiced her missing teeth made her feel self-conscious about her smile and, as a result, she would often not smile at people and "try to hide it [missing teeth] as much as possible." Further, R37 voiced her teeth had, at times, caused her to have some pain when eating. R37's care plan, printed 3/23/21, identified R37 had a self-care deficit related to respiratory conditions and low back pain. The care plan directed R37 required assistance of one to complete personal hygiene tasks; however, the care plan lacked any identified problem statements, goal(s), or interventions to ensure R37 maintained good oral hygiene despite being assessed as needing oversight and/or assistance to ensure dental care was completed and having numerous missing teeth. When interviewed on 3/23/21, at 1:50 p.m. nursing assistant (NA)-C stated the staff offer to brush R37's teeth; however, she often refuses assistance or will voice she did it herself. NA-C	F 791	A facility wide audit to ensure a new oral assessment is in place was completed by clinical leadership on 4/12/2021 and to ensure that if they would like to see a dentist it has been offered. No new residents were identified as requesting to see dental sooner than the next date of onsite visit. Staff inservice was completed on 4/20/2021 to ensure that residents who request to see dentist are added to the list and reported to clinical leadership for further follow up. Monitoring will be accomplished through an audit by DON or designee x1 daily for 1 week, weekly for 4 weeks, and monthly or as indicated by QA committee to ensure that any resident with concerns elated to dentition are followed up on timely. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification. Allegation of compliance is 4/28/2021.	

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F 791	Continued From page 85	F 791		

expressed she was unsure if R37 was actually doing her own oral cares or not. NA-C stated she recalled R37 making comments about her poor dentition and, as a result, she would try to "keep her mouth closed" so people didn't see her missing teeth. NA-C stated she was unaware R37 had reported complaints of pain when chewing due to her teeth; however, again reiterated R37 had reported not smiling at others because "she hates her smile."

R37's medical record was reviewed and lacked any evidence R37's reported concerns with her dentition had been acted upon and addressed with a dental provider for resolution despite being assessed as missing numerous teeth, and reporting to the direct care staff she "hates her smile" due to her dental condition.

On 3/24/21, at 8:47 a.m. registered nurse manager (RN)-A was interviewed. RN-A explained residents were assessed upon admission for their dental condition(s), and she recalled completing R37's assessment (dated 2/11/21) which found R37 was "missing many" teeth. RN-A reviewed R37's medical record and stated R37 had elected to receive dental services upon her admission; however, was unable to recall ever hearing "any specific complaints" about her teeth at the time. RN-A voiced she "was not aware" R37 had been making comments to the direct care staff about not wanting to smile due to her dental condition and, as a result, no follow-up or appointments had been sought to help R37. RN-A expressed those comments should have been reported so they could be acted upon and addressed with a dental provider as there were options available for treatment despite the COVID-19 pandemic and oral

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F 791	Continued From page 86 concerns should be addressed to help a person's self-esteem and maintain their weight. RN-A added unresolved dental issues could become "a big problem." A provided Dental Services policy, dated 12/2016, identified 24-hour and emergency dental care would be provided through various avenues including referral(s) to community dentists. Further, the policy outlined the social services department would help coordinate any needed transportation or appointments. However, the policy lacked any dictation or guidance on how the facility would ensure voiced dental complaints were addressed or acted upon to ensure resolution.	F 791		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a known food allergen was not served to 1 of 1 residents (R505) reviewed who had a listed anaphylactic reaction (a severe, potentially life threatening allergic reaction) to fish. This resulted in the potential for a severe allergic reaction.	F 806	Allergies, preferences, intolerances Each resident receives and the facility provides— §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;	4/28/21

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F 806	Continued From page 87 Findings include: R505's admission Minimum Data Set (MDS), dated 3/8/21, indicated R505 was cognitively intact, was able to understand others and make himself understood, and required set-up support with eating. Further, R505's care plan, dated 3/1/21, identified R505 required a therapeutic diet related to an allergy to fish. R505's allergy flowsheet, dated 3/10/21, identified R505 was allergic to fish and epinephrine. The flow sheet listed R505's reaction to fish as, "Severe." When interviewed on 03/22/21, at 1:24 p.m. R505 stated he had an allergy to fish and was given fish two Fridays (3/12/21 and 3/19/21) in a row by facility staff. R505 expressed concern about this and voiced he needed to be careful with cross contamination. R505 provided his meal slips (used to alert staff to allergies and diets), dated 3/12/21 and 3/19/21, which outlined R505 had a listed allergy to fish. During interview and observation on 03/23/21, at 01:32 p.m. assistant culinary manager showed surveyor the white board in the kitchen and stated that instructions for new residents such as name, diet orders, allergies, special equipment, etc. will be on the board for at about a week so all culinary staff can reference the information. Observation of evening meal on 03/23/21, at 05:13 p.m. meal staff were observed utilizing resident dietary cards to ensure residents were served meals per dietary requirements. Staff provided necessary assistance with drink, food	F 806	Resident 505 Discharged on 3/25/2021. To ensure other residents food allergies are adhered to a facility wide audit was conducted on 4/20/2021 by facility CDM. Tray tickets are now printed in on colored paper for resident with a food allergy to ensure staff have a visual reminder of the allergy while serving meals. Staff education was completed on 4/20/2021 regarding the importance of following a resident listed allergy. Culinary staff were educated to the food allergy policy on 4/23/2021 by CDM. Monitoring will be accomplished through an audit of meals by CDM or designee x1 daily for 1 week, weekly for 4 weeks, and monthly or as indicated by QA committee to ensure resident food allergies are not served. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification Allegation of compliance is 4/28/2021.	

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F 806	Continued From page 88 and supervision to maintain a safe meal environment. Review of Allergy Report identified R505 had Fish allergy. Additional 5 residents were listed with allergies to Shellfish, Milk, Pistachio, Milk, Corn and Onion, and Mushrooms. Based on further record review and interviews, no concerns were identified. When interviewed on 03/25/21, at 10:47 a.m. facility culinary director stated there was a grievance on her desk regarding R505's fish allergy and him being served fish products despite the known allergy. She stated R505's family called in on 3/19/21, and she was in the middle of completing the grievance process but would talk with her cook and provide staff education to help prevent ongoing episodes of R505 being served the known food allergen. The culinary director confirmed R505's allergy was listed upon admission on 3/1/21, and voiced there was a communication board posted in kitchen that listed allergies along with R505's dietary card. The culinary director confirmed that was how staff would make sure a specific food was not delivered. When interviewed on 03/25/21, at 11:19 a.m. licensed practical nurse (LPN)-D stated if a resident had an allergy to epinephrine and was having an anaphylactic episode, she would check the medication list for something else and if there was nothing available, she would call primary provider, on call provider, or 911 if needed. When interviewed on 03/25/21, at 11:22 a.m. RN-A stated resident allergies are put in the electronic health record when admitted to the	F 806		

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F 806	Continued From page 89 facility and put on the dietary slip. She stated she got a call from R505's brother on 3/19/21 and he stated R505 received fish on his meal tray two Fridays in a row. RN-A stated she talked to the culinary director right away and gave her the grievance. Further, she stated if R505 would have ingested fish, she would have expected to send to him to the hospital. RN-A stated Benadryl would not do anything, and that the facility needed to call 911. When interviewed on 03/25/21, at 12:01 p.m. the director of nursing (DON) stated resident allergies were listed on medication sheets and can been seen by the staff in the electronic health record. The DON confirmed that the nursing assistants and dietary staff communicated daily. She stated dietary staff delivered meal trays to residents. The DON was aware of R505's fish allergy and the delivery of the fish to him. She stated it went back to the dietary department. She stated she would need to see what R505's reactions were. The DON confirmed it was anaphylaxis and that he had an allergy to epinephrine. Further, she stated if R505 had contact with the fish, then a call would be placed to 911 immediately, along with an assessment. DON stated it would be "all hands on deck and anaphylaxis meant his throat would start swelling and he would need the crash cart." DON stated the crash cart was well equipped, although confirmed it was not equipped for R505 due to his allergy of epinephrine. DON stated there was a grievance filed and was not able to answer for the dietary department, and that the dietary staff had to answer to the administrator. The DON confirmed a pharmacy review was completed and did not have anything listed as a back up to the epinephrine.	F 806		

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F 806	Continued From page 90 When interviewed on 03/25/21, at 12:21 p.m. the administrator stated she was aware of a grievance filed related to R505's fish allergy. She stated dietary staff needed to follow the meal tray ticket to make sure the food allergy was not served to the resident. When interviewed on 03/25/21, at 01:07 p.m. R505 stated cross contamination was very scary to him. He stated his wife was usually with him to watch for any items, such as salads, that would have fish hidden in them. R505 stated he was allergic to epinephrine, which made his situation even more complex. Record review revealed grievance dated 3/19/21, initiated by RN-A. Resolution listed, "cook will take time to review allergy section of menu before plating." Two separate incidents were provided to surveyor, both completed on 3/25/21 confirmed dietary staff delivered fish to R505 on 3/12/21 and 3/19/21. Facility policy "Food Allergies and Intolerance's," revised August 2017, indicated "residents with food allergies and/or intolerance are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident expose to the allergen(s)." Further identified, meals for residents with severe food allergies are specially prepared so that cross-contamination with allergens does not occur and allergies and intolerance's and are documented in the assessment notes and incorporated into the residents care plan.	F 806		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/28/21

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F 880	Continued From page 91	F 880		

Continued From page 91

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:

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F 880	Continued From page 92 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practice for 1 of 1 residents (R40) reviewed for urinary catheter cleaning procedures. Findings include: R40's admission Minimum Data Set (MDS) dated 2/16/21, identified moderately impaired cognition, indwelling urinary catheter, extensive assistance	F 880	DPOC F880 3/25/2021 Equipment/Environment • LPN-E was re-educated and competency checked to catheter bag care on 3/24/2021 and educated on cleaning of catheter bags on 4/22/2021. • The facility identified that a total of 3 residents have the ability to be impacted by this practice. Catheter bag competencies were initiated for all Licensed nurses and CNA's on 3/30/2021.	

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F 880	Continued From page 93 needed with bed mobility, transferring, dressing, personal hygiene, and toileting, and independent with eating. R40's current medical diagnoses included CVA (stroke), CKD (chronic kidney disease), and type 2 diabetes mellitus (DM2), and arthritis. R40's care plan dated 3/4/21, identified R40 had a self-care deficit related to CVA, polyarthritis, heart failure, DM2, CKD, weakness. Interventions noted as: assist of one with personal hygiene. During an observation on 03/24/21, at 7:27 a.m. licensed practice nurse (LPN)-E entered resident R40's room, applied gloves, and removed a urinary collection leg bag from a basin located on the floor of R40's closet. LPN-E wiped off the top connection site on the urinary collection leg bag with an alcohol swab. LPN-E rolled up R40's pant leg and placed a towel under the connection site of the large urinary collection bag attached to R40. LPN-E then wiped the connection site of the large urinary collection bag with an alcohol swab, pulled tubing apart, removed the large urinary collection bag and placed it in the bathroom sink. LPN-E then connected the urinary collection leg bag to R40. LPN-E looked in the bathroom for the vinegar and located it on the closet on the floor. LPN-E stated they use a mixture of fifty percent vinegar and fifty percent water in a container. LPN-E poured an unmeasured amount of vinegar and water into a plastic container. LPN-E stated "I am not familiar with this type of catheter bag, it is totally different than I have seen." At 7:42 a.m. LPN-E removed her gloves, washed her hands, and stated "I will be right back" and exited the room. At 8:00 a.m. LPN-E re-entered R40's room applied gloves, filled a syringe with the vinegar water solution she	F 880	Polices/Procedures/System Changes • The Director of Nursing and Infection Preventionist reviewed and revised the policy on disinfecting catheter bags to ensure they meet the standard of practice. The policy/procedure will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Training/Education • Facility educated licensed nurses and CNA's to catheter bag changing and cleaning on 3/30/2021-4/23/2021. • Catheter bag competencies were initiated for all Licensed nurses and CNA's on 3/30/2021-4/23/2021. The nursing leadership team will work together to ensure facility staff compliance and competence. Monitoring/Auditing • The infection preventionist or designee will audit staff competency on catheter bag changing for residents who currently have catheter bags daily in the morning and at night when the bags are to be changed per MD orders for 7 days. The audit results will determine decrease in frequency, 100% compliance on the audits will result in decrease of frequency for staff providing direct care to residents and/or entering the residents rooms.	

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	245361	A. BUILDING ______ B. WING ______	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

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F 880	Continued From page 94	F 880		

had mixed earlier. LPN-E held the urinary collection bag over the toilet with the tubing looped around her hand and did not straighten it out. LPN-E attempted to flush the catheter bag and tubing upwards from the bottom drain port with the syringe over the toilet 3 times. The solution drained into the toilet and did not go into the urinary catheter collection bag. The tubing attached to the catheter bag was not flushed with the vinegar water solution. LPN-E dumped the remaining approximately fifty percent of the vinegar water solution into the toilet. LPN-E placed a cap on the end of the tubing of the urinary catheter collection bag, laid it in the basin, and paced it on the closet floor. LPN-E removed her gloves, washed her hands, and exited the room. LPN-E failed to properly sanitize the urinary collection bag and tubing to prevent growth of bacteria.

During an interview on 03/24/21, at 8:47 a.m. LPN-E indicated the wash basin was located on the floor of the closet and the urinary collection leg bag hung on the towel rack in the bathroom. LPN-E identified she had taken 2 full syringes of the vinegar water solution and flushed the urinary collection leg bag from the bottom drain port. LPN-E also indicated the urinary collection leg bag should be flushed through the top port that connects to the bag. LPN-E stated she was unable to connect the syringe to the top port so had used the bottom one instead.

During an interview on 3/25/21, at 11:12 a.m. ADON stated the urinary collection leg bag should be rinsed out with fifty percent water and fifty percent vinegar mixed solution. ADON identified a syringe that would fit the tubing was expected to be used for this process. ADON also identified

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F 880	Continued From page 95 the urinary bag system should be cleansed from top to bottom and the cleansing solution should drain out from the bottom port of the collection bag to prevent the introduction of bacteria. ADON identified nursing staff had received education regarding this competency. During an interview on 3/25/21, at 12:23 p.m. director of nursing (DON) stated on 11/9/20, a skills competency fair had been completed with the nursing staff. DON identified seventeen skills were covered and included catheter cares. A check list for the catheter cares was requested and DON was unable to locate that document. DON indicated staff nurses are expected to contact her if they have questions on the steps on how to complete catheter cares. DON stated a little bit of vinegar and water should be mixed together in a paper cup. DON indicates the urinary drainage bag should be placed in the sink and the vinegar water solution poured or injected with a syringe into the tubing attached to the bag from the top to bottom so that it ran down the tubing first and then into the catheter collection bag. DON also indicated the collection bag should be filled half full of the solution twice to make sure it is all cleaned out. DON indicated a cap should be placed on the top end of the tubing to avoid contamination of the system. DON stated the sanitation of the urinary catheter bag and tubing is expected to be done from top to bottom, clean to dirty, to try and prevent infections. Review of a facility document titled Sanitation of Catheter Leg & Bedside Bags undated identified Purpose: To prevent growth of bacteria in catheter bags, that are not currently connected to the catheter drainage system. Procedures: Place the catheter bag that was just disconnected from	F 880		

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F 880	Continued From page 96 catheter into the clean wash basin. Make sure the end of catheter bag is covered with alcohol packet and drainage port is clamped. Take disconnected catheter bag in basin to soiled utility room. Mix 1 part vinegar with 3 parts water (1/2 cup vinegar with 1 ½ cups water). Remove alcohol packet from insertion end of catheter bag tubing and instill solution into catheter tubing, into bag. Swish the solution around inside the bag for 30 seconds to 1 minute. Empty solution from the bag. Rinse catheter tubing/bag with tap water. Empty tap water from bag. Allow to air dry, in clean wash basin. Store in resident's room on top shelf of closet.	F 880		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions 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 potentially defective and/or worn toilet equipment was assessed for safety after resident-involved events caused by failure of the resident room toilet(s). The lack of ongoing, routine monitoring and assessment of these toilets had potential to affect 39 of 54 residents residing in the nursing home. Findings include: R45's quarterly Minimum Data Set (MDS), dated 3/1/21, identified R45 had intact cognition and required extensive assistance with toileting. Further, the MDS outlined R45 had sustained	F 921	483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. All facility toilets were braced with PVC piping and caulked by the maintenance department by 4/2/2021. To ensure compliance with this the MDH engineer Rex Stromquist was contacted and approved of this method on 4/13/2021. Staff education was initiated on 4/20/2021 to the facility practice for reinforced toilets	4/28/21

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F 921	Continued From page 97 "two or more" falls since the previous assessment and/or admission. When interviewed on 03/22/21, at 4:49 p.m. R45 stated he had sustained a fall in his bathroom approximately three or four months ago when he was sitting on the toilet and it broke beneath him. R45 did not obtain a major injury but did have to change rooms as a result. R45 added the ordeal was embarrassing and scary to him. When interviewed on 03/23/21, at 3:12 p.m. licensed practical nurse (LPN)-E voiced they had worked at the facility for several years and verified she was working when R45's toilet had broken resulting in his fall. LPN-E stated she found R45 laying on his side in the bathroom with water and broken toilet pieces on the floor. Further, LPN-E stated R45's toilet failure was not the first time such event had happened and explained she recalled three or four more incidents like it where the toilet had broken away from the wall causing the resident to fall. On 3/23/21, at 3:38 p.m. the director of maintenance (DOM) was interviewed. He explained the facility used wall-mounted toilets which could support weight up to 500 pounds (lbs) and had to, at times, place pieces of PVC pipe underneath of the toilet bowl to support residents' who weighed more. DOM voiced he had not been tracking or monitoring which toilets had this PVC bracing placed underneath of them. A short time later, DOM provided surveyor with document identifying 15 of 54 resident toilets the facility had assessed to required PCV bracing. When interviewed on 3/24/21, at 1:14 p.m. registered nurse (RN)-A recalled when R45 fell to	F 921	in in place and any issues need to be reported to maintenance for follow up. Monitoring will be accomplished through an added preventative maintenance program to facility toilets to check for cracks and the placement of the PVC piping by the maintenance director or designee. Results will be reported to the facility QAPI committee for review and follow-up. Deficient practices will be corrected upon identification. Allegation of compliance is 4/28/2021.	

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F 921	Continued From page 98	F 921		

the floor as a result of the toilet breaking. RN-A stated R45 did not weigh over 300 lbs. at the time of the event and did not recall if he had sustained any injuries as a result of the incident. RN-A then reviewed R45's completed skin assessment at the time and verified no major injuries had been obtained. Further, RN-A stated she did not think R45's weight (less than 300 lbs.) would cause the toilet to fail and break and added she was aware to ask for support braces for larger residents.

During the recertification survey, from 3/22/21 to 3/25/21, documentation was requested to demonstrate the facility had complete an assessment of their remaining wall-mounted toilets to ensure safety with resident use after R45 sustained a fall when one broke. There was no documentation provided which demonstrated the toilets had been observed or assessed for cracks or disrepair to ensure they were safe for continued use. Further, there was no documentation provided which outlined which, if any, toilets had been replaced or repaired in the facility to ensure safe operating use.

On 3/25/21, at 9:34 a.m. a subsequent interview was held with DOM who provided a listing of current toilets in use which had the PVC bracing placed underneath of them. DOM acknowledged he was unsure which, if any, toilets outside of R45's had been replaced and verified there was no system in place to check the state of repair of the toilets and replace them, if needed. Further, DOM stated he was only aware of the one fall involving a broken toilet which was R45's fall a few months prior.

On 3/25/21, at 10:04 a.m. the facility administrator was interviewed and verified she

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F 921	Continued From page 99 had been employed at the nursing home since 2019. She explained she had been aware of only R45's fall which involved a toilet failing and breaking away from the wall, and acknowledged the current system in place was to brace the toilet(s) with PVC piping or use a commode for any larger residents. The administrator expressed she was unaware of any listings or monitoring being completed with the toilets (or their replacement) in the nursing home. When interviewed on 3/24/21, an MDH engineering department representative voiced the nursing home records indicated the building was originally built in 1978, and there were no other construction projects listed since 1988. He expressed installation of support braces, including the use of PVC piping, was not sufficient to hold or repair a cracked or defective toilet as such a toilet would require replacement. Further, all remaining toilets in the nursing home which were installed in 1978 should be replaced. A facility' policy on toilet repair and/or maintenance was requested, however, was not received.	F 921		

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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		

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2 000	Continued From page 1	2 000		

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 3/22/21 to 3/25/21, 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.

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 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

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2 000	Continued From page 2 MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths.	2 265		4/28/21

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2 265	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the medical provider was notified of a change in condition for 1 of 1 residents (R55) reviewed that had documented increased periods of low oxygen (O2) saturations (sats) and an unresponsive episode which lasted approximately one minute whom was sent the following day to a routine renal dialysis appointment. R55 had required a hospital admission directly from the dialysis appointment related to low O2 sats and low blood pressure (BP), who subsequently passed two days later. Findings include: R55's quarterly Minimum Data Set (MDS), dated 10/14/20, identified R55 had intact cognition and communication abilities. The MDS identified R55 had been free of falls since the prior MDS assessment and had diagnosis of orthostatic hypotension (abnormal decrease in BP when standing), congestive heart failure (impaired heart pumping), end stage renal disease which required dialysis management, and chronic respiratory failure (failure of lungs to function properly) with O2 used at that time; however, R55 was not considered to have a life-limiting prognosis. R55's alteration in oxygen/gas exchange respiratory status care plan, dated 6/24/20, identified R55 had periods of low blood O2 sats in which he would refuse to wear the O2 at times. Interventions to assist R55 with the goal of "adequate gas exchange" included the following: monitor and document respiratory status, monitor O2 sats as ordered and as needed, keep medical provider informed of changes. R55' care plan failed to identify R55 had history of unresponsive episodes or low BP. R55's treatment administration record (TAR),	2 265	Corrected	

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2 265	Continued From page 4	2 265		

dated 11/1/20 - 11/30/20 directed staff to monitor R55's O2 sats during the day and evening shifts. The TAR identified R55 had an order for O2 at 0-4 liters (L) via nasal cannula (N/C) to maintain O2 sats of 90% or greater at rest and 0-5L with exertion for low O2 sats. Further, the TAR identified R55 had two O2 sat readings of 89% on 11/3/20 and 11/5/20 where the remainder of the O2 sats ranged from 90 to 98% and consistently required 4L of O2 daily. The TAR lacked evidence of documentation responses for the day shift O2 monitoring from 11/26/20 - 11/30/20. In addition, the TAR directed staff to monitor R55's BP after dialysis on Monday, Wednesday, and Fridays. R55's BP ranged from 103/64 to 108/60. The TAR lacked evidence a BP reading after dialysis on 11/27/20.
On 11/26/20, R55's rapid COVID-19 rapid test had been negative.
On 11/27/20, time stamped 6:53 p.m. a nursing assistant (NA) had updated registered nurse (RN)-A that "[R55's] BP was low." R55 had been asleep in his wheelchair when RN-A entered R55's room. R55 had responded to verbal command but had "quickly fell asleep." R55's O2 nasal cannula had been in his nares; however, the portable O2 machine had been "off." R55 was switched to a standard O2 machine and assisted back to bed with a two person pivot transfer. R55 had stated he "just didn't feel good." RN-A had instructed the trained medication aide (TMA) to administer R55 Midodrine (medication used to manage low BP when standing) if he had not received Midodrine that day. The note indicated, "Will continue to watch and reassess resident." The progress note lacked documentation of BP or O2 sats readings at the time of the entry or that the medical provider had been contacted on status.
R55 lacked evidence of documented progress

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2 265	Continued From page 5	2 265		

note entries from 11/27/20, at 6:53 p.m. to 11/28/20, at 4:11 p.m.
On 11/28/20, time stamped 4:11 p.m. R55 had fallen to the floor at approximately 2:45 p.m. after he had attempted to pick up a dropped fork while he sat in his wheelchair. R55 had sustained a left elbow skin tear that measured 2.6 inches by 3 inches wide. R55 had been alert and oriented to person, place, and time. R55's blood pressure had been reported to be "up and down but has seemed to level out within normal range as of now." The progress note lacked documentation the medical provider had been contacted on status.
R55 lacked documented progress note entries from 11/28/20, at 4:11 p.m. to 11/30/20, at 5:30 a.m.
On 11/30/20, time stamped 5:30 a.m. R55 had "went limp and did not respond to staff for approximately one minute" when two staff had assisted him into bed with a mechanical stand lift during cares the evening prior. R55, once he again responded to staff, had O2 sats at 89% on 3.5L of O2. R55 had stated he had felt cold in which he also felt cold to touch. The progress note indicated R55 had been checked on throughout the night and he had rested "quietly without complaint." That morning, R55 had stated he had felt "tired and foggy." He had been afebrile; however, his O2 sats had been 85% which required the nurse to increase the O2 flow to 4L. The progress note lacked documentation the medical provider or dialysis had been contacted and/or updated on status.
On 11/30/20, time stamped 11:13 a.m. R55 had been sent to the emergency room (ER) from the dialysis center due to low blood oxygen saturations; however, the ER had transferred R55 to the St. Cloud Hospital due to elevated tropin levels and a positive ER COVID-10 test. Staff had

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2 265	Continued From page 6 updated dialysis on R55's condition; however, the progress note lacked documentation R55's facility medical provider had been contacted on status. On 12/2/21, the facility had received a call from the St. Cloud Hospital which indicated R55 had passed away that day. An Inpatient Discharge Death Summary, dated 12/2/20, indicated R55 had arrived to dialysis on 11/30/20 with O2 sats "in the 60's" and a BP of 80/40. Due to R55's low O2 sats and initial low BP, R55 had been sent to the local ER for evaluation and subsequently admitted to a transfer hospital. R55's principle hospital discharge diagnosis had been acute on chronic hypoxic respiratory failure secondary to COVID-19, with additional diagnosis of acute on chronic systolic heart failure and type II myocardial infarction (heart attack). During interview on 3/25/21, at 9:25 a.m. licensed practical nurse (LPN)-C explained her mode of physician communication for resident changes in status would depend on the nature of the change. If the change was "severe" she would "contact the doctor right away" and if it was "less significant" she would fax the medical provider. In either situation LPN-A stated she would document the medical provider follow-up in the resident's record. LPN-C explained if a resident were to present as unresponsive or have abnormally low O2 sats she would contact the physician "right away" due to these being changes in condition. When interviewed on 3/25/21, at 10:11 a.m. care coordinator LPN-B stated if a resident were to present with abnormally low O2 sats and/or had an unresponsive episode she "would call the doctor" and would put monitoring in place due to these being changes in a resident's condition. During interview on 3/25/21, at 10:40 a.m. case manager registered nurse (RN)-A confirmed	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 265	Continued From page 7 R55's O2 sats "would drop on occasion but not too bad" and that R55's O2 sats on 11/16/20, of 69% had not been normal for him. RN-A explained staff had educated R55 on the need to keep his O2 N/C in place as ordered as he would remove the N/C independently; however, he had not been known to turn the O2 machine off. RN-A felt R55 had typically been free of adverse consequences when he removed his O2. RN-A acknowledged she had been unaware of R55's 11/29/20 evening unresponsive episode. After RN-A reviewed R55's 11/30/20 progress note, she stated she "would have sent him in." RN-A confirmed she would have expected staff "at a minimum" to contact the medical provider after R55's unresponsive episode and then again after the abnormal O2 sats on 11/30/20 for follow-up. Further, RN-A stated then if R55 would have refused any medical provider orders and/or directions she would have expected documentation to support the follow-up. RN-A explained she would have also initiated increased vitals monitoring as her biggest concern would have been COVID-19. RN-A stated "something was brewing" for R55. RN-A explained the risk of staff not updating medical providers on residents' changes in conditions was "this [death]." When interviewed on 3/25/20, at 11:07 a.m. the director of nursing (DON) stated she would have expected staff to update R55's medical provider on his unresponsive episode and increased periods of lower O2 sats as these would be considered a change in condition for R55. Further, the DON explained she would have expected to see supporting documentation that staff had followed up with the medical provider. The DON confirmed R55 had not had COVID-19 testing on 11/29/20 after the unresponsive episode or on 11/30/20 before going to dialysis despite the DON's explanation the facility's	2 265		

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2 265	Continued From page 8	2 265		

"primary focus" of "resident care delivery" around the time of R55's unresponsive episode had been COVID-19 and "infection control."

During interview on 3/25/21, at 11:58 a.m. nurse practitioner (NP)-A stated R55 had been "stable" and "doing fairly well" after his gastrointestinal (GI) bleed in September. NP-A reviewed available R55 clinic notes during the interview and confirmed the only notes present past 11/16/20 had been related to negative COVID-19 test results. NP-A voiced she had last examined R55 on 11/9/20 for a "regulatory visit." NP-A acknowledged she had not been provided any updates which concerned R55's 11/28/20 fall, the unresponsive episode on 11/29/20, or his abnormal O2 sats. NP-A denied any recollection of R55 having had unresponsive episodes in the past and she further explained R55 typically had not experienced issues with lower O2 sats despite R55's having not wanted to wear the O2 at all times as prescribed. NP-A stated she would have expected staff to contact the clinic about R55's changes in condition as she "would have done more of a workup" which would have included a COVID-19 test. In addition, NP-A explained, "We would have been fairly aggressive to monitor him due to COVID running rampant at that time [in the facility]."
During a telephone interview on 3/25/21, at 12:20 p.m. LPN-F stated on the evening of 11/29/20, R55 had "went limp" when staff "had him in the lift." LPN-F believed he had similar episodes of this in the past "but not too frequent." LPN-F had been unable to provide further details about other unresponsive episodes R55 may have had. LPN-F acknowledged R55's O2 sats were typically "in the 90's;" however, they would drop to about 85 - 88% but only with exertion. LPN-F had been unable to remember if R55 had signs or

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2 265	Continued From page 9 symptoms of respiratory distress on 11/29/20 or 11/30/20. LPN-F confirmed she had not contacted the medical provider about R55's unresponsive episode or overall status and further confirmed she had also not updated dialysis on 11/30/20 regarding R55's status that morning. LPN-F stated she had felt R55's unresponsive episode had been a concern; however, due to her belief he had this type of episode in the past she only monitored R55. LPN-F explained if a resident's condition were to change she would take "the proper steps" of monitoring their vitals and calling the medical provider. A policy Change in Resident Condition, dated 6/2019, directed staff to notify the resident's physician/healthcare provider when there had been an accident or incident which involved the resident, a significant change in the resident's mental physical or mental condition, and/or a need to transfer the resident to a hospital. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could in-service staff on policy and/or procedures for contacting medical provider(s) and/or resident representative(s) with any resident changes in condition. They could than audit resident records to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
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.	2 565		4/28/21

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2 565	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to include assessed dental concerns and subsequent interventions to ensure good oral hygiene was maintained for 1 of 2 residents (R37) reviewed for dental hygiene care. Findings include: R37's admission Minimum Data Set (MDS), dated 2/18/21, identified R37 had intact cognition and required extensive assistance to complete her activities of daily living (ADLs). Further, the MDS outlined R37 had no broken teeth and/or likely cavities present. R37's MHM (Monarch Health Management) Oral/Dental Evaluation, dated 2/11/21, identified R37 had observed plaque or debris on her teeth along with, " ... several missing teeth." R37 was recorded as not wearing dentures and required set-up for oral cares. When interviewed on 3/22/21, at 3:33 p.m. R37 voiced she needed dental care as "they're [her teeth] falling out." R37 expressed she had numerous missing teeth which made her self-conscious of her smile and, as a result, she tried to "hide it as much as possible." R37 proceeded to show her teeth to the surveyor, and was observed to have several missing teeth on both the top and lower palate. However, R37's care plan, printed 3/23/21, was reviewed and lacked any identified problem statements, goal(s), or interventions to ensure R37 maintained good oral hygiene despite being assessed as needing oversight and/or assistance to ensure dental care was completed and having numerous missing teeth.	2 565	Corrected	

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2 565	Continued From page 11	2 565		

When interviewed on 3/23/21, at 1:50 p.m. nursing assistant (NA)-C stated she noticed R37 had several missing teeth and, as a result, "tries to keep her mouth closed" as she "hates her smile." NA-C explained they attempt to help R37 clean her teeth but she often refuses or will verbalize she would do it later on her own. However, NA-C added, she was unsure if it was actually getting done or not then.
On 3/24/21, at 9:56 a.m. registered nurse manager (RN)-A was interviewed and verified the care plan lacked any problem statements, goals or interventions regarding R37's dental care or needs. RN-A explained since there had been no issues recorded on R37's MDS, dated 2/18/21, she "wouldn't think to care plan it." However, RN-A voiced she was aware R37 had numerous missing teeth and stated it should have been added to the care plan to ensure staff were "looking at the whole person" and getting care completed.
A provided Care Planning policy, dated 6/2019, outlined the interdisciplinary team (IDT) would develop and implement a comprehensive care plan no later than 21 days after admission for each resident. The policy continued, "The goal of the person centered, individualized care plan is to identify problem areas and their causes, and develop interventions that are targeted and meaningful to the resident."
SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could audit all current residents to ensure dental status concerns are addressed and care planned, and that resident oral care preferences are carried out. They could then in-service staff to ensure dental care plans are in place and oral cares are acted upon timely then audit to ensure ongoing compliance.

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2 565	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
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 record review the facility failed to ensure assessed and care planned interventions were implemented immediately after a fall in order to minimize recurrent falls and/or injury for 1 of 1 residents (R55) reviewed for falls. Further the facility failed to ensure adequate supervision to prevent accidents for 1 of 1 residents (R40) reviewed for accidents. Findings include: FALL INTERVENTIONS R55's quarterly Minimum Data Set (MDS), dated 10/14/20, identified R55 had intact cognition and	2 830	Corrected	4/28/21

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2 830	Continued From page 13	2 830		

communication abilities. Further, the MDS indicated R55 required limited physical assist for mobility and most activities of daily living (ADL's) in which R22 had instability during surface transitions and walking. The MDS identified R55 had been free of falls since the prior MDS assessment and had diagnosis of orthostatic hypotension (abnormal decrease in blood pressure when standing) and respiratory failure (failure of lungs to function properly) with oxygen used at that time.

R55's care plan, revised on 10/12/20, indicated R55 had been a fall risk related to history of falls, weakness, and assistance needed with transfers. R55's fall goal had been to be safe and free from falls. The care plan indicated a revision on 11/24/20 which identified call don't fall signs had been placed, along with anti-roll back brakes added to R55's wheelchair. The care plan failed to identify any further revisions after 11/24/20.

R55's Fall Review Evaluation, dated 1/15/20, identified R55 had multiple falls in the prior six months in which he took more than three fall risk medications and had fall risk diagnosis. The evaluation indicated R55 had been oriented and alert and had no issues with his memory. R55's vision was impaired and required use of a device and hands-on assist to move from place to place in which he had been unable to independently come to a standing position. Care plan interventions at the time of the evaluation were as follows: proper footwear at all times; room to be kept clear of clutter and debris; personal items and call light within reach.

A progress note, entered on 11/16/20, at 12:44 p.m. indicated R55 had been found lying on the floor after he had been previously noted in his

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2 830	Continued From page 14	2 830		

wheelchair with a small laceration on top of his head and a raised swollen area above the right eye. The progress note did not identify any new fall prevention interventions or documentation to support a reason for no new fall prevention interventions in response to the fall.

A Fall Scene Investigation Form, dated 11/17/20, indicated R55 had lost his strength and appeared to get weak after dialysis. The form identified R55 did not have his oxygen on prior to the fall and that R55 had been "sleepy." Further, the form identified weakness and low blood oxygen saturations had appeared to be the root cause of the fall and directed staff to lay R55 down in bed when his blood oxygen saturations were below 90%.

An Incident Review and Analysis V-3, dated 11/24/20, at 3:09 p.m. identified R55 had a fall on 11/16/20, at 12:10 p.m. The incident report indicated dietary staff had heard a crash in which R55 had been found on the floor in his room. R55 had not known what happened; however, the incident report identified R55 had returned from dialysis that day with his oxygen "off" and had oxygen blood saturations of 69% at that time. Staff had applied oxygen after they obtained the low oxygen saturation reading and "5 minutes later was on floor." Further, the incident report indicated R55 had not always been aware of his limitations and required assist of one. Call don't fall signs were placed on 11/24/20 in response to the fall.

A progress note, entered on 11/28/20, at 4:11 p.m. indicated at approximately 2:45 p.m. R55 had been found lying on the floor with a sustained left elbow skin tear. The progress note identified R55 stated he fell after he reached for a fork he

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2 830	Continued From page 15	2 830		

had dropped on the floor while seated in his wheelchair. A fork had been found under him when staff assisted him up off of the floor and he had been incontinent during the incident. The progress note did not identify any new fall prevention interventions or documentation to support a reason for no new fall prevention interventions in response to the fall.

R55's electronic medical record (EMR) lacked evidence of a Fall Scene Investigation Form related to R55's 11/28/20 fall.

R55's EMR lacked evidence of an Incident Review and Analysis V-3 related to R55's 11/28/20 fall. An Incident Review and Analysis V-3 had been requested related to R55's 11/28/20 fall; however, none had been provided.

R55's record lacked evidence his physician was notified of the fall.

On 3/24/21, information had been requested to support R55's 11/28/20 fall had been reviewed by the interdisciplinary team (IDT). An unnamed, undated piece of paper had been provided to the surveyor on 3/24/21, which indicated typed information R55 had been found on the floor on 11/28/20 at 4:11 p.m. Further, this indicated R55 had been free of injury and intervention(s) for the fall were "TBD [to be determined]." A hand written note on the piece of paper indicated, "This is pulled from daily clinical morning meeting report on 11/30/2020 (Monday) where falls/interventions, injuries are reviewed. (patient was admitted to hosp [hospital] on 11/30/20)."

When interviewed on 3/25/21, at 10:11 a.m. LPN-B stated staff were expected to put an "immediate intervention" in place after a resident

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2 830	Continued From page 16	2 830		

fall which would help decrease further potential falls. The intervention(s) put into place after the fall would then be reviewed during the next IDT meeting for any needed adjustments. LPN-B stated staff always have a nurse who is on-call if they required assist with fall intervention decision making at the time of the fall. LPN-B explained staff were also expected to fill out an Incident Review and Analysis, along with a Risk Management report, after each resident fall.

During interview on 3/25/21, at 10:40 a.m. care manager registered nurse (RN)-A stated staff were expected to put "immediate interventions" in place after a resident fall. RN-A explained she would have looked to see if R55 had a grabber, "maybe Dycem (non-slip material)," or some other intervention as she "would have done something." RN-A reviewed R55's EMR and acknowledged R55's 11/28/20 fall progress note; however, she confirmed the EMR lacked information that identified immediate fall intervention(s) had been implemented or that the fall had been followed up on by facility management, to which RN-A voiced, "Does not look like anything was done." RN-A explained staff should have communicated the fall to management for follow up as staff "should have been trained" on facility expected fall procedures.

When interviewed on 3/25/21, at 11:07 a.m. the director of nursing (DON) stated the nurse and the nursing assistants would talk after a fall and "initiate something." The DON explained fall interventions were "usually done immediately" and she would expect the interventions to be documented. Further, the DON explained IDT reviewed falls in which staff discussed the effectiveness of the fall interventions. The DON reviewed R55's EMR and confirmed the lack of

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2 830	Continued From page 17	2 830		

documented interventions after his 11/28/20 fall.

A policy Fall Prevention and Management, revised 2/2021, indicated the purpose of the policy was to identify residents at risk for falls, to implement fall prevention interventions, and to provide guidelines for post-fall resident assessment and fall root cause identification. The policy directs staff post-fall to notify the resident's medical provider and family in an appropriate time frame, to complete an incident review and analysis, and record in the EMR "appropriate interventions taken to prevent future falls." In addition, the policy directs staff to re-evaluate fall interventions if a resident continues to fall, to evaluate the chain of events or circumstances preceding the fall, and that falls will be reviewed by the IDT daily.

ADEQUATE SUPERVISION AND GAIT BELT USE

R40's admission (MDS) dated 2/16/21, identified moderately impaired cognition, extensive assist needed for bed mobility, transfers, dressing, toilet use, and personal hygiene. R40 also required one person physical assistance to walk in room. R40's medical diagnoses included arthritis and cerebral vascular accident (CVA) (stroke) with an indwelling urinary catheter, and a fall within the last month.

R40's Visual/Bedside Kardex Report document dated 2/19/21, identified R40 required assist of one and front wheeled walker (FWW) to ambulate short distances and to walk in room.

R40's care plan dated 3/4/21 identified fall risk related to history of falls, weakness, CVA, heart

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2 830	Continued From page 18	2 830		

failure, and DM2 (diabetes mellitus); follow PT (physical therapy) and OT (occupational therapy) instructions for mobility functional; alteration in mobility related to CVA polyarthritis, heart failure, DM2, CKD [chronic kidney disease], and weakness; follow PT instructions; assist with one and FWW ambulation; assist one to two with movement in bed and in/out of bed; assist one and FWW with transfers; self-care deficit related to CVA, polyarthritis, heart failure, DM2, CKD, and weakness; assist one with dressing and personal hygiene.

R40's fall review evaluation dated 2/10/21, identified history of falls in the last six months one to two times; medication use and diagnoses that may contribute to falls: diuretics (water pills used to increase urine production in kidneys), NSAIDS (nonsteroidal anti-inflammatory drugs); gait while standing in one spot, walking straight forward and while make a turn exhibits loss of balance while standing and requires wide base support. Fall review summary identified R40 has the potential risk for fall r/t (related to) age, decreased mobility, history of falls, medication listed above, and diagnosis of CVA; resident is continent of bowel and bladder and has indwelling Foley for neurogenic bladder; assist of one and FWW for transfers and currently does not self transfer.

Review of R40's occupational therapy recertification, progress report & updated therapy plan dated 3/12/21, identified R40 needed SBA [stand by assistance] with FWW for standing balance, toileting transfer with SBA, and current assistance of one per PT.

R40's progress note dated 3/23/21, at 10:55 a.m. identified R40 required daily skilled care for stroke, received PT and OT and transfers with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 19 assist of one. Review of R40's physical therapy treatment encounter notes dated 3/24/21, identified "discussed and instructed/educated pt [patient] [R40] that PT would like to to [sic] ask for assist with all transfers due to fall risks. Continue to stress to pt [R45] to use call light for assist with mobility, transfer training wheelchair with SBA. During an observation on 03/23/21, at 2:10 p.m. R40 sat on toilet in bathroom by herself with wheel chair placed next to her. At 2:13 p.m. R40 had gotten herself off the toilet, back into her wheelchair, and pushed her feet on the floor to wheel herself back to the bedside table for a drink of water. During an observation on 3/24/21, at 7:16 a.m. R40 sat on the edge of the bed completely dressed and bent over to tie her shoes. R40 stood up, held onto the bedside railing, and pivoted herself into the wheel chair located in front of her without assistance. R40 bent down and unhooked indwelling urinary catheter bag and placed it on her lap. R40 pushed the call light on to request help with the indwelling urinary catheter bag. During an observation on 3/24/21, at 7:45 a.m. nursing assistant (NA)-G entered R40's bathroom and placed gloves on. R40, without a gait belt on, pushed herself up off the toilet to a standing position and took hold of the bar on the wall. NA-G provided perineal cares and pulled her pants up while R40 hung onto the bar on the bathroom wall. R40 pivoted herself into the wheelchair. The facility staff failed to transfer R40 with the use of a gait belt.	2 830		

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2 830	Continued From page 20	2 830		

During an observation on 03/25/21 08:18 a.m. a dietary aid knocked on R40's closed door and waited for a response and heard nothing, she knocked again and then opened door. R40 was observed to open the bathroom door and pushed herself in the wheelchair with her feet. R40 wore the same blue sweatshirt and tan slacks on she wore yesterday. R40 verified she had gotten herself dressed and stated "Yes, shoes and all by myself."

During an interview with R40 on 3/23/21, at 1:56 p.m. stated she was headed to the bathroom right now. R40 stated, "I take myself and I don't know if I am supposed to." R40 indicated the staff must know it, as she is not asking them for help and is getting there somehow. R40 also stated "I try to be careful, wheel myself to the bathroom and use the bar on the wall to pull myself up. R40 also indicated therapy told her she was getting much stronger.

During an interview on 03/23/21, at 3:07 p.m. trained medication aid (TMA)-C indicated R40 was toileted about every 2 hours and transferred with assist of one. TMA-C indicated R40 does not really transfer by herself. TMA-C identified a transfer belt is placed on R40 and assistance of one is needed to stand because she may lean backwards and we want to prevent a fall. TMA-C also indicated R40 sometimes needed cues to hang onto the bar on the wall.

During an interview on 03/23/21, at 3:19 p.m. NA-K identified R40 was one assist to go to the bathroom. NA-K also stated we have rarely had to help R40 to the bathroom, she has taken herself but I have not seen that. NA-K indicated she placed the wheelchair next to the bed at a forty-five degrees, R40 grabs the bed railing on

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2 830	Continued From page 21	2 830		

her own, and I have also transferred her from the wheel chair to bed. NA-K verified she had helped boost R40 up more times than not to get her out of the wheelchair. NA-K also verified the charting on R40 indicated she should have assist of one to transfer.

During an interview on 03/24/21, at 8:04 a.m. NA-G indicated a gait belt was not used during the transfer with F40 in her bathroom today at 7:45 a.m. NA-G identified a gait belt should be used when R40 transferred and staff need to be in the room because she had fallen prior to coming to this facility. NA-G stated staff need to make sure R40 does not fall. NA-G also stated she is aware R40 transferred herself and she had told her coworkers and indicated they had also noted R40 self-transfer. NA-G identified she had also informed LPN-H.

During an interview on 3/24/21, at 8:47 a.m. LPN-E identified R40 required assistance of one to transfer. LPN-E stated she had caught R40 self transfer regularly and going to the bathroom by herself. LPN-E indicated she reminded R40 to call for help. LPN-E also indicated she had informed PT so they are well aware of it. LPN-E indicated R40 should have on a gait belt during all transfers. LPN-E stated "I did not place a belt on her this morning" during a transfer R40 is too quick and does not like it. LPN-E identified the transfer gait belt is used for safety to help prevent falls.

During an interview on 3/24/21, at 12:42 p.m. OT identified R40 should be provided with stand by assistance of one due to being unsteady with walking and transfers. OT also identified R40 should have supervision with transfers onto the toilet from the wheel chair. OT also verified a gait

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2 830	Continued From page 22	2 830		

transfer belt should be used anytime you transfer R40. OT stated she heard R40 had been self transferring in the rehabilitation meeting today.

During an interview on 03/24/21, at 01:45 p.m. PT identities every time physical therapy worked with R40 she would be assessed, then progress notes are entered every ten days or on tenth visit. PT stated R40 should not be self-transferred, should put on the call light, and wait for staff to arrive to help her. PT indicated she had not been made aware R40 had self transferred.

Facility policy titled Monarch Healthcare Management [MHN] Safe Resident Handling Program last revised on 3/20/20, identified gait belts must be used for ambulatory residents when indicated in the patient care plan to allow employees to hold onto the belt to provide support and stabilize the resident when walking. A gait belt must also be used during a stand pivot transfer to provide guidance to the resident, when indicated in the care plan.

SUGGESTED METHOD OF CORRECTION: The DON or designee, could audit all current fall risk residents and resident falls to ensure care plan interventions are in place and acted upon toto help mitigate fall risk. The DON or designee, could in-service staff on fall risk interventions and care plan implementation and audit for compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving	2 850		4/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 850	Continued From page 23 Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine grooming to 1 of 1 residents (R26) reviewed for activities of daily living (ADLs) and was dependent on staff for care. Findings include: R26's face sheet, dated 3/24/21, indicated R26 had Parkinson's disease (disorder that affects movement), major depressive disorder, anxiety disorder, post traumatic stress disorder, dementia in other diseases classified elsewhere with behavioral disturbances (impairment of memory and functioning), and muscle weakness. R26's MDS dated 2/3/21, indicated severe cognitive impairment and required extensive assistance with activities of daily living. R26's care plan revised on 2/10/21, indicated limited physical mobility related to weakness and required 2 staff at times for cares. R26 has self care performance deficit with activities of daily living related to Parkinson's, post traumatic stress disorder, confusion at time, personal hygiene requires 2 assist total dependence with all personal hygiene when he refuses care allow time and reproach. Review of R26's tasked dated 3/2021, indicated personal hygiene was signed off at least daily from march 1st through March 25th. Review of Weekly Skin Inspection dated 3/19/21, indicated R26 had a bedbath and was not	2 850	Corrected	

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2 850	Continued From page 24 shaved. During observation on 3/22/21, at 1:27 p.m. R26 had scruffy chin/cheek. During observation on 3/23/21, at 8:48 a.m. R26 seated in Broda chair in day room. Mask in place and had long hairs under chin and on cheeks. Unable to see under mask or upper lip due to mask being in place. During observation on 3/23/21, at 9:04 a.m. R26's mask was removed by staff and noted 1/4-3/4 inch coarse, gray and white hairs on chin, under chin, and cheeks. R26 stated staff shave him but further stated not "for a while". During observation on 3/23/21, at 2:06 p.m. hospice nurse in R26's room. R26 continues to have long facial hair 1/4-3/4 inch remains in place. R26 appeared calm and cooperative with hospice nurse. During observation on 3/23/21, at 3:20 p.m. R26 sitting up in Broda chair and still has not been shaved. 1/4-3/4 inch coarse, gray and white hairs on chin, under chin, and cheeks. During observation on 3/24/21, at 8:52 a.m. R26 sitting up in Broada chair, continues to be unshaved. During interview on 3/24/21, at 9:28 a.m. nursing assistant (NA)-E stated she tried to shave R26 this morning but his razor is broken. NA-E stated she tries to shave the resident every day if possible. NA-E stated she is not sure how long his razor has not been working, but appears he hasn't been shaved in a while. NA-E stated she will bring the razor to the social worker and try to find another razor to shave him. During interview on 3/24/21, at 12:54 p.m. registered nurse (RN)-B stated she was only made aware of the broken shaver today and family will not supply a new one as they just got him one. RN-B stated as long as he wishes to be shaved he should be. RN-B stated that she	2 850		

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2 850	Continued From page 25 already is working on getting him a new one. During interview on 3/24/21, at 1:04 p.m. NA-E stated that R26 was now shaved and she applied some oil to his face as it was rough. NA-E stated R26 tolerated being shaved well. NA-E further stated that she found out that someone lost the head to the razor and that is why it is not working, but not sure how long it hasn't been working for. NA-E stated if a residents razor is not working there is a spare on the North end that they can used and clean and that they should also bring the broken razor to the social worker. During observation on 3/24/21, at 1:05 p.m. R26 face appears smooth and without scruffy hair on face or neck. During interview on 3/24/21, at 1:44 p.m. NA-B stated she shaves residents every week or so, but some need to be shaved daily if there hair grows fast. NA-B stated R26's razor has been broken for about a week or so and that there is a universal one on North side that staff can use. NA-B further stated that if a resident looked scruffy and hair was growing out they should go to the North end to get the universal razor. NA-B stated R26 use to have really long facial hair, however, now prefers it to be shaved. During interview on 3/25/21, at 9:24 a.m. licensed practical nurse (LPN)-B stated R26 requires staff assistance for being shaved and the head of the razor is broken, but staff should still be able to use the side piece for shaving him or using the universal razor on the North end. LPN-B stated R26 does have behaviors and sometimes will hit out at staff when being shaved, however they should attempt it at a later time. During interview on 3/25/21, at 9:52 a.m. Director of nursing (DON) stated men should be shaved according to the care plan and each resident is different in this expectations. DON stated if someone's razor is broken they should use the	2 850		

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2 850	Continued From page 26	2 850		

one at the facility until their razor is replaced and should be reported to the unit manager. DON stated it would not be acceptable to leave them unshaved. DON stated they do a periodic walk through to make sure that residents are being shaved. DON further stated shaving should be under personal hygiene which is done daily and with R26 should be reproached if he had behaviors during first attempt.
Shaving the resident policy revised 2/2018, indicated "The purpose of this procedure is to promote cleanliness and to provide skin care. The following information should be recorded in the resident's medical record: the date and time that the procedure was performed, the name and title of the individual who performed the procedure, If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. Any problems or complaints made by the resident related to the procedure, if the resident refused the treatment, the reason(s) why and the intervention taken. The signature and title of the person recording the data. Reporting:notify the supervisor if the resident refuses the procedure. report other information in accordance what facility policy and professional standards of practice."
SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could audit all current residents for facial hair to ensure shaving preferences are being carried out. They could then in-service staff to ensure shaving preferences are acted upon timely then audit to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 895	Continued From page 27	2 895		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned range of motion (ROM) exercises were consistently implemented to prevent decline and reduce the risk of contracture for 1 of 2 residents (R14) reviewed for mobility and ROM. Findings include: R14's annual Minimum Data Set (MDS), dated 10/16/20, identified R14 had intact cognition and demonstrated no delusions or other behaviors. Further, R14 required extensive assistance to complete most of her activities of daily living (ADLs); however, the section to record functional limitation(s) to her ROM were dashed and did not record if any impairment existed. R14's Therapy Recommendations sheet, dated 6/11/19, identified a Restorative Nursing Program for R14 which included, "U/E [upper extremity] ROM 6x/wk [six times a week] - 10 reps [repetitions]," and, "L/E [lower extremities] Ex's	2 895	Corrected	4/28/21

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2 895	Continued From page 28	2 895		

[exercises] 2x/wk - 15 reps." Further, R14's care plan, dated 3/5/21, identified R14 was alert and orientated to person, place and time. The care plan outlined R14 had limited physical mobility and directed to provide gentle ROM daily with cares along with, "UE/LE ROM 7X/Week 10 Reps."

On 3/22/21, at 2:10 p.m. R14 was observed in her room. R14 had visible contractures of the fingers of her left hand with an applied splint in place; along with a rolled up washcloth present in the slightly closed fist of her right hand. R14 stated she was supposed to be on a ROM program for her upper and lower extremities; however, it was not always getting completed due to poor staffing in the facility. R14 voiced she went to an offsite campus for other rehab exercises a couple times a week, however, still needed the ROM programs done at the nursing home to prevent further loss of her mobility. R14 expressed these concerns had been reported to the nurses but they just always tell her "we're working on it." Further, R14 voiced she felt her fingers and joints felt tighter in the past weeks and attributed it to the lack of her ROM programs being completed.

When interviewed on 3/24/21, at 10:04 a.m. nursing assistant (NA)-C stated R14 had several exercises she was supposed to be doing including a NuStep and "standing frame" program; however, these would often be refused. NA-C voiced she was aware R14 wore braces on her upper extremities and acknowledged hearing R14 voice her ROM exercises weren't being completed adding, "She does a lot [complain about it]." NA-C stated R14's ROM was supposed to be done "when she wakes up," however, then voiced she was unaware a lower extremity ROM program was care planned adding, "As far as I [knew] we didn't have to [do the lower ROM]."

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2 895	Continued From page 29	2 895		

NA-C expressed R14's exercises may not be getting done consistently as R14 favors certain staff members to care for her and others may not complete the programs "the way she wants," however, verified she was unsure. NA-C explained R14 had not really complained about increased pain, nor had NA-C observed more tightening or stiffening in R14's extremities in the past months. Further, NA-C stated any attempted or completed exercises, including ROM programs, would be recorded by the NA staff in the PointClickCare charting system.
During interview on 3/24/21, at 10:25 a.m. NA-F stated she routinely worked with R14 and voiced she had heard R14 complain before that "her contraction" was "kind of stiff," however, NA-F did not feel R14 had sustained a decline in her overall ROM in the past months. NA-F voiced R14 had mentioned before her ROM programs to her upper and lower extremities were not being completed adding she last heard her voice such a complaint "maybe a week ago or so." Further, NA-F expressed she believed the night shift was responsible to complete R14's ROM exercises adding, "I want to say nights do [them]."
R14's Documentation Survey Report(s) v2, dated 2/2021, identified tasks to be completed for R14. This included, "Floor Aides: L/E exercise 2x/wk 15 reps also Be [sic] sure do ROM daily on evening her hands, arms and legs, 7 days per week this needs to be done daily by the CNA's if there is no restorative aids [sic]." This was recorded as being completed only two times in February 2021, on 2/1/21 and 2/4/21. The remainder of the areas to record the exercise minutes and rep(s) were either left blank, or had "NA [not applicable]" dictated. In addition, the report outlined another task which read, "Floor Aides: Passive ROM U/E ROM 5x/wk 10 reps." This was recorded as being completed only once

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2 895	Continued From page 30 in February 2021, on 2/1/21. The remainder of the areas to record the exercise minutes and rep(s) were either left blank, or had "NA [not applicable]." R14's Documentation Survey Report v2, dated 3/2021, identified tasks to be completed for R14. This included, "Floor Aides: L/E exercise 2x/wk 15 reps also Be sure do ROM daily on evening her hands, arms and legs, 7 days per week this needs to be done daily by the CNA's if there is no restorative aids [sic]." This was recorded as being completed only three times in March (so far) on 3/9/21, 3/10/21, and 3/15/21. R14 was recorded as refusing the exercises only three times, on 3/19/21, 3/20/21, and 3/24/21. The remainder of the areas to record the exercise minutes and rep(s) were either left blank, or had "NA [not applicable]" dictated. There was no evidence R14 had been provided or offered her LE ROM exercises the week of 3/1/21 to 3/6/21. In addition, the report outlined a task which read, "Floor Aides: Passive ROM U/E ROM 5x/wk 10 reps." This was also recorded as being completed only two times in March (so far) on 3/9/21 and 3/15/21. R14 was recorded as refusing the exercises only four times, on 3/10/21, 3/19/21, 3/20/21, and 3/24/21. The remainder of the areas to record the exercise minutes and rep(s) were either left blank, or had "NA [not applicable]" or "No" dictated. Further, R14's medical record was reviewed and lacked any other evidence demonstrating when R14's ROM exercises had been completed and/or refused. When interviewed on 3/24/21, at 1:29 p.m. registered nurse manager (RN)-A voiced R14 had a previous spinal cord injury and required extensive assistance with her mobility and ADLs as a result. RN-A reviewed R14's medical record, including the recorded minutes and reps for each exercise, and verified the exercises were not	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775	A. BUILDING: ______ B. WING ______	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, I	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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2 895	Continued From page 31 being completed or documented as they should be; nor was there evidence to demonstrate the ROM exercises were offered and refused. RN-A expressed there was "room for improvement" and voiced she was not sure if the exercises were getting done or not. RN-A stated R14's ROM exercise programs should be completed and documented as care planned to help prevent further contracture and promote strengthening adding, "They need to be done." A provided Range of Motion Exercises policy, dated 10/2010, directed how to complete ROM for a resident which included ensuring a physician's order was in place for such procedure and reviewing the care plan prior to starting for any "special needs" of the resident. The policy then outlined specific physical step(s) on how to complete various ROM exercises and concluded with directing appropriate documentation was recorded in the medical record, and, "Report other information in accordance with facility policy and professional standards of practice." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could audit all residents receiving range of motion programming to ensure range of motion is being provided as directed. They could then in-service staff to ensure range of motion programming is acted upon and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director	2 900		4/28/21

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2 900	Continued From page 32 of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed follow pressure ulcer interventions for 2 of 2 residents (R4 and R26) identified at risk for pressure ulcers. Findings include: R4's annual minimum data set (MDS) dated 3/17/21, indicated severe cognitive impairment along with needed extensive assistance with bed mobility and transfers. R4's face sheet dated 3/24/21, indicated diagnosis included: unspecified dementia with behavioral disturbances (Brain impairment in memory and judgement), peripheral vascular disease, insomnia (difficulty with sleeping), Alzheimer disease with late onset (a progressive disease that destroys memory and other important mental functions). R4's provider orders dated 12/23/20, indicated use foot cradle under blanket when resident is in bed to reduce pressure on feet/toes. Monitor scabs on right/left toes every shift discontinue when they heal. Betadine swab sticks swab 10%	2 900	Corrected	

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2 900	Continued From page 33 apply to first and second toes topically every morning and at bedtime for wound care. R4's tissue tolerance evaluation and skin risk factors dated 3/16/21, indicated moderate risk for skin breakdown. R4's Care plan, revised 3/4/21, indicated ADL's extensive assistance with dressing, showering, bed mobility and personal hygiene. R4's care plan further indicated vulnerable with mobility limitation, communications, staff will provide daily cares as per care plan and will notify nursing when plan needs updating for accuracy. Risk for skin integrity with interventions of monitoring skin integrity every shift with cares and on bath days, apply lotion to dry skin, and reposition approximately every 2-3 hours and as needed (prn). R4's care plan indicated risk for skin integrity which lacked any information about the foot cradle. R4's weekly skin assessment dated 3/17/21, indicated right toes remains discolored ongoing. Review of skin assessment dated 3/10/2, indicated right foot great toe and second digit scabbed areas ongoing. During observation on 3/22/21, 1:15 p.m. R4 laying on left side in bed with blankets on top of feet covering entire body. Foot cradle was observed sitting on the floor next to the wall under the tray table. During observation on 3/23/21, at 1:59 p.m. R4 laying on left side with blankets covering body from neck to below toes, foot cradle was again observed sitting on the floor, next to the wall under the tray table. No concave mattress was observed in use. During interview on 3/23/21, at 2:35 p.m. nursing assistant (NA)-A stated being unaware of R4 should be using the foot cradle while in bed but would assume the cradle should be kept on her bed and utilized to prevent further break down of	2 900		

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2 900	Continued From page 34	2 900		

her toes. NA-A stated R4 had scabs on her toes that the nurses are monitoring. NA-A stated she has never seen the foot cradle on R4's bed. NA-A further stated she follows the Kardex which tells her how to care for the residents and did not see this listed on there.
Immediately following interview, at 2:42 p.m. NA-A left R4's room, without implementing foot cradle, and walked down the hallway into another residents room, R4 continues to lay on left side with blankets on her feet/toes and foot cradle on the floor.
During observation on 3/24/21, at 7:24 a.m. R4 lying in bed toes/feet have blankets on them and foot cradle sitting on floor, next to wall and under the tray table.
During interview on 3/24/21, at 7:24 a.m. NA-B stated R4 has sores on her right great toe and second toe of the right foot which the trained medication aid or nurse will treat before getting R4 up for the day. NA-B stated since she has been employed she has never seen the foot cradle being used which has been for approximately 7-8 months and would look to the Kardex for interventions for the residents.
During interview on 3/24/21, at 9:19 a.m. Licensed practical nurse (LPN)-A stated R4 should have the foot cradle on the bed if there was an order for it. LPN-A stated R4 has scabs on her right toes that are being monitored and treatments done per order. LPN-A further stated the staff look to the care plan/Kardex when caring for residents and would think that those interventions should be on there.
During interview on 3/24/21, at 9:21 a.m. LPN-B stated that R4 should be using the foot cradle due to her sores on her toes. LPN-B stated it is important the foot cradle to prevent further break down and relieving pressure to her toes. LPN-B stated all interventions should be on the care plan

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2 900	Continued From page 35	2 900		

for staff to follow as this indicated how to care for the resident.
During interview on 3/25/21, at 9:56 a.m. Director of nursing (DON) stated R4's foot cradle should be on her bed to prevent pressure on her feet and to prevent further breakdown and would expect that it would be listed on the Care plan. DON stated she would expect staff to be following the residents care plan.
R26's face sheet dated 3/24/21, indicated diagnosis include: Parkinson's disease (disorder that affects movement), major depressive disorder, anxiety disorder, post traumatic stress disorder, dementia in other diseases classified elsewhere with behavioral disturbances (impairment of memory and functioning), and muscle weakness.
R26's MDS dated 2/3/21, indicated severe cognitive impairment and required extensive two assist with transfers and bed mobility. R26's required extensive assistance with activities of daily living.
R26's order summary report dated 3/24/21, indicated Left (L) heel- remove pressure by floating heel with a pillow under calf and applying a heel cushion boot. Heel protectors to both feet. Offload heels in bed. Position blankets over bed frame. Monitor right lateral heel bruise non-blanchable as well as left heel and left toes redness. Monitor bruise on top of right great toe every shift.
Review of weekly pressure wound evaluation are as follows:
-3/19/21, right heel pressure length 2.5 x 2.5 0 depth unstageable.
-3/12/21, right heel pressure length 3.0 x 1.2 0 depth unstageable.
-3/4/21, right heel pressure length 2.5 x 1.0 0 depth unstageable.
R26's care plan revised on 2/10/21, Risk for

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2 900	Continued From page 36	2 900		

alteration in skin integrity interventions to include turn and reposition every 2-2.5 hours. Elevate heels off the bed, foot cradle added to foot of bed to keep blankets off resident's toes, place pillow under legs as tolerated. Heal protectors when not wearing shoes. Notify hospice of any skin concerns.
During observation on 3/23/21, at 2:06 p.m. R26 lying in bed, blankets are tucked under mattress and resting on residents feet, no elevation of bilateral feet on a pillow.
During interview on 3/24/21, at 7:24 a.m. NA-B stated staff know how to care for residents by their care plan/Kardex. NA-B stated these (care plan/Kardex) list out the interventions to follow and how to transfer the resident.
During observation on 3/24/21, at 8:52 a.m. R26 sitting up in Broda chair. LPN-A removed old dressing which had serosanguinous drainage noted scant amount, cleansed with wound cleanser and dried with gauze. Wound was noted to be eschar in the center with pink surrounding skin which was blanchable. LPN did not measure wound. Applied Mepilex with boarder. R26 tolerated well. LPN-A stated hospice measures and provides wound treatments.
During interview on 3/24/21, at 9:28 a.m. NA-E stated R26 should have pressure boots on at all times, unsure if legs are to be elevated, has not seen the foot cradle in a long time, but thinks it was removed due to the air mattress and bumping his feet. NA-E stated R26 has a sore on the right foot that has a dressing on it. NA-E added she uses the Kardex which is at the desk to know how to care for the residents.
During interview on 3/24/21, at 12:54 p.m. hospice registered nurse (RN)-B stated R26 was kicking the foot cradle so they got that discontinue and he should be having feet up on a pillow as he allows to prevent further breakdown

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2 900	Continued From page 37 of skin. During observation on 3/24/21, at 1:02 p.m. R26 lying in bed with blankets over bedrail and bilateral feet elevated on a pillow. NA-E stated she placed R26 feet up on a pillow to reduce pressure now that she knows it needs to be done. During interview on 3/24/21, at 1:08 p.m. LPN-A further stated the foot cradle was removed from his care plan by the care manager since being made aware that it was still in place by state agency. LPN-A further stated staff should be following provider orders to elevate R26's feet to prevent further breakdown. LPN-A stated care manager updates the care plan/Kardex and this should reflect the plan of care for each resident. During interview on 3/25/21, at 9:24 a.m. LPN-B stated R26 should have his heels elevated on pillow as ordered to prevent further break down and further stated R26 wears heel protects as well. LPN-B stated blankets should be folded over the rail of the bed to relieve pressure and prevent further break down to resident's skin. LPN-B stated staff should be following R26 interventions that were ordered by the doctor. During observation on 3/25/21, at 9:36 a.m. R26 sitting in chair with blanket covering bilateral arms and had both heel protects on his feet. During interview on 3/25/21, at 9:52 a.m. DON stated R26's sheets should be pulled off of his feet to prevent pressure injury or add to skin break down. DON stated heel floating was important to reduce pressure of R26's heels. DON further stated it is expected for staff to follow the plan of care. Skin assessment and wound management policy dated 7/2018, indicated " Wound care will be provided per nursing or provider order. Procedure will be performed utilizing safe and sanitary methods in an effort to prevent contamination or the spread of infection. Document treatment or	2 900		

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2 900	Continued From page 38 refusal of treatment in the resident's medical record." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could audit all current residents to ensure pressure ulcer related physician orders have been care planned and then audit to ensure care planned interventions are being implemented. They could then in-service staff to ensure physician orders and care planned interventions are being carried out then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure voiced dental concerns were addressed and acted upon for 1 of 2 residents (R37) reviewed for dental care. Findings include: R37's admission Minimum Data Set (MDS), dated	21325	Corrected	4/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21325	Continued From page 39	21325		

2/18/21, identified R37 had intact cognition and required extensive assistance with her activities of daily living (ADLs), and had no obviously broken teeth or likely cavities. Further, R37's Census list, printed 3/24/21, identified R37 resided at the nursing home and listed her payer source as Medicaid.
R37's MHM (Monarch Health Management) Oral/Dental Evaluation, dated 2/11/21, identified R37 had observed plaque or debris present on her teeth along with, " ... several missing teeth." R37 was recorded not wearing any dentures and required set-up for oral cares. Further, the assessment outlined, "Staff will assist resident to set up dental appointments and transportation as needed." The completed assessment lacked any dictation regarding if R37 had been offered and/or refused a dental appointment at the time; nor any dictation on when R37's last dental appointment had been prior to her admission to the nursing home.
When interviewed on 3/22/21, at 3:33 p.m. R37 voiced she had concerns with her dentition as "they're [her teeth] falling out." R37 showed her teeth to the surveyor and was observed to have several missing teeth on both the top and lower palate. R37 stated she needed to see a dentist to get them addressed; however, nobody had helped her arrange those services. R37 voiced her missing teeth made her feel self-conscious about her smile and, as a result, she would often not smile at people and "try to hide it [missing teeth] as much as possible." Further, R37 voiced her teeth had, at times, caused her to have some pain when eating.
R37's care plan, printed 3/23/21, identified R37 had a self-care deficit related to respiratory conditions and low back pain. The care plan directed R37 required assistance of one to complete personal hygiene tasks; however, the

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21325	Continued From page 40	21325		

care plan lacked any identified problem statements, goal(s), or interventions to ensure R37 maintained good oral hygiene despite being assessed as needing oversight and/or assistance to ensure dental care was completed and having numerous missing teeth.

When interviewed on 3/23/21, at 1:50 p.m. nursing assistant (NA)-C stated the staff offer to brush R37's teeth; however, she often refuses assistance or will voice she did it herself. NA-C expressed she was unsure if R37 was actually doing her own oral cares or not. NA-C stated she recalled R37 making comments about her poor dentition and, as a result, she would try to "keep her mouth closed" so people didn't see her missing teeth. NA-C stated she was unaware R37 had reported complaints of pain when chewing due to her teeth; however, again reiterated R37 had reported not smiling at others because "she hates her smile."

R37's medical record was reviewed and lacked any evidence R37's reported concerns with her dentition had been acted upon and addressed with a dental provider for resolution despite being assessed as missing numerous teeth, and reporting to the direct care staff she "hates her smile" due to her dental condition.

On 3/24/21, at 8:47 a.m. registered nurse manager (RN)-A was interviewed. RN-A explained residents were assessed upon admission for their dental condition(s), and she recalled completing R37's assessment (dated 2/11/21) which found R37 was "missing many" teeth. RN-A reviewed R37's medical record and stated R37 had elected to receive dental services upon her admission; however, was unable to recall ever hearing "any specific complaints" about her teeth at the time. RN-A voiced she "was not aware" R37 had been making comments to the direct care staff about not wanting to smile

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21325	Continued From page 41 due to her dental condition and, as a result, no follow-up or appointments had been sought to help R37. RN-A expressed those comments should have been reported so they could be acted upon and addressed with a dental provider as there were options available for treatment despite the COVID-19 pandemic and oral concerns should be addressed to help a person's self-esteem and maintain their weight. RN-A added unresolved dental issues could become "a big problem." A provided Dental Services policy, dated 12/2016, identified 24-hour and emergency dental care would be provided through various avenues including referral(s) to community dentists. Further, the policy outlined the social services department would help coordinate any needed transportation or appointments. However, the policy lacked any dictation or guidance on how the facility would ensure voiced dental complaints were addressed or acted upon to ensure resolution. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could audit all current residents to ensure dental service needs are being met. They could then in-service staff to ensure resident dental needs are being communicated to the appropriate person and dental needs are followed up on then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the	21385		4/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21385	Continued From page 42 infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practice for 1 of 1 residents (R40) reviewed for urinary catheter cleaning procedures. Findings include: R40's admission Minimum Data Set (MDS) dated 2/16/21, identified moderately impaired cognition, indwelling urinary catheter, extensive assistance needed with bed mobility, transferring, dressing, personal hygiene, and toileting, and independent with eating. R40's current medical diagnoses included CVA (stroke), CKD (chronic kidney disease), and type 2 diabetes mellitus (DM2), and arthritis. R40's care plan dated 3/4/21, identified R40 had a self-care deficit related to CVA, polyarthritis, heart failure, DM2, CKD, weakness. Interventions noted as: assist of one with personal hygiene. During an observation on 03/24/21, at 7:27 a.m. licensed practice nurse (LPN)-E entered resident R40's room, applied gloves, and removed a urinary collection leg bag from a basin located on the floor of R40's closet. LPN-E wiped off the top connection site on the urinary collection leg bag with an alcohol swab. LPN-E rolled up R40's pant leg and placed a towel under the connection site of the large urinary collection bag attached to R40. LPN-E then wiped the connection site of the large urinary collection bag with an alcohol swab, pulled tubing apart, removed the large urinary collection bag and placed it in the	21385	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775	A. BUILDING: ___ B. WING ___	C 03/25/2021

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21385	Continued From page 43 bathroom sink. LPN-E then connected the urinary collection leg bag to R40. LPN-E looked in the bathroom for the vinegar and located it on the closet on the floor. LPN-E stated they use a mixture of fifty percent vinegar and fifty percent water in a container. LPN-E poured an unmeasured amount of vinegar and water into a plastic container. LPN-E stated "I am not familiar with this type of catheter bag, it is totally different than I have seen." At 7:42 a.m. LPN-E removed her gloves, washed her hands, and stated "I will be right back" and exited the room. At 8:00 a.m. LPN-E re-entered R40's room applied gloves, filled a syringe with the vinegar water solution she had mixed earlier. LPN-E held the urinary collection bag over the toilet with the tubing looped around her hand and did not straighten it out. LPN-E attempted to flush the catheter bag and tubing upwards from the bottom drain port with the syringe over the toilet 3 times. The solution drained into the toilet and did not go into the urinary catheter collection bag. The tubing attached to the catheter bag was not flushed with the vinegar water solution. LPN-E dumped the remaining approximately fifty percent of the vinegar water solution into the toilet. LPN-E placed a cap on the end of the tubing of the urinary catheter collection bag, laid it in the basin, and paced it on the closet floor. LPN-E removed her gloves, washed her hands, and exited the room. LPN-E failed to properly sanitize the urinary collection bag and tubing to prevent growth of bacteria. During an interview on 03/24/21, at 8:47 a.m. LPN-E indicated the wash basin was located on the floor of the closet and the urinary collection leg bag hung on the towel rack in the bathroom. LPN-E identified she had taken 2 full syringes of the vinegar water solution and flushed the urinary collection leg bag from the bottom drain port.	21385		

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21385	Continued From page 44 LPN-E also indicated the urinary collection leg bag should be flushed through the top port that connects to the bag. LPN-E stated she was unable to connect the syringe to the top port so had used the bottom one instead. During an interview on 3/25/21, at 11:12 a.m. ADON stated the urinary collection leg bag should be rinsed out with fifty percent water and fifty percent vinegar mixed solution. ADON identified a syringe that would fit the tubing was expected to be used for this process. ADON also identified the urinary bag system should be cleansed from top to bottom and the cleansing solution should drain out from the bottom port of the collection bag to prevent the introduction of bacteria. ADON identified nursing staff had received education regarding this competency. During an interview on 3/25/21, at 12:23 p.m. director of nursing (DON) stated on 11/9/20, a skills competency fair had been completed with the nursing staff. DON identified seventeen skills were covered and included catheter cares. A check list for the catheter cares was requested and DON was unable to locate that document. DON indicated staff nurses are expected to contact her if they have questions on the steps on how to complete catheter cares. DON stated a little bit of vinegar and water should be mixed together in a paper cup. DON indicates the urinary drainage bag should be placed in the sink and the vinegar water solution poured or injected with a syringe into the tubing attached to the bag from the top to bottom so that it ran down the tubing first and then into the catheter collection bag. DON also indicated the collection bag should be filled half full of the solution twice to make sure it is all cleaned out. DON indicated a cap should be placed on the top end of the tubing to avoid contamination of the system. DON stated the sanitation of the urinary catheter bag and	21385		

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21385	Continued From page 45 tubing is expected to be done from top to bottom, clean to dirty, to try and prevent infections. Review of a facility document titled Sanitation of Catheter Leg & Bedside Bags undated identified Purpose: To prevent growth of bacteria in catheter bags, that are not currently connected to the catheter drainage system. Procedures: Place the catheter bag that was just disconnected from catheter into the clean wash basin. Make sure the end of catheter bag is covered with alcohol packet and drainage port is clamped. Take disconnected catheter bag in basin to soiled utility room. Mix 1 part vinegar with 3 parts water (1/2 cup vinegar with 1 ½ cups water). Remove alcohol packet from insertion end of catheter bag tubing and instill solution into catheter tubing, into bag. Swish the solution around inside the bag for 30 seconds to 1 minute. Empty solution from the bag. Rinse catheter tubing/bag with tap water. Empty tap water from bag. Allow to air dry, in clean wash basin. Store in resident's room on top shelf of closet. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could audit residents who assist with toileting care to ensure resident hand hygiene is performed after toileting processes, along with ensuring catheter cleaning procedures are being followed. They could then in-service staff to ensure infection control practices are being carried out then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing	21435		4/28/21

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21435	Continued From page 46 home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to promote activities of interest for 1 of 2 residents (R37) reviewed who complained about a lack of meaningful activities in the facility on weekend and evening hours. In addition, the facility failed to ensure activities of interest were consistently provided to promote quality of life for 1 of 1 resident (R7) observed to not attend activities. Findings include: R37's admission Minimum Data Set (MDS), dated 2/18/21, identified R37 had intact cognition and required extensive assistance with her activities of daily living (ADLs). Further, the MDS outlined it was, "Very important," to R37 to do her favorite activities while in the nursing home. The MDS recorded R37 considered having music to listen to, being around animals, and doing activities with groups of people also as, "Very important." When interviewed on 3/22/21, at 3:16 p.m. R37 voiced she enjoyed going to the activity programs in the nursing home and attended "every one of them" offered. However, R37 expressed there	21435	Corrected	

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21435	Continued From page 47	21435		

was not enough activities to do on the weekend or evening hours adding, "There's nothing." R37 stated she just sits in her room and watches television then. Further, R37 stated she had mentioned to the staff before about needing more activities on the weekends and evenings but is just told "we're working on it."
R37's most recent MHM (Monarch Health Management) Therapeutic Recreation Evaluation, dated 2/15/21, identified R37 was alert and oriented to person, place and time with dictation reading, "wants to attend all activities." The assessment outlined R37's activity preferences which included cards, other games, crafts or art, walking or wheeling outdoors, trips or shopping, gardening or plants, and, "would like all the activities, besides reading." R37 was listed as being enthusiastic and willing to try the activities at the nursing home; and needed minimal cues or prompts to engage in group-based activities. A section labeled, "Program Plan," outlined R37 enjoyed bingo, music, church, crafts, and games; along with one-to-one activities and cards. A final section item labeled, "Resources / Interventions required," had written dictation which outlined, "no comment."
R37's care plan, dated 3/4/21, identified R37 was independent to choose the activities she wanted to attend and listed a goal which read, "To encourage to attend activities for socialization, for something to do, and or a little busy work." The care plan listed two interventions to help R37 meet this goal which read, "Keep a current activity calendar in room for their viewing and choosing pleasure ..." and, "Respect the residents right to refuse the offer of activities, but make all we have available if they would like to."
During interview on 3/23/21, at 1:50 p.m. nursing assistant (NA)-C stated R37 attended activities "once in awhile" she recalled; however, had

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21435	Continued From page 48	21435		

repeatedly heard R37 voice there was "nothing to do in this damn place." NA-C explained R37 had last complained of such over this past weekend and expressed she didn't want to remain in the nursing home due to there was "nothing to do." NA-C stated R37 was frequently observed to be "pretty much just in her room" and looking out the window or rummaging through her belongings.
When interviewed on 3/23/21, at 2:02 p.m. NA-G stated R37's activity involvement seemed to "depend on her mood" but acknowledged she did witness her attend various group-based activities such as bingo. NA-G stated she had heard R37 complain in the past of a lack of things to do in the nursing home and ask staff repeatedly, "What can I do[?]" or, "What is there to do?" NA-G stated she felt R37 was offered activities throughout the day but added she "can't say 100%."
R37's medical record was reviewed and lacked any evidence R37 had been comprehensively reassessed for her activity desire and/or involvement needs despite repeated complaints to the staff about a lack of activities of being bored. There was no evidence the facility had reviewed what, if any, options were available to include or provide R37 with additional activities involvement to ensure her quality of life while residing in the nursing home.
On 3/23/21, at 2:53 p.m. therapeutic recreation assistant (TR)-A was interviewed and verified she had worked with R37 throughout her stay at the nursing home. TR-A explained R37 did attend the activity programs and would often "share her thoughts" on them which were "both good and bad." R37 routinely attended activities such as bingo, Jingo and "Fancy Fingers" which TR-A voiced R37 as being typically receptive to most activities programs offered to her. TR-A stated she was aware R37 had voiced there "could be

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21435	Continued From page 49 more activities" on the weekends and in the evenings and added R37 made these comments to her "everyday I work." As a result, TR-A stated she brought R37 down to her supervisor, therapeutic recreation director (TRD), and had them discuss the issue. When questioned on actions or the assessment of R37 since she's been making such comments, TR-A voiced she had approached the issue with more just directing her to "come to what we have" as she has no ability to change the activity programs. R37's POC (Point of Care) Response History - Activity flowsheet, dated 3/10/21 to 3/23/21, identified all the activities R37 had attended during the period. This identified only four (4) days (3/11/21, 3/12/21, 3/16/21, and 3/18/21) R37 was recorded as having an activity completed during the evening hours (after 5:00 p.m.). The sheet recorded R37 as attending the provided table game and group movie on 3/13/21 (Saturday), and the religious service and table game on 3/13/21 (Sunday). Further, on 3/20/21 (Saturday) R37 attended the table game and food event, and the religious service and a 1:1 visit on 3/21/21 (Sunday). There was no other evidence provided demonstrating what, if any, other personal or group activities had been offered or attempted with R37 on these weekend days. On 3/23/21, at 3:03 p.m. TRD was interviewed and verified knowledge R37 had voiced concerns with a lack of activities on the weekends and evening hours. TRD voiced she provided R37 with an activities calendar and explained to her there was "something every single day" for her to do" adding these programs were what they had been able to offer "at this time" given the low census and staffing needs of the department. TRD acknowledged she had not comprehensively reassessed R37 to determine what, if any, individual or other group activities could be	21435		

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21435	Continued From page 50	21435		

provided to her; nor had she started a formal grievance process to ensure R37's concerns were addressed. TRD voiced it was important to ensure residents were assessed and their activities needs' met to ensure their quality of life at the nursing home.
A provided "Documentation, Activities" policy, dated 6/2018, identified TRD was responsible to ensure appropriate departmental documentation was maintained, and any completed activity assessments would be recorded in the medical record. However, the provided policy lacked any steps or procedures on ensuring voiced issues or concerns with the activity department were addressed and/or assessed to ensure resident' quality of life.
R7's admission minimum data set (MDS) dated 12/24/21, identified severely impaired cognition, required total assistance with transfers, and extensive assistance with her activities of daily living (ADLs). The MDS also identified R7 considered listening to music, the news, and religious services also as very important.
Review of R7's Moments Hospice document identified activities: Keep a current calendar in her room for her viewing and choosing pleasure of the activities we offer. Respect her right to refuse this offer of activities.
R7's care plan last revised 1/11/21, identified R7 independent to choose the activities she would like to attend while here. We will encourage, once she is feeling up to it if she would like to participate or receive the 1:1 activities that we offer. The care plan listed two interventions to help R7 meet this goal: "Keep a current activity calendar in room for their viewing and choosing pleasure ..." and, "Respect the residents right to refuse the offer of activities, but make all we have available if they would like to."
R7's medical record was reviewed from

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21435	Continued From page 51 admission 12/16/20 through 3/23/21 lacked any evidence R7 had been comprehensively reassessed for her activity interest and/or involvement in the facility offered activities R7's activity assessment was requested however, not received. During observations on 3/23/21, at 1:41 p.m., 2:44 p.m., 3:34 p.m., and 3:52 p.m. R7 sat in the Broda chair awake while watching the television game show "password puzzle." When asked at 3:52 p.m., R7 stated, "I like talk shows." Review of the Meeker Manor March activity events calendar for 3/23/21, indicated 8:15 a.m. to 9:30 a.m. spa hand massages, 9:30 a.m. to 11:15 a.m. devotional readings, room to room 1:1 visiting with everyone, 9:30 a.m. to 11:15 a.m., 2 p.m. matching game chapel, and 6:45 p.m. to 7:30 p.m. Dominoes. The POC response history - activity flow sheet dated 3/23/21, identified R7 at 11:09 a.m. and 3:16 p.m. as unavailable. R7's POC response history - activity flow sheet, dated 3/11/21 to 3/23/21 (13 days), identified all the activities R7 had attended during the period. The flowsheet identified only three days (3/12/21, 3/18/21, and 3/21/21) R7 was recorded as having an activity completed. The sheet recorded R7 as attending the group movie on 3/12/21 (Friday), reading/local paper/library cart/book club 3/18/21 (Thursday), and religious service 3/21/21 (Sunday). Further, on 3/11/21 R7 was recorded for the scheduled activity ([Manicure/painting fingernails) as not applicable. Additionally, the activity flowchart identified twenty-one (21) times R7 was not available out of twenty-nine (29) times approached. During an interview on 3/24/21, at 11:33 a.m. licensed practical nurse (LPN)-F indicated R7's activities included reading to her in the room. LPN-F also indicated the hospice aids spends a lot of time interacting with R7. LPN-F also	21435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21435	Continued From page 52 identified R7 really enjoys a manicure. During an interview on 3/24/21, at 12:09 p.m. recreation director (RD) identified the documentation titled POC Response History identified R7 was unavailable. RD verified unavailable indicated R7 maybe in the bathroom, hospice was with her, or sleeping in her room. RD indicated we do not wake residentis up when we see they are sleeping. RD also identified R7 played bingo with staff assistance and was very happy to get to play. During a follow-up interview on 3/25/21, at 9:47 a.m. with RD verified R7 attended only three activities in a 14 day period of time. RD indicated when activity staff prepared for a large group activity they did not have time to complete one-to-one time with R7. RD also verified R7 did not receive one-to-one time activity on the POC Response History in a 13 day period of time (3/11/21 - 3/23/21). RD stated we certainly could improve on the one-to-one time with R7. RD also stated printed articles from the newspaper had been given to R7 to read however RD was not sure if R7 was able to read them independently. RD indicated activity staff checked with R7 once and then if not available, they moved on to check with other residents; they are unable to check more than once. RD identified R7 did not have any one-to-one activity visits and needed to be assessed to determine what changes could have been made to spend more time with her. At 10:45 a.m. RD-B approached surveyor and identified the POC Response History Document did not identify why one-on-one activities were not being completed and why R7 resident was unavailable. RD-B stated this document will be changed to better assess each resident's situation and provide more individualized care. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could audit all	21435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21435	Continued From page 53 current residents to ensure activity preferences and needs have been assessed and care planned for meaningful weekend and evening hour activity involvement. They could then in-service staff to ensure activity preferences are being offered then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure concerns related to potential burn hazards surrounding higher hot water temperatures in resident accessible locations were communicated and addressed by maintenance for 15 of 15 residents (R4, R8, R10, R19, R23, R29, R34, R37, R47, R48, R50, R52, R505, R555, R556) who communicated the hot water in their bathroom faucets were too hot. Findings include: On 3/22/21, from 1:10 p.m. to 6:57 p.m. several resident room bathroom sink faucets were tested amongst all four facility' units. 15 occupied resident rooms (R4, R8, R10, R19, R23, R29, R34, R37, R47, R48, R50, R52, R505, R555, R556) were found to have hot running water in the bathroom faucets which required surveyor to pull hand away after only a few seconds to avoid	21665	Corrected	4/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
21665	Continued From page 54 getting burned. When interviewed on 3/22/21, at 2:18 p.m. R47 had initially verbalized, "Look out, it [hot water in bathroom sink] can be hot," after the surveyor asked permission to check the bathroom sink water temperature. R47 denied having been burned by the hot water; however, R47 explained she does not put her hands directly under the water faucet stream as staff brought a basin of water to her for morning and evening cares. R47 confirmed staff had knowledge about the "water getting hot when it is running." R47 explained staff wet the washcloth from the basin and waited "a little bit" to ensure the washcloth was not too hot before they gave the washcloth to her. During interview on 3/22/21, at 2:57 p.m. R10 stated she had felt the hot water had been too hot. R10 explained due to this, "I have to use the cold [water] when I wash my hands." When interviewed on 3/22/21, at 3:28 p.m. R37 denied she had ever burned herself while she used the water; however, R27 stated she had noticed "it [the water temperature] was too hot" that day while she had been washing her hair. R37 explained 3/22/21 had been the first day she had noted the water to be "that hot; however, on 3/21/21 she stated she had witnessed a nurse using the water "and it was steaming." On 3/22/21, at 6:36 p.m. the director of maintenance (DOM) used an analog spike thermometer to assess the bathroom sink hot water temperatures in eight of the 15 resident rooms after he had been updated on the surveyors' findings. None were verified to be over 120 degrees Fahrenheit. During the hot water check, the DOM stated he had not been aware of any staff hot water concerns. During interview on 3/22/21, at 6:44 p.m. nursing assistant (NA)-A stated she had felt the bathroom water temperatures were hot and had periods	21665		

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	00775	A. BUILDING: ____ B. WING ____	C 03/25/2021

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21665	Continued From page 55 where the temperature had been "uncomfortable" to her. Further, NA-A stated the water could burn residents' hands which prompted her to stay "close" to them when they used the water to make sure it was not too hot. NA-A explained she had concerns about the hot water temperatures since she started employment with the facility one and a half months ago; however, she voiced she had been unsure if she had communicated this concern to a nurse. When interviewed on 3/22/21, at 6:47 p.m. NA-I stated when she worked with the residents and the hot water had been turned on by itself, without the cold, she had been unable to put her hands under the water stream. NA-I confirmed when she provided care to R47 she had to "shake" the wet washcloth out so it became cooler and not so hot on R47's body. NA-I stated she had felt there were concerns with the water since she had started employment at the facility approximately two months ago; however, she voiced she had not communicated this concern to anyone, in which she added "but most everybody knows [concerns with the hot water temperatures]." During interview on 3/23/21, at 3:12 p.m. NA-J stated, "If you put it [hot water knob] all the way to the hottest setting it is going to burn." NA-J explained, "You have to play around until you get it (the water temperature knob] in the center...there is a trick to it." NA-J stated based on this concern he will usually adjust the water temperatures for the residents so "they do not burn themselves." NA-J denied he had communicated this concern to anyone. When interviewed on 3/25/21, at 9:25 a.m. licensed practical nurse (LPN)-C denied knowledge of resident or staff hot water concerns prior to the interview; however, LPN-C explained the hot water in the "library area" had been "a little hot" that morning when she had turned on just the	21665		

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21665	Continued From page 56 hot water. LPN-C had denied she felt this had been a concern at the time as she had added cold water to the hot and thus she had not communicated the initial hotness to other staff. On 3/25/21, at 9:50 a.m. the DOM and the maintenance assistant (MA)-A were interviewed and confirmed MA-A checked designated resident accessible water temperature locations weekly. The DOM stated acceptable hot water temperatures should be 115 degrees Fahrenheit or less to meet state regulations and 120 degrees Fahrenheit or less to meet federal regulations. The DOM explained he had adjusted the water temperature "about two months ago" due to higher water temperatures having been reported with showers, with a result of lower temperatures after follow up; however, the DOM and the MA-A denied they had knowledge of staffs' current hot water concerns. The DOM stated after he reviewed the weekly water temperature logs during the interview that he had not been previously made aware of the temperatures that had been greater then 115 degrees Fahrenheit. The DOM explained he would expect MA-A to update him on these elevated readings with an additional statement, "but with me running around, things slipped through the cracks." The DOM explained he expected all staff to bring hazard concerns to him or the MA-A "right away" as resident safety was a top priority and water temperature's outside the regulations had the potential to burn or injure the residents. The DOM and the MA-A denied knowledge of a facility policy which directed them on how to check resident accessible water temperatures; however, a policy had been provided after the interview. During interview on 3/25/21, at 10:11 a.m. care coordinator (LPN)-B denied any knowledge that residents or staff had hot water concerns and had not experienced any concerns with the hot water	21665		

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21665	Continued From page 57	21665		

personally. LPN-B explained she expected staff to report issues with hot water to the "maintenance supervisor right away" and alert other staff of the potential risks.
A Logbook Documentation: Air Temps, Water Temps, Eye Washes temperature monitoring report, dated 2/23/21 through 3/23/21, identified designated facility locations for water temperature monitoring which included individual headings for Lane 1, Lane 2, Lane 3, and Lane 4 "Resident" and Lane 1, Lane 2, Lane 3, and Lane 4 "Resident 2". The report indicated water checks had been performed on 2/23/21, 3/1/21, 3/9/21, and 3/17/21 and identified all documented temperatures taken on these four days showed all Resident and Resident 2 Lane checks had temperatures which ranged from 116 and 119 degrees Fahrenheit. On 3/23/21, the hot water documentation for these same areas identified temperatures which ranged from 103 to 112 degrees Fahrenheit.
An undated policy Water Temps: Test and Log the Hot Water Temperatures directed staff to "Ensure patient room water temperatures are between 105 [degrees] and 115 [degrees] Fahrenheit (or as specified by state requirements). Minnesota had not been identified in the list of differed requirements. Further, the policy directed staff to record the results in the water temperature log and "Note any discrepancies," "Adjust water heater settings as required," and "Retest as necessary." The policy instructs staff to use a "dial thermometer" to test water temperatures which should be calibrated on a regular basis.
SUGGESTED METHOD OF CORRECTION: The director of maintenance or designee, could audit hot water temperatures supplied to sinks and bathing fixtures to ensure they are within a range of 105-115 degrees. They could then obtain a thermometer addressed in the facility policy

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21665	Continued From page 58 Testing and Logging Water Temperatures and audit to ensure ongoing compliance with testing and hot water temperature ranges. The director of nursing (DON) or designee, could then in-service staff to ensure staff report facility hazards as directed then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
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 potentially defective and/or worn toilet equipment was assessed for safety after resident-involved events caused by failure of the resident room toilet(s). The lack of ongoing, routine monitoring and assessment of these toilets had potential to affect 39 of 54 residents residing in the nursing home. Findings include: R45's quarterly Minimum Data Set (MDS), dated 3/1/21, identified R45 had intact cognition and required extensive assistance with toileting. Further, the MDS outlined R45 had sustained "two or more" falls since the previous assessment and/or admission.	21685	Corrected	4/28/21

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21685	Continued From page 59 When interviewed on 03/22/21, at 4:49 p.m. R45 stated he had sustained a fall in his bathroom approximately three or four months ago when he was sitting on the toilet and it broke beneath him. R45 did not obtain a major injury but did have to change rooms as a result. R45 added the ordeal was embarrassing and scary to him. When interviewed on 03/23/21, at 3:12 p.m. licensed practical nurse (LPN)-E voiced they had worked at the facility for several years and verified she was working when R45's toilet had broken resulting in his fall. LPN-E stated she found R45 laying on his side in the bathroom with water and broken toilet pieces on the floor. Further, LPN-E stated R45's toilet failure was not the first time such event had happened and explained she recalled three or four more incidents like it where the toilet had broken away from the wall causing the resident to fall. On 3/23/21, at 3:38 p.m. the director of maintenance (DOM) was interviewed. He explained the facility used wall-mounted toilets which could support weight up to 500 pounds (lbs) and had to, at times, place pieces of PVC pipe underneath of the toilet bowl to support residents' who weighed more. DOM voiced he had not been tracking or monitoring which toilets had this PVC bracing placed underneath of them. A short time later, DOM provided surveyor with document identifying 15 of 54 resident toilets the facility had assessed to required PCV bracing. When interviewed on 3/24/21, at 1:14 p.m. registered nurse (RN)-A recalled when R45 fell to the floor as a result of the toilet breaking. RN-A stated R45 did not weigh over 300 lbs. at the time of the event and did not recall if he had sustained any injuries as a result of the incident. RN-A then reviewed R45's completed skin assessment at the time and verified no major injuries had been obtained. Further, RN-A stated she did not think	21685		

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21685	Continued From page 60 R45's weight (less than 300 lbs.) would cause the toilet to fail and break and added she was aware to ask for support braces for larger residents. During the recertification survey, from 3/22/21 to 3/25/21, documentation was requested to demonstrate the facility had complete an assessment of their remaining wall-mounted toilets to ensure safety with resident use after R45 sustained a fall when one broke. There was no documentation provided which demonstrated the toilets had been observed or assessed for cracks or disrepair to ensure they were safe for continued use. Further, there was no documentation provided which outlined which, if any, toilets had been replaced or repaired in the facility to ensure safe operating use. On 3/25/21, at 9:34 a.m. a subsequent interview was held with DOM who provided a listing of current toilets in use which had the PVC bracing placed underneath of them. DOM acknowledged he was unsure which, if any, toilets outside of R45's had been replaced and verified there was no system in place to check the state of repair of the toilets and replace them, if needed. Further, DOM stated he was only aware of the one fall involving a broken toilet which was R45's fall a few months prior. On 3/25/21, at 10:04 a.m. the facility administrator was interviewed and verified she had been employed at the nursing home since 2019. She explained she had been aware of only R45's fall which involved a toilet failing and breaking away from the wall, and acknowledged the current system in place was to brace the toilet(s) with PVC piping or use a commode for any larger residents. The administrator expressed she was unaware of any listings or monitoring being completed with the toilets (or their replacement) in the nursing home. When interviewed on 3/24/21, an MDH	21685		

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21685	Continued From page 61 engineering department representative voiced the nursing home records indicated the building was originally built in 1978, and there were no other construction projects listed since 1988. He expressed installation of support braces, including the use of PVC piping, was not sufficient to hold or repair a cracked or defective toilet as such a toilet would require replacement. Further, all remaining toilets in the nursing home which were installed in 1978 should be replaced. A facility' policy on toilet repair and/or maintenance was requested, however, was not received. SUGGESTED METHOD OF CORRECTION: The director of maintenance, or designee, could visually inspect all resident toilets for any obvious defects and repair as needed. They could then develop a plan for ongoing inspection and auditing. The director of maintenance, or designee, could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

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	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**03/24/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Meeker Manor was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections	K 000		

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

Electronically Signed — 04/22/2021

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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K 000	Continued From page 1	K 000		

State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to: FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Meeker Manor is a one-story building with a partial basement. The original building was constructed in 1978, with building additions constructed in 1979 and 1988. The original building and both building additions are fully fire sprinkler protected, and were determined to be of Type V(000) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification.

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

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K 000	Continued From page 2 The facility has a capacity of 75 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101), section 9.7.1.1 and the 2010 edition of NFPA 13, The Standard for the Installation of Sprinkler Systems, section 8.6.3.3. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of	K 351	K 351- Sprinkler System- Installation Sprinkler head located in PPE storage room was moved on 4/15/2021 Sprinkler heads will be maintained by monthly preventative maintenance program.	4/15/21

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K 351	Continued From page 3 residents, staff and visitors. Findings include: On the facility tour between 9:00 AM to 1:30 PM on 03/24/2021, observations revealed a sprinkler head is in the PPE Storage room is closer to a soffit than the allowable 4 inches. This deficient condition was confirmed by the Environmental Service Director.	K 351	Facility will monitor though monthly review of documentation in PM system. Facility is alleging compliance on 4/15/2021.	