#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	DICARE/MEDICAID CERTIFICATIO		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 REHABILITA (L4) 600 SOUTH DAVIS AVENUE (L5) LITCHFIELD, MN	(L6) <b>55355</b>	4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
<ol> <li>EFFECTIVE DATE CHANGE OF OWNERSHIP</li> <li>(L9) 07/14/2016</li> </ol>	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESI	<u>02</u> (L7) RD 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY         05/07/2021         (L34)           8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICI 04 SNF 08 OPT/SP 12 RH		FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b):	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of Tr 2. Technical Personnel 3. 24 Hour RN	ne Following Requirements: 6. Scope of Services Limit 7. Medical Director
12. Total Facility Beds       75       (L18)         13. Total Certified Beds       75       (L17)	<ul><li>1. Acceptable POC</li><li>B. Not in Compliance with Program Requirements and/or Applied Waivers:</li></ul>	4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: <b>A</b> *	<ul> <li>Patient Room Size</li> <li>9. Beds/Room</li> <li>(L12)</li> </ul>
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SN 75 (L37) (L38) (L39)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLIC			
17. SURVEYOR SIGNATURE Susie Haben, Unit Supervisor	Date : 05/12/2021 (L1)	18. STATE SURVEY AGENCY A	orcement Specialist 05/12/2021
PART II - TO	BE COMPLETED BY HCFA REGION	·	(L20) ATE AGENCY
<ul> <li>DETERMINATION OF ELIGIBILITY</li> <li><u>X</u> 1. Facility is Eligible to Participate</li> <li><u>2</u>. Facility is not Eligible (L21)</li> </ul>	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) ::
22. ORIGINAL DATE 23. LTC AGRE OF PARTICIPATION BEGINNE 10/01/1986 (L24) (L41)		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety
A. Suspen	ATIVE SANCTIONS sion of Admissions: (L44) Suspension Date:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
	(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	<b>06201</b> (L31	)	
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 04/30/2021 (L33	DETERMINATION APPR	OVAL



#### Protecting, Maintaining and Improving the Health of All Minnesotans

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,

Mighing

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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,

Mitig

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

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

ID: 64LU

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MEDICARE/MEDICAID CERTIFICATION A	ND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY 1	THE STAT	<b>FE SURVEY AGENCY</b>		Facility ID: 00775
1. MEDICARE/MEDICAID PROVI           (L1)         245361           2.STATE VENDOR OR MEDICAIE           (L2)         134543500		3. NAME AND ADDRESS OF FACILITY (L3) <b>MEEKER MANOR REHABILITATI</b> (L4) <b>600 SOUTH DAVIS AVENUE</b> (L5) <b>LITCHFIELD, MN</b>		ION CENTER, LLC (L6) 55355	<ol> <li>TYPE OF ACTI</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	<ol> <li>Recertification</li> <li>CHOW</li> <li>Complaint</li> </ol>	
5. EFFECTIVE DATE CHANGE O (L9) 07/14/2016		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint
6. DATE OF SURVEY 03/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	25/2021 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END 12/31	ING DATE: (L35)
<ul> <li>11LTC PERIOD OF CERTIFICATI</li> <li>From (a): To (b):</li> <li>12.Total Facility Beds</li> <li>13.Total Certified Beds</li> </ul>	ON 75 (L18) 75 (L17)	Compliance 1. A X B. Not in Con	ance With equirements e Based On: cceptable POC	gram	2. Technical Person 3. 24 Hour RN 4. 7-Day RN (Rural 5. Life Safety Code	7. Medical E 7. Medical E I SNF) 8. Patient Ro	Services Limit Director om Size
14. LTC CERTIFIED BED BREAKI		Requirements	and/or Applied	walvels.	* Code: <b>B</b> * 15. FACILITY MEETS	(L12)	
18 SNF 18/19 SN 75		ICF	IID		1861 (e) (1) or 1861 (j) (1):	: (L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY RE         17. SURVEYOR SIGNATURE	MARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):	18. STATE SURVEY AGEN	ICY APPROVAL	Date:
Austin Fry, HFE NE I	I	0	4/28/2021	(L19)	Melissa Poepping, En	forcement Specialist	04/30/2021 (L20)
P	ART II - TO BE	COMPLETED H	BY HCFA RI	EGIONAI	OFFICE OR SINGLE	E STATE AGENCY	
19. DETERMINATION OF ELIGIE         1. Facility is Eligible to         2. Facility is not Eligible	o Participate		IPLIANCE WIT HTS ACT:	H CIVIL		Financial Solvency (HCFA-25 ontrol Interest Disclosure Stm pove :	
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTIO	ON:	(L30)
OF PARTICIPATION <b>10/01/1986</b>	BEGINNINC	G DATE	ENDING DA	TE	<u>VOLUNTARY</u> 01-Merger, Closure	00 INVOLU 05-Fail to	<u>JNTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimb		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATT A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termin 04-Other Reason for Withdraw	val 07-Provi	der Status Change
(L27)	B. Rescind Su	uspension Date:	(L44) (L45)			00-Activ	e
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS		
20. TERMINATION DATE.	2)		er huudie 100.				
	(L28)	06201		(L31)			
31. RO RECEIPT OF CMS-1539		. DETERMINATION	I OF APPROVAI	-			
	(L32)			(L33)	DETERMINATION AF	PPROVAL	



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 <u>Tamika.Brown@cms.hhs.gov.</u>

# 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: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			I		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-			MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY IPLETED
		245361	B. WING				C 25/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E(	)00			
	with the Centers for (CMS) Appendix Z requirements was or recertification surver Rehabilitation Center compliance.	ey. Meeker Manor er was found to be in full					
F 000	INITIAL COMMENT	ſS	FC	000			
	was completed by s Department of Hea Rehabilitation Cent	/21, a recertification survey surveyors from the Minnesota lth (MDH). Meeker Manor er was found to be not in CFR Part 483, Requirements e Facilities.					
		e complaint investigations were ne of the recertification survey.					
		laint(s) were found to be 61051C; with deficiencies F689.					
		laint(s) were found to be 5361049C, H5361050C, 1053C					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat						
		acceptable electronic POC, an ur facility may be conducted to					
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 04/29/2021

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		C
		245361	B. WING			25/2021
NAME OF F	ROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZI	•	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 000	Continued From pa	ge 1	FO	00		
		ntial compliance with the en attained in accordance with				
	Reasonable Accom CFR(s): 483.10(e)(	modations Needs/Preferences 3)	F 5	58		4/28/21
	endanger the health other residents. This REQUIREMEN by: Based on observat review, the facility fi device to alert staff for 1 of 1 residents			§483.10(e)(3) The right to receive services in the fact reasonable accommodation needs and preferences end so would endanger the here the resident or other resident	cility with on of resident xcept when to do ealth or safety of	
	1/28/21, identified F cognition, required his room, and had s injury since his adm R25's care plan, da was at risk for falls cognition and seizu outlined several inter risk of falls which in reach."	inimum Data Set (MDS), dated R25 had moderately impaired supervision with locomotion in sustained a fall with major hission to the nursing home. ted 2/20/21, identified R25 and injury due to impaired re activity. The care plan erventions to help reduce his holuded, "Keep call-light within p.m. R25 was observed		Resident 25 call light has on 3/22/2021. Resident 2 4/22/2021. To ensure other residents reasonable accommodati call light audit was perfore 3/22/2021 to ensure all re- lights. Staff were inservic to ensure the importance being in place and access residents. Monitoring will be accomp an audit by center admini- for 1 week, weekly for 4 w monthly or as indicated b to ensure call lights are in	5 discharged on s have on of needs a med on esidents have call ed on 4/20/2021 of call lights sible to plished through stration x1 daily veeks, and y QA committee	

Facility ID: 00775

If continuation sheet Page 2 of 100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		
		245361	B. WING		C 03/25/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 558	Continued From pa	-	F 55			
	adjacent to R25's b to insert an electron	er box was present on the wall ed which had two visible ports nic call light; however, there ugged into these ports, nor was		committee for review and follo Deficient practices will be corre identification		
	there any other call inside R25's room the need for assista When questioned of	light(s) or devices present which could be used to signal ance from staff, if R25 needed. on how he would alert staff if 5 responded only with, "Yea,		Allegation of compliance is 4/2	8/2021.	
	was alerted by the risk and not having by his care plan. No verified it lacked a to alert staff to a ne voiced she was una call light device in h without one on 3/22	p.m. nursing assistant (NA)-D surveyor to R25 being a fall a call light in reach as outlined A-D observed R25's room and call light or any audible devices eed for assistance. NA-D aware R25 had been without a his room prior to being found 2/21; however, she expressed uld have a bell or call light to ded assistance.				
	R25 had previously wanting to harm hir	e, dated 1/28/21, identified voiced comments about mself and, as a result, the staff ue to keep bell in room vs call ne."				
	nursing assistant (I independent with h supervision and cur them. NA-C stated and had, in the pas attention when he r voiced she had hea call light or bell in h	on 3/23/21, at 1:48 p.m. NA)-C voiced R25 was fairly is cares but required es to ensure he completed R25 was "a fall risk" though t, used his call light to get staff' needed something. NA-C ard R25 was found without a is room on 3/22/21; however, s unaware why he did not have				

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245361	B. WING _			C 25/2021
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558		p.m. registered nurse	F 55	58		
	from the acute hosp voiced he wanted to the call light around nursing home had o cord and provide a needed help. Howe self-harm had since longer considered a call light should hav accessible. RN-A e long R25 had went alert staff while in h it." Further, RN-A vo a call light or some	as interviewed. R25 admitted bital where he had previously b harm himself by wrapping his neck. As a result, the decided to remove the call light bell so he could alert staff if he ver, RN-A voiced the threat of e passed and R25 was no at risk for such behavior so his re been replaced so he had it kpressed she was unsure how without a call light or device to i room and added, "I missed biced all residents should have audible alert device available vent falls and ensure staff can eds.				
F 580 SS=D	however, was not re Notify of Changes ( CFR(s): 483.10(g)(	Injury/Decline/Room, etc.)	F 58	30		4/28/21
	<ul> <li>(i) A facility must im consult with the res consistent with his of representative(s) w</li> <li>(A) An accident invo results in injury and physician intervention</li> <li>(B) A significant char mental, or psychosod deterioration in heat</li> </ul>	mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which has the potential for requiring				

If continuation sheet Page 4 of 100

PRINTED: 04/29/2021

	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		. 0936-039 E SURVEY
	IDENTIFICATION NUMBER:	· ·			IPLETED
	245361	B. WING _		C 03/25/202	
ER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE
al complication need to alter d to discontin nent due to ac nence a new f decision to tra- ent from the fa 15(c)(1)(ii). hen making n ) of this section rtinent informa- ailable and pro- cian. he facility mus- ent and the re- there is- change in roo- ecified in §483 change in res- law or regular 0) of this section he facility mus- te the address e number of th sentative(s). 10(g)(15) ssion to a com s a composite 5) must discle ysical configu- ons that comp and must spe- changes betw r §483.15(c)(9) REQUIREMEI	http://www.secondecommons.comm	F 58			
	ER OR SUPPLIER DR REHABILIT SUMMARY STA EACH DEFICIENCY EGULATORY OR L nued From pa al complication need to alter ed to discontin nent due to ac nence a new f decision to tra ent from the fa .15(c)(1)(ii). hen making n ) of this section ritinent informa ailable and pro- cian. he facility must ent and the res- change in roco becified in §483 change in res- law or regular 0) of this section he facility must ent and the res- change in roco becified in §483 change in res- law or regular 0) of this section he facility must ent and the res- change in roco becified in §483 change in res- law or regular 0) of this section he facility must to the addresse e number of the sentative(s). .10(g)(15) ssion to a composite .5) must disclored pysical configu- ons that compa and must spec- changes betwr r §483.15(c)(9) REQUIREMEI	RECTION       IDENTIFICATION NUMBER:         245361         ER OR SUPPLIER         DR REHABILITATION CENTER, LLC         SUMMARY STATEMENT OF DEFICIENCIES         EACH DEFICIENCY MUST BE PRECEDED BY FULL         EGULATORY OR LSC IDENTIFYING INFORMATION)         nued From page 4         al complications);         need to alter treatment significantly (that is, ed to discontinue an existing form of ment due to adverse consequences, or to nence a new form of treatment); or         . decision to transfer or discharge the ent from the facility as specified in .15(c)(1)(ii).         hen making notification under paragraph (g)         .) of this section, the facility must ensure that tritinent information specified in §483.15(c)(2)         alable and provided upon request to the cian.         he facility must also promptly notify the ent and the resident representative, if any, there is-         change in room or roommate assignment becified in §483.10(e)(6); or         change in resident rights under Federal or         law or regulations as specified in paragraph (D) of this section.         he facility must record and periodically te the address (mailing and email) and enumber of the resident sentative(s).	ICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULT         IDENTIFICATION NUMBER:       245361       B. WING         IDER OR SUPPLIER       245361       B. WING         CR REHABILITATION CENTER, LLC       SUMMARY STATEMENT OF DEFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX         CAR CHABILITATION CENTER, LLC       SUMMARY STATEMENT OF DEFICIENCIES       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX         FG8       al complications);       need to alter treatment significantly (that is, dd to discontinue an existing form of nence a new form of treatment); or       nedecision to transfer or discharge the ent from the facility as specified in .15(c)(1)(ii).         hen making notification under paragraph (g)       of this section, the facility must ensure that ritinent information specified in §483.15(c)(2)         ailable and provided upon request to the cian.       he facility must also promptly notify the ent and the resident representative, if any, there is-         change in room or roommate assignment weified in §483.10(e)(6); or       change in resident rights under Federal or law or regulations as specified in paragraph 0) of this section.         be facility must record and periodically te the address (mailing and email) and e number of the resident sentative(s).       10(g)(15)         sign to a composite distinct part. A facility is a composite distinct part (as defined in .5) must disclose in its admission agr	EXERCISES       (X1) PROVIDER/SUPPLIENCUA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         245361       B. WING         ER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP COL 600 SOUTH DAVIS AVENUE LITCHFIELD, MM S5365         SUMMARY STATEMENT OF DEFICIENCIES EQUIDATORY OR LSC IDENTIFYING INFORMATION)       ID PREVIDENCY OWISTE BE PROVIDENCES CROSS-REFERENCED TO THE AF DEFICIENCY)         nued From page 4 al complications); .need to alter treatment significantly (that is, dto discontinue an existing form of ment due to adverse consequences, or to nence a new form of treatment); or .decision to transfer or discharge the ent from the facility must ensure that trinent information specified in .15(c)(1)(i).       F 580         10 discontinue an existing form of ment due to adverse consequences, or to nence a new form of treatment); or .decision to transfer or discharge the ent from the facility must ensure that trinent information specified in .15(c)(1)(i).       F 580         he facility must also promptly notify the ent and the resident representative, if any, there is- change in room or roommate assignment ecified in \$483.10(c)(6); or .law or regulations as specified in paragraph 0) of this section. the facility must record and periodically te the address (mailing and email) and e number of the resident sentative(s).       ID .0 (g)(15) sion to a composite distinct part. A facility is a composite distinct part. A facility is a composite distinct part. A facility is a composite distinct part (as defined in .5) must disclose in its admission agreement ysical configuration, including the various ons that comprise the composite distinct and must specify the policies that apply to changes between Its different locations r §483.15(c)(	Interview       (X1) PROVIDERSUPPLIERCLA DENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DAT A BUILDING         245361       B: WING       03         ER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355       03         SAMMARY STATEMENT OF DEFICIENCIES EQUIDATORY OR LISC IDENTIFYING INFORMATION)       PRETA PRETA       STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355         SUMMARY STATEMENT OF DEFICIENCIES EQUIDATORY OR LISC IDENTIFYING INFORMATION)       PRETA PRETA       CROSS-REFERENCED CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY         nued From page 4 al complications); need to alter treatment significantly (that is, do to discontinue an existing form of nent due to adverse consequences, or to nence a new form of treatment); or decision to transfer or discharge the ent from the facility must ensure that tritnent information specified in \$483.15(c)(2) alable and provided upon request to the cian. the facility must also promptly notify the ent and the resident representative, if any, there is- change in regident rights under Federal or law or regulations as specified in paragraph 0) of this section. the facility must record and periodically te the address (mailing and email) and e number of the resident sentative(s).       Notification of Changes.         10(g)(15) siston to a composite distinct part. A facility s a composite distinct part (as defined in .5) must disclose in its admission agreement systal configuration, including the various ons that comprise the composite distinct and must specify the policies that apply to changes between its different locations r §483.15(c)(0).       Notifi

Facility ID: 00775

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X	COMF	SURVEY PLETED
		245361	B. WING _			C 03/2	) 25/2021
NAME OF I	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 580	of a change in conc reviewed that had c of low oxygen (O2) unresponsive episc one minute whom v routine renal dialys required a hospital dialysis appointmen low blood pressure passed two days la Findings include: R55's quarterly Min 10/14/20, identified communication abi had been free of fa assessment and ha hypotension (abnor standing), congesti pumping), end stag required dialysis mar respiratory failure ( properly) with O2 u was not considered	dition for 1 of 1 residents (R55) documented increased periods saturations (sats) and an ode which lasted approximately was sent the following day to a is appointment. R55 had admission directly from the nt related to low O2 sats and (BP), who subsequently	F 58	30	resident; consult with the resident's physician; and notify, consistent with or her authority, the resident representative(s) when there is— (A) An accident involving the resident which results in injury and ha 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 discon an existing form of treatment due to adverse consequences, or to comme a new form of treatment); or (D) A decision to transfer or discharge the resident from the facilit specified in §483.15(c)(1)(ii). (ii) When making notification unde paragraph (g)(14)(i) of this section, the	as ntinue ence ity as er he	
	respiratory status c identified R55 had which he would refu- Interventions to ass "adequate gas excl monitor and docum O2 sats as ordered provider informed c	oxygen/gas exchange are plan, dated 6/24/20, periods of low blood O2 sats in use to wear the O2 at times. sist R55 with the goal of hange" included the following: nent respiratory status, monitor l and as needed, keep medical of changes. R55' care plan 5 had history of unresponsive 2.			facility must ensure that all pertinent information specified in §483.15(c)(2) available and provided upon request 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 roomr assignment as specified in §483.10(e) or (B) A change in resident rights under Federal or State law or regulat as specified in paragraph (e)(10) of th section.	2) is to y mate e)(6); tions	

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TATES			()(0)			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМ	E SURVEY PLETED
		245361	B. WING			C 2 <b>5/2021</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 580	Continued From pa	ge 6	F 5	80		
	R55's treatment ad dated 11/1/20 - 11/3 R55's O2 sats durin The TAR identified 0-4 liters (L) via nas O2 sats of 90% or g exertion for low O2 identified R55 had t 11/3/20 and 11/5/20 O2 sats ranged from required 4L of O2 d of documentation re monitoring from 11/ the TAR directed st dialysis on Monday R55's BP ranged from TAR lacked evidence on 11/27/20, R55's had been negative. On 11/26/20, R55's had been negative. On 11/27/20, time s assistant (NA) had (RN)-A that "[R55's asleep in his wheel R55's room. R55 had command but had ' nasal cannula had the portable O2 ma switched to a stand back to bed with a th had stated he "just instructed the traine administer R55 Mid	ministration record (TAR), 30/20 directed staff to monitor ing the day and evening shifts. R55 had an order for O2 at sal cannula (N/C) to maintain greater at rest and 0-5L with sats. Further, the TAR two O2 sat readings of 89% on 0 where the remainder of the m 90 to 98% and consistently laily. The TAR lacked evidence esponses for the day shift O2 /26/20 - 11/30/20. In addition, aff to monitor R55's BP after , Wednesday, and Fridays. om 103/64 to 108/60. The ce a BP reading after dialysis	ΓJ	<ul> <li>(iv) The facility must recorperiodically update the addrand email) and phone numbresident representative(s).</li> <li>Resident 55 passed away of To ensure that current residexperiencing change of comappropriate notifications to a and representative's facility inserviced on 4/20/2021. Lid were educated on 3/30/202 change of condition policy to notification. A facility wide a conducted on 4/15/2021 to change of conditions and actinclude appropriate notifications and actinclude appropriate notification for 1 were sidents audits of incidents and accidents and change of condition for 1 were residents and change of condition for 1 were sidents and change of condition for 1 were residents and change of condition for 1 wer</li></ul>	ress (mailing per of the on 12/2/2020. lents idition have self, physician staff were censed nurses 1 to the o include udit was ensure that all ccidents tions in the shed by daily dents and eek. 5 s and indition weekly s of incidents of condition ilts will be committee for ent practices ification	

		AND HUMAN SERVICES					FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245361	B. WING	;				C 25/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COI	)E		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 7	F	580				
		t the time of the entry or that r had been contacted on						
		ce of documented progress 1/27/20, at 6:53 p.m. to m.						
	fallen to the floor at he had attempted to he sat in his wheeld elbow skin tear that inches wide. R55 h person, place, and had been reported seemed to level out now." The progress	stamped 4:11 p.m. R55 had approximately 2:45 p.m. after o pick up a dropped fork while chair. R55 had sustained a left t measured 2.6 inches by 3 ad been alert and oriented to time. R55's blood pressure to be "up and down but has t within normal range as of a note lacked documentation er had been contacted on						
		ented progress note entries 11 p.m. to 11/30/20, at 5:30						
	"went limp and did approximately one assisted him into be during cares the ev again responded to 3.5L of O2. R55 hav which he also felt c note indicated R55 throughout the nigh without complaint." he had felt "tired an afebrile; however, h	stamped 5:30 a.m. R55 had not respond to staff for minute" when two staff had ed with a mechanical stand lift ening prior. R55, once he staff, had O2 sats at 89% on d stated he had felt cold in old to touch. The progress had been checked on it and he had rested "quietly That morning, R55 had stated id foggy." He had been his O2 sats had been 85% nurse to increase the O2 flow						

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM	: 04/29/2021 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
	245361	B. WING _			C / <b>25/2021</b>
NAME OF PROVIDER OR SUPPLIE	R	· [	STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
MEEKER MANOR REHABII	ITATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
PREFIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
the medical provident contacted and/or On 11/30/20, tim been sent to the dialysis center du saturations; how to the St. Cloud I levels and a posi updated dialysis progress note lad medical provider On 12/2/21, the fit the St. Cloud Ho passed away that An Inpatient Disc 12/2/20, indicate 11/30/20 with O2 80/40. Due to R5 BP, R55 had bee evaluation and s transfer hospital. discharge diagno hypoxic respirate COVID-19, with a chronic systolic fit myocardial infare During interview practical nurse (I physician commu- status would dep If the change wa the doctor right a	ess note lacked documentation ider or dialysis had been updated on status. e stamped 11:13 a.m. R55 had emergency room (ER) from the ue to low blood oxygen ever, the ER had transferred R55 Hospital due to elevated tropin tive ER COVID-10 test. Staff had on R55's condition; however, the cked documentation R55's facility had been contacted on status. acility had received a call from spital which indicated R55 had	F 58			

Facility ID: 00775

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		<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI F	CONSTRUCTION		<u>). 0938-039</u> TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:					MPLETED	
		245361	B. WING			03	C 6/ <b>25/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE			
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			SOUTH DAVIS AVENUE CHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 580	Continued From page 9 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			580				
	consequences whe acknowledged she 11/29/20 evening u RN-A reviewed R55 she stated she "wo confirmed she wou minimum" to conta R55's unresponsive the abnormal O2 se Further, RN-A state refused any medica directions she woul documentation to se explained she woul	Ily been free of adverse en he removed his O2. RN-A had been unaware of R55's nresponsive episode. After 5's 11/30/20 progress note, uld have sent him in." RN-A Id have expected staff "at a ct the medical provider after e episode and then again after ats on 11/30/20 for follow-up. ed then if R55 would have al provider orders and/or Id have expected upport the follow-up. RN-A Id have also initiated increased s her biggest concern would						

Facility ID: 00775

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	60	MPLETED C	
		245361	B. WING _			8/25/2021	
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 580	have been COVID- was brewing" for R staff not updating n changes in condition When interviewed of director of nursing expected staff to up on his unresponsive periods of lower O2 considered a chang Further, the DON e expected to see su staff had followed u The DON confirme testing on 11/29/20 episode or on 11/30 despite the DON's "primary focus" of " the time of R55's u COVID-19 and "infe During interview on practitioner (NP)-A and "doing fairly we (GI) bleed in Septe R55 clinic notes du confirmed the only had been related to results. NP-A voice on 11/9/20 for a "re acknowledged she updates which condu unresponsive episo abnormal O2 sats. of R55 having had past and she further not experienced iss	19. RN-A stated "something 55. RN-A explained the risk of nedical providers on residents' ons was "this [death]." on 3/25/20, at 11:07 a.m. the (DON) stated she would have odate R55's medical provider e episode and increased 2 sats as these would be ge in condition for R55. explained she would have pporting documentation that ip with the medical provider. d R55 had not had COVID-19 after the unresponsive D/20 before going to dialysis explanation the facility's resident care delivery" around nresponsive episode had been	F 58	30			

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	COF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		ING	· · ·	MPLETED
						С
		245361	B. WING		03	8/25/2021
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZI	P CODE	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 580	••••••	-	F 5	80		
	have expected staf R55's changes in c done more of a wo included a COVID- explained, "We wo	cribed. NP-A stated she would f to contact the clinic about condition as she "would have rkup" which would have 19 test. In addition, NP-A uld have been fairly aggressive to COVID running rampant at cility]."				
	p.m. LPN-F stated R55 had "went limp lift." LPN-F believed this in the past "but been unable to pro unresponsive episo LPN-F acknowledg typically "in the 90's about 85 - 88% but been unable to rem symptoms of respin 11/30/20. LPN-F co the medical provide episode or overall s she had also not up regarding R55's sta stated she had felt had been a concer he had this type of monitored R55. LP condition were to c	e interview on 3/25/21, at 12:20 on the evening of 11/29/20, o" when staff "had him in the d he had similar episodes of a not too frequent." LPN-F had vide further details about other odes R55 may have had. led R55's O2 sats were s;" however, they would drop to a only with exertion. LPN-F had nember if R55 had signs or ratory distress on 11/29/20 or onfirmed she had not contacted er about R55's unresponsive status and further confirmed odated dialysis on 11/30/20 atus that morning. LPN-F R55's unresponsive episode n; however, due to her belief episode in the past she only N-F explained if a resident's hange she would take "the onitoring their vitals and calling er.				
	6/2019, directed sta physician/healthcar been an accident o	Resident Condition, dated aff to notify the resident's re provider when there had r incident which involved the ant change in the resident's				

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
	ST CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING			C	
		245361	B. WING		03	8/25/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 580	Continued From pa	ige 12	F 580				
	mental physical or	mental condition, and/or a eresident to a hospital.					
F 656 SS=D	Develop/Implement CFR(s): 483.21(b)(	t Comprehensive Care Plan 1)	F 656			4/28/21	
	§483.21(b)(1) The fimplement a compresent rights set fights set fights and time medical, nursing, a needs that are ident assessment. The cidescribe the followi (i) The services that or maintain the resist physical, mental, arrequired under §483.24, §48 provided due to the under §483.24, §48 provided due to the under §483.10, inclitreatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resist (iv) In consultation w resident's represent (A) The resident's cidescription of the test of the resident's cidescription of the test of the test of the resident's cidescription of the test of test of the test of test of the test of test	t are to be furnished to attain ident's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the					

		& MEDICAID SERVICES				). <u>0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			( )	TE SURVEY MPLETED
		245361	B. WING		03	C 3/25/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 656	community was ass local contact agenc entities, for this pur	sessed and any referrals to ies and/or other appropriate pose.	F 6	856		
	<ul> <li>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>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.</li> <li>Findings include:</li> <li>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.</li> </ul>				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	t
	Oral/Dental Evaluat R37 had observed along with, " seve	rch Health Management) tion, dated 2/11/21, identified plaque or debris on her teeth eral missing teeth." R37 was aring dentures and required s.			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	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
	voiced she needed teeth] falling out." R numerous missing self-conscious of he	on 3/22/21, at 3:33 p.m. R37 dental care as "they're [her 37 expressed she had teeth which made her er smile and, as a result, she nuch as possible." R37			plans and timing and revision. Facility sta inserviced on 4/20/2021. Audit of the comprehensive care plans wi 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	II

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	` ´co∧	E SURVEY PLETED
		245361	B. WING _				C 25/2021
NAME OF I	PROVIDER OR SUPPLIER	•		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			OUTH DAVIS AVENUE HFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 656	Continued From pa	age 14	F 65	6			
	proceeded to show was observed to ha both the top and low		De	API committee for review and eficient practices will be correc entification.			
	However, R37's ca reviewed and lacke statements, goal(s) R37 maintained go assessed as needi to ensure dental ca numerous missing		All	legation of compliance 4/28/20	021.		
	When interviewed on ursing assistant (In had several missing to keep her mouth smile." NA-C explain clean her teeth but verbalize she would However, NA-C ad actually getting dom						
	manager (RN)-A wa care plan lacked ar or interventions reg needs. RN-A expla issues recorded on she "wouldn't think RN-A voiced she wa missing teeth and s added to the care p	a.m. registered nurse as interviewed and verified the ny problem statements, goals garding R37's dental care or ined since there had been no a R37's MDS, dated 2/18/21, to care plan it." However, vas aware R37 had numerous stated it should have been olan to ensure staff were le person" and getting care					
	outlined the interdis develop and impler	anning policy, dated 6/2019, sciplinary team (IDT) would ment a comprehensive care 21 days after admission for					

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						0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED	
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		245361	B. WING		03/	25/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	Continued From pa	age 15	F 656	5			
	the person centere identify problem are develop interventio meaningful to the r						
	Care Plan Timing a CFR(s): 483.21(b)(		F 657	7		4/28/21	
	§483.21(b)(2) A co be-	ehensive Care Plans mprehensive care plan must					
	<ul><li>(i) Developed within 7 days after completion of the comprehensive assessment.</li><li>(ii) Prepared by an interdisciplinary team, that</li></ul>						
	includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the						
	resident. (C) A nurse aide wi resident.	th responsibility for the					
	(E) To the extent putter the resident and the	ood and nutrition services staff. racticable, the participation of e resident's representative(s). st be included in a resident's					
	medical record if th and their resident r	e participation of the resident epresentative is determined the development of the					
	disciplines as deter or as requested by						
		evised by the interdisciplinary sessment, including both the d quarterly review					
	This REQUIREME	NT is not met as evidenced tion, interview, and document		Comprehensive Care Plans Timing			

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	СОМ	E SURVEY PLETED
		245361	B. WING			C 25/2021
	PROVIDER OR SUPPLIER	2.0001		STREET ADDRESS, CITY, STATE, ZIP C		25/2021
		ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 657	Continued From pa	age 16	F 6	57		
	review, the facility f care plan for 2 of 3 reviewed for provis Findings include: R4's annual minimu 3/17/21, indicated s along with needing mobility and transfe R4's face sheet dat diagnosis included: behavioral disturba memory and judge disease, insomnia Alzheimer disease disease that destro important mental fu R4's provider order use foot cradle und bed to reduce pres R4's tissue tolerand factors dated 3/16// skin breakdown. R4's Care plan, rev extensive assistand bed mobility and pe indicated vulnerabl communications, s per care plan and v needs updating for	ailed to revise and follow the resident (R4 and R26) ions of care. um data set (MDS) dated severe cognitive impairment extensive assistance with bed ers. ted 3/24/21, indicated c unspecified dementia with nces (brain impairment in ment), peripheral vascular (difficulty with sleeping), with late onset (a progressive ys memory and other unctions). To dated 12/23/20, indicated ler blanket when resident is in sure on feet/toes. ce evaluation and skin risk 21, indicated moderate risk for rised 3/4/21, indicated ADL's ce with dressing, showering, ersonal hygiene. R4's care plan e with mobility limitation, taff will provide daily cares as vill notify nursing when plan accuracy. R4's care plan		Revision §483.21(b) Comprehensive §483.21(b)(2) A comprehen must be—(i) Developed with after completion of the com assessment. (ii) Prepared b interdisciplinary team, that i not limited to-¬ (A) The attending ph (B) A registered nurse responsibility for the resider (C) A nurse aide with for the resident. (D) A member of food services staff. (E) To the extent prace participation of the resident resident's representative(s) explanation must be include resident's medical record if participation of the resident resident representative is do practicable for the developm resident's care plan. (F) Other appropriate professionals in disciplines by the resident. (iii) Reviewed and revise interdisciplinary team after e assessment, including both comprehensive and quarter assessments. Resident 4's care plan was	sive care plan nin 7 days prehensive by an ncludes but is ysician. e with nt. responsibility d and nutrition cticable, the and the and the e and their etermined not nent of the staff or as determined s requested by d by the each the ly review	
	information about t risk for falls and int	kin integrity which lacked any he foot cradle. R4's had a high erventions of use of a concave mind where the edge of the		updated. Resident 4's plan longer requires the concave foot cradle. Resident 26's plan of care v	e mattress or	

Facility ID: 00775

			(X2) MU	דוחו ה	CONSTRUCTION	OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
			A BOILD				C
		245361	B. WING				25/2021
NAME OF	PROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			0 SOUTH DAVIS AVENUE FCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 657	Continued From pa	age 17	F 6	57			
	bed was.				and updated. Resident 26 no lor requires the foot cradle or use or		
la fe ot th	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.				Sleeves. A full house audit was conducted facility residents and completed 3/26/2021 to ensure that interver skin integrity and falls are in place appropriate.	on ntions for	
	laying on left side w from neck to below observed sitting on under the tray table observed in use. During interview or	on 3/23/21, at 1:59 p.m. R4 with blankets covering body toes, foot cradle was again the floor, next to the wall b. No concave mattress			Facility regional nurse consultan educated clinical leadership on 3 to completion of comprehensive plans and timing and revision. F- inserviced on 4/20/2021. A facilit audit of care plans was complete 4/25/2021.	8/31/2021 care acility staff y wide	
	should be using the would assume the bed and utilized to her toes. NA-A stat that the nurses are has never seen the further stated she f	ated being unaware of R4 e foot cradle while in bed but cradle should be kept on her prevent further break down of red R4 had scabs on her toes monitoring. NA-A stated she e foot cradle on R4's bed. NA-A follows the Kardex which tells the residents and did not see			Audit of the comprehensive care be completed within one week a care plan due date per the MDS by the DON or designee for 30 c Results will be reported to the fa QAPI committee for review and Deficient practices will be correct identification. Allegation of compliance 4/28/20	fter the schedule ays. cility follow-up. ted upon	
	NA-A left R4's roor cradle, and walked residents room, R4	ing interview, at 2:42 p.m. n, without implementing foot down the hallway into another continues to lay on left side er feet/toes and foot cradle on					
	lying in bed toes/fe	on 3/24/21, at 7:24 a.m. R4 et have blankets on them and n floor, next to wall and under					

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245361	B. WING				C <b>25/2021</b>
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	During interview on stated R4 has sore: second toe of the ri medication aid or n R4 up for the day. N been employed she cradle being used v approximately 7-8 r Kardex for interven During interview on Licensed practical r should have the foc was an order for it a as she is a high fall the staff look to the for residents and w interventions should During interview on stated that R4 shou on her bed and shou due to her sores on got switched when LPN-B stated it is in mattress on her bed use of the foot crad down and relieving stated all intervention for staff to follow as the resident. LPN-E and get items adde with hospice. During interview on of nursing (DON) st be on her bed to pr to prevent further b	a 3/24/21, at 7:24 a.m. NA-B s on her right great toe and ight foot which the trained urse will treat before getting NA-B stated since she has a has never seen the foot which has been for months and would look to the tions for the residents. a 3/24/21, at 9:19 a.m. nurse (LPN)-A stated R4 ot cradle on the bed if there along with a concave mattress Is risk. LPN-A further stated c care plan/Kardex when caring rould think that those	F	557			

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		AND HUMAN SERVICES			FORM	: 04/29/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245361	B. WING			C 25/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 657	further stated the co R4's bed as the car to help residents ar bed. DON stated th Kardex/care plan w client and should be R26's face sheet da diagnosis include: F that affects movem disorder, anxiety dis disorder, dementia elsewhere with beh (impairment of men muscle weakness. R26's MDS dated 2 cognitive impairmer assist with transfers required extensive a daily living. R26's order summa indicated Left (L) he floating heel with a a heel cushion boot R26's care plan rev risk for alteration in include turn and rep Elevate heels off the foot of bed to keep place pillow under le protectors when no hospice of any skin any interventions or lacked interventions	oncave mattress should be on re plan indicated which is used re aware of the edge of the nat staff look to the when providing cares to the e updated. ated 3/24/21, indicated Parkinson's disease (disorder ent), major depressive sorder, post traumatic stress in other diseases classified avioral disturbances mory and functioning), and 2/3/21, indicated severe nt and required extensive two s and bed mobility. R26's assistance with activities of ary report dated 3/24/21, eel- remove pressure by pillow under calf and applying	F 65	7		

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE SURVEY COMPLETED	
		245361	B. WING				C <b>25/2021</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 657	During observation laying in bed, blank and resting on reside bilateral feet on a p sleeve shirt. Did no resident's arms. During observation sitting in Broda cha covering his lap, rig of chair. R26 report came in room and a R26 replied yes. NA heel protector. NA- R26 replied no. NA know. During interview on stated staff know he their care plan/Kard the interventions to resident. During interview on stated R26 should I times, but unsure if stated she has not time, but thinks it w mattress and R26 k he likes a blanket o sleeves but would r has not seen the G he should have a b sleeves. NA-E state know how to care fe nurses updates the	on 3/23/21, at 2:06 p.m. R26 tets are tucked under mattress dents feet, no elevation of illow, R26 was wearing a short it view any Gerri sleeves on on 3/23/21, at 3:20 p.m. R26 ir in short sleeves has blanket ght arm is resting on arm rest ted pain in right foot. NA-A asked if R26 was having pain, A-A repositioned right foot and A asked if that was better and -A stated would let someone a 3/24/21, at 7:24 a.m. NA-B ow to care for residents by dex. NA-B stated these list out follow and how to transfer the a 3/24/21, at 9:28 a.m. NA-E have pressure boots on at all flegs are to be elevated. NA-E seen the foot cradle in a long was removed due to the air pumping his feet. NA-E stated on him and use to wear Gerri remove them. NA-E stated she erri sleeves in a long time and lanket on him in place of the ed she uses the Kardex to or the residents. NA-E stated	F	\$57			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE C	CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY
AND PLAN C			A. BUILD	NG	co	COMPLETED	
			B. WING		03	C 6/25/2021	
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	•		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			SOUTH DAVIS AVENUE CHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
<ul> <li>F 657 Continued From page 21</li> <li>kicking the foot cradle so they got that discontinue and he should be having feet up on pillow as he allows to prevent further breakdow of skin. RN-B further stated R26 should be monitored for pain as he does have nonverbal cues of wincing during dressing changes. RN-E stated important to keep R26 comfortable and free of pain.</li> <li>During observation on 3/24/21, at 1:02 p.m. R20 lying in bed with blankets over bedrail and bilateral feet elevated on a pillow.</li> <li>During interview on 3/24/21, at 1:08 p.m. LPN-A stated R26 does have PRN pain medication an 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</li> </ul>		idle so they got that e should be having feet up on a to prevent further breakdown er stated R26 should be as he does have nonverbal ring dressing changes. RN-B keep R26 comfortable and on 3/24/21, at 1:02 p.m. R26 ankets over bedrail and ted on a pillow. n 3/24/21, at 1:08 p.m. LPN-A ave PRN pain medication and ne was having pain. LPN-A bot cradle was removed from e care manager since being till in place by state agency.	F 6	57			
	treatment plan and monitor and know LPN-A stated she r which indicated Ge verified staff are ch he does refuse the sure that feet are e if not using these in removed from the stated staff should elevate R26's feet LPN-A stated she u and this should refi resident. During interview or stated R26 doesn't	in the care plan for staff to how to care for the residents. reviewed the treatment plan erri sleeves are to be on and becking this off, however stated se and staff should be making elevated and sleeve are on but nterventions they should be plan of care. LPN-A further be following provider orders to to prevent further breakdown. updates the care plan/Kardex lect the plan of care for each					

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	H AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245361	B. WING				C 25/2021
NAME OF PROVIDER OR SUPPLIEF	र		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER MANOR REHABILI	TATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
<ul> <li>use in place of Geneed them any low himself around in does not see pain care plan and this LPN-B stated R26 on pillow as order down and further protectors as well be folded over the pressure and preversident's skin.</li> <li>During observation sitting in chair with and had both hee</li> <li>During interview of stated R26 is vuln carefully for pain. The care plan for part of R26's plan DON further state goes through the their care plans/K over the last montusing the Kardex importance of car as it is the actual when caring for rewere any changes be update as well change.</li> <li>Care planning rev accordance with seach resident will</li> </ul>	page 22 plan lacked evidence of blanket erri sleeves) and doesn't really inger as he is not wheeling wheelchair. LPN-B stated she management listed on R26 should be fixed right away. Should have his heels elevated ed to prevent further break stated R26 wears heel . LPN-B stated blankets should e rail of the bed to relieve vent further break down to n on 3/25/21, at 9:36 a.m. R26 in blanket covering bilateral arms I protectors on his feet. on 3/25/21, at 9:52 a.m. DON herable and the staff watch him DON further stated it looked like bain is missing and should be to help keep him comfortable. di t was surprising to her as she care plans. DON further stated ardex are a work in progress th as they are transitioning to system. DON stated the e plans to be revised/updated plan of care for staff to follow esidents. DON stated if there is in a residents care is should to notify other staff of the	F 6	557			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION (X3) D.	ATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
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		245361	B. WING _	0	3/25/2021	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 657	Continued From pa	ge 23	F 65	7		
	<ul> <li>Continued From page 23</li> <li>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."</li> <li>F 677 ADL Care Provided for Dependent Residents</li> <li>SS=D CFR(s): 483.24(a)(2)</li> <li>§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</li> </ul>		F 67	7 ADL's §483.24(a)(2) A resident who is unable to	4/28/21	
	grooming to 2 of 2 reviewed for activiti	ailed to provide routine residents (R26 and R31) es of daily living (ADLs) and nt on staff for their cares.		carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and ora hygiene;		
	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.			Resident 26 shaving preferences and pla 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.	an	
				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 shavin preferences was completed on 4/21/202		

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STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATI	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
245361		B. WING			C 03/25/2021		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 677	R26's care plan rev limited physical mo required 2 staff at ti care performance of living related to Par disorder, confusion requires 2 assist to personal hygiene w time and reproach. Review of R26's tas personal hygiene w from march 1st thro Review of Weekly S indicated R26 had a shaved. During observation had scruffy chin/cho During observation seated in Broda cha and had long hairs Unable to see under mask being in place During observation mask was removed inch coarse, gray a chin, and cheeks. F further stated not "f	<ul> <li>vised on 2/10/21, indicated bility related to weakness and imes for cares. R26 has self deficit with activities of daily kinson's, post traumatic stress at time, personal hygiene tal dependence with all when he refuses care allow</li> <li>sked dated 3/2021, indicated vas signed off at least daily bugh March 25th.</li> <li>Skin Inspection dated 3/19/21, a bedbath and was not</li> <li>on 3/22/21, at 1:27 p.m. R26 eek.</li> <li>on 3/23/21, at 8:48 a.m. R26 air in day room. Mask in place under chin and on cheeks. er mask or upper lip due to e.</li> <li>on 3/23/21, at 9:04 a.m. R26's 1 by staff and noted 1/4-3/4 nd white hairs on chin, under R26 stated staff shave him but</li> </ul>	F 67	<ul> <li>7</li> <li>Staff were inserviced on 4/20/24 facility practice for shaving and preferences. Facility CNAs were on 3/30/2021 to ADL cares and resident preference to shave ar care.</li> <li>Monitoring will be accomplished an audit by center administratio for 1 week, weekly for 4 weeks, monthly or as indicated by QA or to ensure resident bathing preference are maintained. Results will be the facility QAPI committee for follow-up. Deficient practices with corrected upon identification.</li> <li>Alleged date of compliance 4/24</li> </ul>	oral care e educated following ad oral I through n x1 daily and committee erences reported to review and II be		

		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245361	B. WING				C <b>25/2021</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From pa	ige 25	F 6	677			
	sitting up in Broda o	on 3/23/21, at 3:20 p.m. R26 chair and still has not been h coarse, gray and white hairs , and cheeks.					
		on 3/24/21, at 8:52 a.m. R26 chair, continues to be					
	assistant (NA)-E sta this morning but his she tries to shave th possible. NA-E stat his razor has not be hasn't been shaved	3/24/21, at 9:28 a.m. nursing ated she tried to shave R26 s razor is broken. NA-E stated he resident every day if ted she is not sure how long een working, but appears he t in a while. NA-E stated she to the social worker and try to o shave him.					
	registered nurse (R made aware of the family will not suppl him one. RN-B state shaved he should b	3/24/21, at 12:54 p.m. (N)-B stated she was only broken shaver today and ly a new one as they just got ed as long as he wishes to be be. RN-B stated that she on getting him a new one.					
	stated that R26 was some oil to his face R26 tolerated being stated that she four head to the razor ar but not sure how low NA-E stated if a res there is a spare on	3/24/21, at 1:04 p.m. NA-E s now shaved and she applied e as it was rough. NA-E stated g shaved well. NA-E further nd out that someone lost the nd that is why it is not working, ng it hasn't been working for. sidents razor is not working the North end that they can d that they should also bring the social worker.					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		245361	B. WING				C 25/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 677	face appears smoo face or neck. During interview on stated she shaves r but some need to b grows fast. NA-B st broken for about a universal one on No NA-B further stated scruffy and hair was to the North end to stated R26 use to h however, now prefe During interview on licensed practical n requires staff assist the head of the raze still be able to use t or using the univers LPN-B stated R26 o sometimes will hit of however they shoul During interview on of nursing (DON) st according to the ca different in this expe someone's razor is one at the facility ur should be reported stated it would not t unshaved. DON sta through to make su	on 3/24/21, at 1:05 p.m. R26 th and without scruffy hair on 3/24/21, at 1:44 p.m. NA-B residents every week or so, e shaved daily if there hair ated R26's razor has been week or so and that there is a orth side that staff can use. that if a resident looked s growing out they should go get the universal razor. NA-B have really long facial hair,	F6	77			
	under personal hyg	iene which is done daily and reproached if he had					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY
		245361	B. WING				C 25/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
MEEKEB		ATION CENTER 11 C		6	00 SOUTH DAVIS AVENUE		
	R MANOR REHABILIT	ATION CENTER, LLC		L	ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 677	Continued From pa behaviors during fir	-	F 6	77			
	indicated "The purp promote cleanliness The following inform the resident's medic that the procedure of title of the individual procedure, If and he the procedure or an ability to participate problems or compla- related to the proce the treatment, the re- intervention taken. person recording the supervisor if the re- report other information	nt policy revised 2/2018, pose of this procedure is to s and to provide skin care. mation should be recorded in cal record: the date and time was performed, the name and al who performed the ow the resident participated in ny changes in the resident's in the procedure. Any aints made by the resident edure, if the resident refused reason(s) why and the The signature and title of the ne data. Reporting:notify the sident refuses the procedure. ation in accordance what rofessional standards of					
	was cognitively inta understood and req complete personal plan, dated 12/28/2	S, dated 2/5/21, indicated R31 act, was able to make herself quired physical assistance to hygiene. Further, R31's care 20, indicated R31 required aff to set up for oral cares twice					
	not set her up or pro three weeks. R31 s this to staff and req	p.m. R31 indicated staff had ovided assistance with oral for stated she had communicated juested staff set her up so she eth, but it did not happen.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COM	E SURVEY PLETED
		245361	B. WING				C 25/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC		-	00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 677	to have a thick, whillower teeth across the substance started a halfway to the end of On 3/23/21, at 8:38 receive help from sitt to assist with oral carbon of the end of the did not be assist with oral carbon of the did not be toothpaste even we thick white colored are prior, on 3/22/21, relower teeth across the observed assist However, R31 was cares. NA-E common set her up to brush she must of have be before because the toothbrush was not the bristles, but the on them, the bristle when light pressure On 3/24/21, at 8:55 get them brushed this is the observed thick, upper and lower teem outh. On 3/24/21, at 9:31 clinical coordinator hygiene included br	<ul> <li>v, R31's teeth were observed te substance on her upper and the front of her mouth. This at the gum line and extended of each tooth.</li> <li>a.m. R31 stated she did not taff to set up her toothbrush or are before going to bed on ning after breakfast and know where her toothbrush or ere. At this time, the same substance observed the day emained on R31's upper and the front of her mouth.</li> <li>a.m. nursing assistant (NA)-E sting R31 with morning cares. not set up to complete oral ented to R31 that she would her teeth after breakfast, but rushed her teeth the evening toothbrush was wet. R31's ed to have a drop of water on bristles had dried toothpaste s were dry and did not move</li> </ul>	F	577			

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		AND HUMAN SERVICES			FORM	: 04/29/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DAT CON	E SURVEY IPLETED C
		245361	B. WING			25/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 677	LPN-B confirmed R required staff assis R31 is able to brush set her up. LPN-B e twice a day, or more requested it. LPN-E confirmed there wa R31's upper and low her mouth. LPN-B I and confirmed it hat toothbrush was use toothbrush, toothpatitems were in, into f On 3/25/21, at 9:55 her bathroom, brush was not set up to bu 3/24/21. The previous substance was no I On 3/25/21, at 10:4 (DON) stated she e completed accordin If the assigned staff care, the assigned another staff was a know so the care care A provided Activities Supporting, policy, "Appropriate care a for residents who a independently." Ora section. A facility policy regar	<ul> <li>31's care plan indicated R31 tance for personal hygiene, if in her teeth, then staff should expected this to be complete e often if the resident</li> <li>B looked in R31's mouth, then s thick, white substance on wer teeth across the front of ooked at R31's toothbrush d been, "a while," since the ed as she threw the ste and emesis basin these the garbage can.</li> <li>a.m. R31 was observed in hing her teeth R31 stated she rush her teeth prior to bed on usly noted thick, white onger noted on R31's teeth.</li> <li>9 a.m. the director of nursing expected oral care to be ng to each resident's care plan. f was not able to complete oral staff should have asked if ble to assist or let the nurse</li> </ul>	F 67			
F 679 SS=D		rest/Needs Each Resident	F 679	9		4/28/21

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		<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	· ·	NG		IPLETED
						С
		245361	B. WING			25/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	•	
				600 SOUTH DAVIS AVENUE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC		LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE
F 679	Continued From no	ao 20	Г ог	70		
1 079	• · · · · · · · · · · · · · · · · · · ·	-	F 67	79		
	CFR(s): 483.24(c)(	1)				
	the comprehensive and the preferences program to support activities, both facili individual activities designed to meet th physical, mental, ar each resident, enco and interaction in th This REQUIREMEN by: Based on observat review, the facility fa assess and develop activities of interest reviewed who comp meaningful activities and evening hours. to ensure activities provided to promote	facility must provide, based on assessment and care plan s of each resident, an ongoing residents in their choice of ity-sponsored group and and independent activities, he interests of and support the hd psychosocial well-being of buraging both independence		Activities Meet Interest/N Resident §483.24(c)(1) The facility based on the comprehen and care plan and the pro- each resident, an ongoin support residents in their activities, both facility-spo and individual activities a activities, designed to me of and support the physic psychosocial well-being of encouraging both indepe	r must provide, eferences of g program to choice of onsored group nd independent eet the interests cal, mental, and of each resident,	
		MENT inimum Data Set (MDS), dated R37 had intact cognition and		Resident 37 was reasses therapeutic recreation ne	sed for	
	of daily living (ADLs was, "Very importar	assistance with her activities s). Further, the MDS outlined it nt," to R37 to do her favorite e nursing home. The MDS		care updated. Resident 7 was reassess therapeutic recreation ne care updated.		
	recorded R37 cons to, being around an	idered having music to listen imals, and doing activities with so as, "Very important."		To ensure other residents accurate therapeutic reci		

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		AND HUMAN SERVICES				FORM	04/29/202 APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	COM	E SURVEY PLETED
		245361	B. WING			03/2	_ 25/2021
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 679	When interviewed of voiced she enjoyed in the nursing home them" offered. How was not enough act or evening hours act stated she just sits television then. Fur- mentioned to the st activities on the we just told "we're worl R37's most recent I Management) Ther dated 2/15/21, iden oriented to person, reading, "wants to a assessment outline which included card walking or wheeling gardening or plants activities, besides r being enthusiastic a at the nursing home prompts to engage section labeled, "Pr enjoyed bingo, mus along with one-to-o section item labeled required," had writte comment."	on 3/22/21, at 3:16 p.m. R37 going to the activity programs e and attended "every one of rever, R37 expressed there tivities to do on the weekend dding, "There's nothing." R37 in her room and watches ther, R37 stated she had aff before about needing more ekends and evenings but is	F 6	79	assessment a facility wide audit wa completed on 3/25/2021. Facility therapeutic recreation staff were ed to proper documentation requireme 3/26/2021 by therapeutic recreation director. Therapeutic recreation dire as part of the QAPI process comple survey of resident preferences relat therapeutic recreation on 3/5/2021 ensure that preferences are being r and determine needs for future programming requests. Therapeutic recreation director evaluated programming for nights and weeker and facility offers programming per resident preferences. Staff inserviced on 4/20/2021 to the practice for therapeutic recreation programming. Monitoring of assessments will be completed through an audit by thera recreation director x1 daily for 1 we weekly for 4 weeks, and monthly or indicated by QA committee to ensur- resident bathing preferences are maintained. Allegation of compliance is 4/28/202	lucated ents on ector eted a ted to to met c nds e facility apeutic ek, as re	

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		AND HUMAN SERVICES				FORM	: 04/29/2021 APPROVED
STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT CON	0. 0938-0391 TE SURVEY MPLETED
		245361	B. WING				C / <b>25/2021</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 679	meet this goal whic activity calendar in choosing pleasure residents right to re make all we have a During interview on assistant (NA)-C sta "once in awhile" she repeatedly heard R do in this damn plac last complained of s and expressed she nursing home due to NA-C stated R37 w "pretty much just in window or rummag When interviewed of stated R37's activity "depend on her mo witness her attend v such as bingo. NA- complain in the pas the nursing home a can I do[?]" or, "Wh stated she felt R37 throughout the day 100%." R37's medical reco any evidence R37 h reassessed for her involvement needs to the staff about a bored. There was n reviewed what, if ar include or provide F	nge 32 th read, "Keep a current room for their viewing and " and, "Respect the fuse the offer of activities, but wailable if they would like to." 13/23/21, at 1:50 p.m. nursing ated R37 attended activities e recalled; however, had 37 voice there was "nothing to ce." NA-C explained R37 had such over this past weekend didn't want to remain in the to there was "nothing to do." vas frequently observed to be her room" and looking out the ing through her belongings. On 3/23/21, at 2:02 p.m. NA-G y involvement seemed to od" but acknowledged she did various group-based activities G stated she had heard R37 at of a lack of things to do in and ask staff repeatedly, "What hat is there to do?" NA-G was offered activities but added she "can't say	F 6	\$79			

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		AND HUMAN SERVICES				I	FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		X3) DATE COMI	E SURVEY PLETED
		245361	B. WING	. <u></u>				C 25/2021
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD B		(X5) COMPLETION DATE
F 679	Continued From pa	ae 33	F	679				
	residing in the nurs	-		510				
	On 3/23/21, at 2:53 assistant (TR)-A way had worked with R3 nursing home. TR-/ activity programs at thoughts" on them bad." R37 routinely bingo, Jingo and "F voiced R37 as bein activities programs she was aware R37 more activities" on evenings and adde to her "everyday I w she brought R37 do therapeutic recreating them discuss the is actions or the assessible had approached the har to "come to what ability to change the R37's POC (Point of Activity flowsheet, of identified all the act during the period. T days (3/11/21, 3/12) was recorded as hat during the evening sheet recorded R37 table game and gro (Saturday), and the game on 3/13/21 (S (Saturday) R37 atte event, and the relig	p.m. therapeutic recreation as interviewed and verified she 87 throughout her stay at the A explained R37 did attend the nd would often "share her which were "both good and y attended activities such as ancy Fingers" which TR-A g typically receptive to most offered to her. TR-A stated 7 had voiced there "could be the weekends and in the d R37 made these comments york." As a result, TR-A stated own to her supervisor, on director (TRD), and had sue. When questioned on ssment of R37 since she's comments, TR-A voiced she e issue with more just directing at we have" as she has no						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/29/2021 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245361	B. WING			( 03/2	_ 25/2021
NAME OF PRO	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER N	IANOR REHABILITA	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
p p a C a w e w t d b c T r r ir p g w e a a A d e w a r r c a a c a s c a s t t d b c t r a i c a s v t t d b c c a a s t t d b c c a a s t t d b c c a a c c a a a c c a a a c c a a a c c a a a c c a a a c c a a a c c a a a c c a a c c a a a c c a a a c c a a c c a a c c a a c c a a c c a a c c a c c a c c a c c a c c a c c c a c c a c c c a c c c a c c c c a c	ersonal or group a ttempted with R37 On 3/23/21, at 3:03 and verified knowled vith a lack of activit vening hours. TRE vith an activities can here was "somethin lo" adding these pro- een able to offer "a ensus and staffing 'RD acknowledged eassessed R37 to ndividual or other gorovided to her; nor rievance process to vere addressed. The nsure residents we activities needs' me to the nursing home a provided "Docume (ated 6/2018, identi- vas maintained, an issessments would ecord. However, the teps or procedures oncerns with the a	ating what, if any, other ctivities had been offered or on these weekend days. p.m. TRD was interviewed dge R37 had voiced concerns ies on the weekends and 0 voiced she provided R37 lendar and explained to her ng every single day" for her to ograms were what they had at this time" given the low needs of the department. I she had not comprehensively determine what, if any, roup activities could be had she started a formal o ensure R37's concerns RD voiced it was important to ere assessed and their t to ensure their quality of life	F 6	579			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED
		245361	B. WING _				C 25/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE TCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	{	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 679	Continued From pa	ge 35	F 67	79			
	12/24/21, identified required total assist extensive assistant living (ADLs). The M considered listening religious services a Review of R7's Mon identified activities: her room for her vie	imum data set (MDS) dated severely impaired cognition, tance with transfers, and we with her activities of daily MDS also identified R7 g to music, the news, and lso as very important. ments Hospice document Keep a current calendar in ewing and choosing pleasure offer. Respect her right to					
	R7's care plan last independent to cho like to attend while she is feeling up to participate or receiv offer. The care plan help R7 meet this g calendar in room fo pleasure" and, "F refuse the offer of a available if they wor R7's medical record admission 12/16/20 evidence R7 had be reassessed for her involvement in the f	revised 1/11/21, identified R7 ose the activities she would here. We will encourage, once it if she would like to ve the 1:1 activities that we a listed two interventions to ioal: "Keep a current activity r their viewing and choosing Respect the residents right to activities, but make all we have					
	not received.						

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		AND HUMAN SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	i í				PLETED
						(	C
		245361	B. WING			03/:	25/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETION DATE
_					DEFICIENCY)		
F 679	Continued From pa	ae 36	F 6	79			
	•••••• •••• •••• ••••	9		10			
		s on 3/23/21, at 1:41 p.m.,					
		., and 3:52 p.m. R7 sat in the while watching the television					
		ord puzzle." When asked at					
		d, "I like talk shows."					
		ker Manor March activity 3/23/21, indicated 8:15 a.m.					
		nd massages, 9:30 a.m. to					
	11:15 a.m. devotion	nal readings, room to room 1:1					
		ne, 9:30 a.m. to 11:15 a.m., 2					
		e chapel, and 6:45 p.m. to s. The POC response history -					
		lated 3/23/21, identified R7 at					
	11:09 a.m. and 3:16	δ p.m. as unavailable.					
	R7's POC response	e history - activity flow sheet,					
		23/21 (13 days), identified all					
	the activities R7 had	d attended during the period.					
		tified only three days (3/12/21,					
		1) R7 was recorded as having ed. The sheet recorded R7 as					
	, , , , , , , , , , , , , , , , , , ,	movie on 3/12/21 (Friday),					
		/library cart/book club 3/18/21					
		igious service 3/21/21					
		on 3/11/21 R7 was recorded ctivity ([Manicure/painting					
		applicable. Additionally, the					
		entified twenty-one (21) times					
	R7 was not availabl approached.	le out of twenty-nine (29) times					
	During an interview	on 3/24/21, at 11:33 a.m.					
	licensed practical n	urse (LPN)-F indicated R7's					
		eading to her in the room.					
		ed the hospice aids spends a ng with R7. LPN-F also					
	identified R7 really						

Facility ID: 00775

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		<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· /	NG	· · ·	MPLETED
						С
		245361	B. WING		03	8/25/2021
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	•	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 679	Continued From pa	age 37	F 67	79		
	recreation director documentation title identified R7 was u unavailable indicate hospice was with h indicated we do no see they are sleep played bingo with s happy to get to play During a follow-up a.m. with RD verifie activities in a 14 da when activity staff activity they did not one-to-one time with not receive one-to- Response History it (3/11/21 - 3/23/21), improve on the one stated printed articl been given to R7 to sure if R7 was able RD indicated activit and then if not avait with other residents more than once. R any one-to-one act assessed to determ been made to sper a.m. RD-B approact the POC Response identify why one-or completed and why RD-B stated this do	d PÓC Response History inavailable. RD verified ed R7 maybe in the bathroom, her, or sleeping in her room. RD t wake residentis up when we ing. RD also identified R7 staff assistance and was very y. interview on 3/25/21, at 9:47 ed R7 attended only three ay period of time. RD indicated prepared for a large group t have time to complete th R7. RD also verified R7 did one time activity on the POC in a 13 day period of time . RD stated we certainly could e-to-one time with R7. RD also les from the newspaper had o read however RD was not e to read them independently. ty staff checked with R7 once ilable, they moved on to check s; they are unable to check D identified R7 did not have ivity visits and needed to be nine what changes could have not more time with her. At 10:45 ched surveyor and identified e History Document did not n-one activities were not being y R7 resident was unavailable. bocument will be changed to a resident's situation and				

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		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	· /	E SURVEY PLETED
						С
		245361	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Quality of Care CFR(s): 483.25		F 6	84		4/28/21
	applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro- practice, the compri- care plan, and the re This REQUIREMEN by: Based on observat review the facility far assess, develop ap adequately monitor promote resident sa residents (R39) revisionage. Findings include: R39's annual Minim 2/12/21, identified F diagnosis of depress physician-prescriber On 3/22/21, at 2:46 R39 in his room, it I dirty dishes and mu- his room that contain numerous empty cor remaining in them. unpleasant odor to had been an unbur- container, approxim contained a spoon	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered		Quality of Care Quality of care is a fundamental pr that applies to all treatment and ca provided to facility residents. Base comprehensive assessment of a re the facility must ensure that reside receive treatment and care in acco with professional standards of prace the comprehensive person-centered plan, and the residents' choices Resident 39 has been educated or handling policy on 4/20/2021. Resi has been informed of risks and be improper food storage. Resident 3 plan has been updated to ensure interventions are placed for proper storage and intervention when resi refuses interventions. An audit of all residents with perso refrigerators was conducted by infe control nurse on 3/26/2021. A care review of all presidents was compl 4/25/2021. There are no other resi with food hoarding behaviors.	re d on the esident, nts ordance ctice, ed care a food dent 39 nefits in 9's care food dent nal ection plan eted on	

Facility ID: 00775

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	СОМ	E SURVEY PLETED
		245361	B. WING _			C 25/2021
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE,	ZIP CODE	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIO DATE
F 684	spoon and the unid covered with darke had felt the contain container "got burie week." On the sam milliliter shallow red container with saue had taken it out of t and "will take it dow had a chance. On t there had been two containers; one cor other contained chi container had been morning and he wo when he had finish help with the dishes however, he explai dishes to the kitche do it, but I could ge stated when he acc together" he broug be washed, in whic on Tuesdays." Whe on staffs' response "They just leave it." obtain his own food himself as he had r facility provided me On 3/23/21, at 2:50 interview with R39, 3/22/21 remained i R39 denied he had dishes and contain	lentified item, had been r colored mold. R39 stated he er held ribs in which the ed" and had "been there a e bed, there had been a 950 ctangular clear plastic erkraut in it. R39 explained he the fridge "yesterday [3/21/21]" vn [to the kitchen]" when he the room's television stand, o clear smaller square plastic ntained cheese sauce and the teken. R39 stated the chicken n there since 11:00 a.m. that buld put it back in the fridge ed eating it. R39 voiced, "Staff s when they have time;" ned, "They could do it [take the en] if there were enough staff to t it done before them." R39 cumulated a "bunch of dishes ht them down to the kitchen to the explained, "I take them en R39 had been questioned to the dirty dishes, he stated, ' R39 voiced he preferred to d items which he heated up by not cared for many of the eals delivered to him.	F 68	Monitoring will be accor an audit by DON or des 1 week, weekly for 4 we or as indicated by QA of ensure proper food stor by infection control nurs Results will be reported QAPI committee for rev Deficient practices will identification. Allegation of compliance	signee x1 daily for beks, and monthly ommittee to rage is maintained se or designee. I to the facility view and follow-up. be corrected upon	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	): 04/29/2021 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		245361	B. WING	i			C / <b>25/2021</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 684	his refrigerator as " ate "a little bit of the denied gastrointest R39's alteration in r dated 2/27/20, indic throwing food away statements of his have refusal of medication alert to mood and b offer "foods/fluids" a non-medication app observed. R39's mod 2/28/20, indicated F intakes greater than which directed staff when R39 had been machines. Prior to documentation of R having brought bac potential food hoard sanitation concerns R39's Clinical Nutrit 2/10/21, identified F pounds with a meal -75%. R39's diabeted diet and medication been meeting his en The assessment ide independent at meal assist. The assess R39 having been no diet orders or potent	cken container placed back in that's good" and voiced he had e chicken for breakfast." R39 inal concerns. mood and behavior care plan, cated R39 had a history of in the garbage, past aving wished to die, and ons which directed staff to "be rehavioral changes" and to as one of the multiple proaches when behaviors orbidly obese care plan, dated R39 had a history of energy n his energy expenditures to encourage low sugar items in seen at the vending 3/25/21, the care plan lacked R39's trips to Walmart with his k high calorie food items, ding tendencies, or food	F	684			
	form, dated 2/12/21	, indicated R39 had a history mart for shopping purposes					

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		245361	B. WING				C <b>25/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	A regulatory medica identified R39 had r excess calories with the dictation indicat "trending down." Fu R39 had a history of major depression th non-compliance. Th documentation R39 tendencies. A progress note, da weight had begun " month." R39 had co carbohydrate diet w approximately 75% provider had been of were to continue to compliance while p R39's weight gain th having been related lacked documentat non-compliance or tendencies. R39's Kardex (nurs 3/23/21, identified u that staff had been and behavioral cha heading, R39 "Inde his own." The Kard Loss" directed staff when he had been and identified R39 I Kardex lacked inter potential food hoard	al provider visit, dated 2/19/21, morbid (severe) obesity due to h a weight of 290; however, ed R39's weight had been arther, the dictation indicated of cognitive impairment and hat had led to issues of he dictation lacked b had potential food hoarding atted 3/1/21, indicated R39's to trend back up in past ontinued on a consistent with meal intakes . Per the note, the medical updated on 2/14/21 and staff encourage R39's diet raising healthy food choices. had been reported as possibly d to diuretic use. The note	Fθ	584			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	СО	MPLETED	
		245361	B. WING		03	C 6/ <b>25/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	•		
MEEKEF	R MANOR REHABILIT	TATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 684	Continued From pa sanitary concerns.	-	F 68	4			
	indicated R39 had carbohydrate diet.	mary Report, dated 3/25/21, been prescribed a consistent The report lacked medical rsing orders to monitor R39's ood practices.					
	assistant (NA)-J st outside food" in wh provided meal but "snack." NA-J ackr R39 with food prep with his personal fr explained he had in could help R39 cle which R39 has had however, NA-J has food items had bee R39 would decline old food he would of having ever observ confirmed he had b to administer medi to supply R39 with had never seen R3 containers in his ro might use the sink visualized the cont stated, "Oh, this is in there." NA-J stat had not seen the c asked R39 if he co	n 3/23/21, at 3:24 p.m. nursing ated R39 enjoyed "a lot of the nich R39 would eat the facility would get hungry and then nowledged he had assisted o and denied he provided R39 ridge management. NA-J n the past asked R39 if he an up the food containers to d periods of declined assist; s emptied the garbage when en disposed of. NA-J voiced if to allow assist to dispose of update the nurse. NA-J denied ved containers with mold. NA-J been in R39's room on 3/22/21 cations and then again that day fresh water. NA-J stated he 39 cleaning any of the used bom; however, he voiced, "He in the bathroom." When NA-J ainers on the spare bed, he not good. There is some mold ted he had been surprised he ontainers on 3/22/21. NA-J had yuld put the sauerkraut he fridge; however, R39 stated					

Facility ID: 00775

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED
		245361	B. WING		03	C / <b>25/2021</b>
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP C	•	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	explained to R39, " been out that long." cheese sauce cont when NA-J read the cheese sauce to R refrigerate after op- you are going to ha obtained R39's app container issues in found a total of 11 of "This is an eye ope explained he defini make sure that thir and that R39 was of the containers. NA- he is hoarding food keeping chicken ou diarrhea from eatin additional statemen When interviewed of trained medication typically had been it times a day when s about every two to worked as a nursin acknowledged R39 and she explained, quite frequently and stated several wee lettuce," "spoiled st	age 43 'You cannot eat food that has " R39 had initially wanted the ainer left alone; however, e label of an unopened can of 39, which directed to ening, R39 voiced, "Well then ave to throw that." NA-J proval to look for additional R39's room in which NA-J had dirty containers. NA-J stated, ening thing there." NA-J tely had to talk to the nurse to ngs were being refrigerated getting the help he needed with -J explained, "We are aware d, but not aware he was ut." NA-J stated R39 could get ng spoiled food with an nt of, "That is very bad." on 3/24/21, at 12:55 p.m. aide (TMA)-B stated she in R39's room two to three she passed medications and two and a half hours when she ng assistant. TMA-B 9 had "a lot of food in his room" ."[R39] goes out to Walmart d buys and abundance." She ks ago she had found "soggy tuff," and "moldy cheese" in B explained around that same	F 684			

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		AND HUMAN SERVICES			FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
		245361	B. WING			C <b>25/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	nurse when these of occurred. TMA-B de place to check R39 other food concerns housekeeping hand During interview on stated she had bee food and that R39 h should have been r during the "last mor going out to Walma put food in his fridg food items in R39's had conversations v expired items in his she took dirty conta about two weeks ag knowledge of who h R39 with container had been directed to concerns. NA-B exp housekeeping may she had told other s had observed. When interviewed of housekeeper (H)-A cleaned R39's room had ever seen dirty unrefrigerated food H-A denied knowled monitor R39's room with dirty dishes or During interview on	the nurse manager or the conversations with R39 had enied a process had been in Vs room for spoiled food or s. She voiced she had thought died it. a 3/24/21, at 1:19 p.m. NA-B en aware that R39 hoarded had food that sat out that refrigerated. NA-B explained inth or two" R39 had been art in which she would help him e. She has observed expired fridge and explained she had with R39 about not keeping fridge. NA-B acknowledged ainers down to the kitchen go; however, she lacked had been responsible to assist management and denied staff to monitor R39's room for food plained she had felt have managed it. She denied staff about any food issues she on 3/24/21, at 1:36 p.m. acknowledged she had n; however, she denied she food containers or sitting out for multiple days. dge of a process in place to n for spoiled food or to assist container management. a/24/21, at 1:43 p.m. dietary	F 684			
	aide (DA)-A acknow	3/24/21, at 1:43 p.m. dietary vledged the kitchen staff or R39] all the time				

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						). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
						С
		245361	B. WING		03	8/25/2021
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE	
MEEKER	MANOR REHABILI	TATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pa	age 45	F 68	34		
		he wants them washed." DA-A				
		brings them [containers] down				
		omfortable with them." She				
		een 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 r	nurse (LPN)-C stated R39 had				
		ing food in his room. LPN-C				
		ve to keep going in there				
		hrow things away." Further, R39 will verbalize to staff that				
		good when staff question him				
		een observed to be laying out				
	in which R39 "will r	normally let us throw things				
		ied having personally seen				
		however, she stated other staff				
		they have and have thrown the denied knowledge of R39				
		sed for hoarding behavior or				
	sanitary food proce	esses. Further, she denied				
		a process or plan in place to				
		n for food concerns. LPN-C				
		communicated R39's food es or food sanitary concerns to				
		her having assumed everyone				
	had already been a					
		n 3/25/21, at 10:11 a.m. care				
		stated R39 "absolutely" had				
		s. She explained R39 had been d been informed he could				
		es out into the community.				
		n R39 comes back from his				
		brings back a lot of things."				
		he has had conversations with				
		getting icky on occasion;" ad R39 had not appeared to be				
	concerned at the ti					

Facility ID: 00775

If continuation sheet Page 46 of 100

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT	E SURVEY	
		245361	B. WING			C / <b>25/2021</b>	
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 684	perishable items; h his wishes but do n She denied R39's h concerns had been planned. LPN-B ex these steps so that he does things so t in our care so we s food. He could get she expected staff issues.	e canned food items versus owever, "we have to respect ot want him to get sick either." hoarding and food sanitation assessed, monitored, or care plained she would work on "we could help manage how hat he can be safeThey are hould keep him safe with his sick." LPN-B acknowledged to inform her about any food	F 6	84			
F 686 SS=D	Individual Consump food brought into the residents would be an individual basis food intended for re- kept in a refrigerate consumed. Further does not require re- in a sanitary manne- staff were to monitor	Prevent/Heal Pressure Ulcer	F 6	86		4/28/21	
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that (ii) A resident with p	sure ulcers. prehensive assessment of a					

Facility ID: 00775

If continuation sheet Page 47 of 100

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/29/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245361	B. WING	÷			25/2021
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION 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 PREF TAG	IX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 686	promote healing, pr new ulcers from de This REQUIREMEN by: Based on observat review the facility fa interventions for 2 d identified at risk for Findings include: R4's annual minimu 3/17/21, indicated s along with needed of mobility and transfe R4's face sheet dat diagnosis included: behavioral disturba memory and judger disease, insomnia ( Alzheimer disease disease that destro important mental fu R4's provider order use foot cradle und bed to reduce press scabs on right/left to when they heal. Be apply to first and se morning and at bed R4's tissue tolerand factors dated 3/16/2 skin breakdown.	andards of practice, to revent infection and prevent veloping. NT is not met as evidenced ion, interview, and document ided follow pressure ulcer of 2 residents (R4 and R26) pressure ulcers. and data set (MDS) dated revere cognitive impairment extensive assistance with bed ers. ed 3/24/21, indicated unspecified dementia with nces (Brain impairment in ment), peripheral vascular difficulty with sleeping), with late onset (a progressive ys memory and other nctions). s dated 12/23/20, indicated er blanket when resident is in sure on feet/toes. Monitor bes every shift discontinue tadine swab sticks swab 10% cond toes topically every time for wound care. and the stated moderate risk for	F	686	Treatments to Prevent/Heal Presulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive asso of a resident, the facility must ensi- that— i. A resident receives care, con- with professional standards of pra- prevent pressure ulcers and does develop pressure ulcers unless the individual's clinical condition dem that they were unavoidable; and ii. A resident with pressure ulcer receives necessary treatment and services, consistent with professi- standards of practice, to promote prevent infection and prevent new from developing. Resident 4 plan of care was revier 3/26/2021 to ensure skin intervent in place and appropriate. Resident 26 plan of care was revier 3/26/2021 to ensure skin intervent in place and appropriate. To ensure other residents skin interventions are active and appro- house wide audit was completed 3/26/2021. Facility nurses and CNA's were en- to the expectation of ensuing app- skin interventions are in place at a	essment sure sistent actice, to anot ne onstrates donal healing, vulcers wed on tions are ewed on tions are opriate, a on ducated ropriate all times	
		ised 3/4/21, indicated ADL's				all times	

Facility ID: 00775

	-	I AND HUMAN SERVICES				FORM	04/29/202 APPROVE 0938-039
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245361	B. WING			03/2	C 25/2021
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 686	extensive assistand bed mobility and per further indicated vul limitation, communicates as per care per when plan needs under skin integrity with ir integrity every shift apply lotion to dry se approximately ever (prn). R4's care platintegrity which lack foot cradle. R4's weekly skin assist indicated right toes Review of skin assist indicated right toes Review of skin assist indicated right foot scabbed areas ong During observation laying on left side in feet covering entire observed sitting on the tray table. During observation laying on left side v from neck to below observed sitting on under the tray table observed in use. During interview on assistant (NA)-A st should be using the would assume the	ce with dressing, showering, ersonal hygiene. R4's care plan ilnerable with mobility ications, staff will provide daily blan and will notify nursing pdating for accuracy. Risk for nterventions of monitoring skin with cares and on bath days, skin, and reposition by 2-3 hours and as needed in indicated risk for skin ed any information about the essessment dated 3/17/21, remains discolored ongoing. essment dated 3/10/2, great toe and second digit	F 6	86	were inserviced on the need to ensist in interventions are in place and appropriate on 4/20/2021. Audits of 3 pressure ulcer intervent will be completed weekly x 4 then r x2 months to ensure that residents being assisted with their intervention their individualized plan. Results wireported to the facility QAPI commineview and follow-up. Deficient prawill be corrected upon identification Allegation of compliance is 4/28/20	tions nonthly are ons per Il be ttee for ctices	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SUR COMPLETE C			I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	04/29/2021 APPROVED 0938-0391
245361     B. WING     03/25/20       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       MEFKER MANOR REHABILITATION CENTER, LLC     600 SOUTH DAVIS AVENUE	STATEMENT OF D	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
MEEKER MANOR REHABILITATION CENTER, LLC			245361	B. WING			03/25/2021	
MEEKER MANOR REHABILITATION CENTER, LLC	NAME OF PROV	ROVIDER OR SUPPLIER						
	MEEKER MA	MANOR REHABILIT	ATION CENTER, LLC					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION DATE
<ul> <li>F 686</li> <li>Continued From page 49</li> <li>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.</li> <li>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.</li> <li>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.</li> <li>During interview on 3/24/21, at 7:24 a.m. NA-B stated She has sores on her 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.</li> <li>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 should think that these interventions for there.</li> </ul>	her that has furl her this Imr NA cra res with the Dun lyin foo the Dun sta sec me R4 bee cra app Kar Dun tick show water the show the the show the the show the the the the the the the the the the	her toes. NA-A stat that the nurses are has never seen the further stated she f her how to care for this listed on there. Immediately followi NA-A left R4's roon cradle, and walked residents room, R4 with blankets on he the floor. During observation lying in bed toes/fea foot cradle sitting o the tray table. During interview on stated R4 has sore second toe of the ri medication aid or n R4 up for the day. I been employed she cradle being used v approximately 7-8 r Kardex for interven During interview on Licensed practical i should have the foo was an order for it. on her right toes the treatments done pe the staff look to the for residents and w	and R4 had scabs on her toes monitoring. NA-A stated she e foot cradle on R4's bed. NA-A follows the Kardex which tells the residents and did not see ing interview, at 2:42 p.m. n, without implementing foot down the hallway into another continues to lay on left side er feet/toes and foot cradle on on 3/24/21, at 7:24 a.m. R4 et have blankets on them and in floor, next to wall and under a 3/24/21, at 7:24 a.m. NA-B is on her right great toe and ight foot which the trained burse will treat before getting NA-B stated since she has e has never seen the foot which has been for months and would look to the titons for the residents. a 3/24/21, at 9:19 a.m. nurse (LPN)-A stated R4 ot cradle on the bed if there LPN-A stated R4 has scabs at are being monitored and er order. LPN-A further stated e care plan/Kardex when caring yould think that those	F 6	\$86			

Facility ID: 00775

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245361	B. WING				C 25/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	During interview on stated that R4 shou to her sores on her important the foot of down and relieving stated all intervention for staff to follow as the resident. During interview on of nursing (DON) st be on her bed to pro- to prevent further bo that it would be listed stated she would ex- residents care plan R26's face sheet da diagnosis include: F that affects movern disorder, anxiety dis disorder, dementia elsewhere with beh (impairment of men muscle weakness. R26's MDS dated 2 cognitive impairment assist with transfers required extensive daily living. R26's order summa indicated Left (L) he floating heel with a a heel cushion bool Offload heels in beo-	3/24/21, at 9:21 a.m. LPN-B ild be using the foot cradle due toes. LPN-B stated it is gradle to prevent further break pressure to her toes. LPN-B ons should be on the care plan a this indicated how to care for 3/25/21, at 9:56 a.m. Director tated R4's foot cradle should event pressure on her feet and reakdown and would expect ed on the Care plan. DON spect staff to be following the ated 3/24/21, indicated Parkinson's disease (disorder ent), major depressive sorder, post traumatic stress in other diseases classified avioral disturbances nory and functioning), and 2/3/21, indicated severe int and required extensive two is and bed mobility. R26's assistance with activities of ary report dated 3/24/21, eel- remove pressure by pillow under calf and applying t. Heel protectors to both feet. d. Position blankets over bed	F	\$86			

		AND HUMAN SERVICES				FORM	D: 04/29/2021 MAPPROVED D. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				TE SURVEY MPLETED	
		245361	B. WING			C 03/25/2021		
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP COD	•		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			000 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 686	Continued From pa	age 51	F 6	86				
	redness. Monitor b every shift.	ruise on top of right great toe						
	as follows: -3/19/21, right heel	pressure wound evaluation are pressure length 2.5 x 2.5 0						
	depth unstageable.	pressure length 3.0 x 1.2 0 pressure length 2.5 x 1.0 0						
	alteration in skin in turn and reposition heels off the bed, for to keep blankets of under legs as tolera	vised on 2/10/21, Risk for tegrity interventions to include every 2-2.5 hours. Elevate oot cradle added to foot of bed f resident's toes, place pillow ated. Heal protectors when not tify hospice of any skin						
	lying in bed, blanke	on 3/23/21, at 2:06 p.m. R26 ets are tucked under mattress dents feet, no elevation of villow.						
	stated staff know h their care plan/Kare	a 3/24/21, at 7:24 a.m. NA-B ow to care for residents by dex. NA-B stated these (care at the interventions to follow r the resident.						
	sitting up in Broda dressing which had noted scant amour cleanser and dried to be eschar in the	on 3/24/21, at 8:52 a.m. R26 chair. LPN-A removed old d serosanguinous drainage it, cleansed with wound with gauze. Wound was noted center with pink surrounding nchable. LPN did not measure						

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245361	B. WING				C 25/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Continued From par wound. Applied Me tolerated well. LPN- and provides wound During interview on stated R26 should H times, unsure if legs seen the foot crade was removed due to bumping his feet. N the right foot that has added she uses the to know how to care During interview on hospice registered kicking the foot crade discontinue and he pillow as he allows of skin. During observation lying in bed with bla bilateral feet elevate she placed R26 fee pressure now that se During interview on further stated the for his care plan by the made aware that it agency. LPN-A furth following provider o prevent further breat manager updates th should reflect the p	nge 52 pilex with boarder. R26 -A stated hospice measures d treatments. 3/24/21, at 9:28 a.m. NA-E have pressure boots on at all s are to be elevated, has not e in a long time, but thinks it o the air mattress and IA-E stated R26 has a sore on as a dressing on it. NA-E e Kardex which is at the desk e for the residents. 3/24/21, at 12:54 p.m. nurse (RN)-B stated R26 was	F 6	i86			
	J. J	3/25/21, at 9:24 a.m. LPN-B have his heels elevated on					

	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION		D. 0938-039 TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		ING		MPLETED
			_			С
		245361	B. WING		03	/25/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
MEEKEF	MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 686	• · · · · · · · · · · · · · · · · · · ·	ge 53 o prevent further break down	F 6	686		
	and further stated F well. LPN-B stated the rail of the bed to further break down	R26 wears heel protects as blankets should be folded over o relieve pressure and prevent to resident's skin. LPN-B be following R26 interventions				
	During observation sitting in chair with	on 3/25/21, at 9:36 a.m. R26 blanket covering bilateral arms protects on his feet.				
	stated R26's sheets feet to prevent pres break down. DON s important to reduce	3/25/21, at 9:52 a.m. DON s should be pulled off of his sure injury or add to skin stated heel floating was e pressure of R26's heels. it is expected for staff to are.				
	dated 7/2018, indic provided per nursin will be performed u methods in an effor the spread of infect refusal of treatment record."	nd wound management policy ated " Wound care will be g or provider order. Procedure tilizing safe and sanitary t to prevent contamination or ion. Document treatment or t in the resident's medical				
F 688 SS=D	Increase/Prevent D CFR(s): 483.25(c)(	ecrease in ROM/Mobility 1)-(3)	F 6	88		4/28/21
	resident who enters range of motion do range of motion un	facility must ensure that a the facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range				

Facility ID: 00775

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		AND HUMAN SERVICES			FORM	04/29/2021 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	Сом	E SURVEY PLETED	
		245361	B. WING		C 03/25/2021		
NAME OF F	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE			
MEEKER	MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 688	Continued From pa	ge 54	F 68	8			
	motion receives ap services to increase prevent further deci- §483.25(c)(3) A res receives appropriat assistance to maint the maximum pract reduction in mobility This REQUIREMEN by: Based on observat review, the facility fa- range of motion (Re- consistently implem- reduce the risk of c (R14) reviewed for Findings include: R14's annual Minim 10/16/20, identified demonstrated no de Further, R14 requir complete most of h (ADLs); however, th limitation(s) to her F record if any impain R14's Therapy Rec 6/11/19, identified a for R14 which inclu ROM 6x/wk [six tim [repetitions]," and, '	num Data Set (MDS), dated R14 had intact cognition and elusions or other behaviors. ed extensive assistance to er activities of daily living ne section to record functional ROM were dashed and did not		<ul> <li>§483.25(c) Mobility.</li> <li>§483.25(c)(1) The facility must en that a resident who enters the faci without limited range of motion do experience reduction in range of runless the resident's clinical condidemonstrates that a reduction in r motion is unavoidable; and</li> <li>§483.25(c)(2) A resident with limiter range of motion receives approprite treatment and services to increase of motion and/or to prevent further decrease in range of motion.</li> <li>§483.25(c)(3) A resident with limiter mobility receives appropriate service equipment, and assistance to mai improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrate unavoidable.</li> <li>Resident 14's range of motion (RC program was evaluated by DON of 4/20/2021 and is reflective of curves of curv</li></ul>	lity es not notion tion ange of ed ate e range r ed icces, ntain or n a bly DM) n		
	plan, dated 3/5/21,	identified R14 was alert and n, place and time. The care		needs. A facility wide audit of ROM progra	ams was		

Facility ID: 00775

	-	AND HUMAN SERVICES			FORM	04/29/202 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	CON	E SURVEY PLETED
		245361	B. WING _			C 25/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	TATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 688	-	-	F 68			
	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			performed to ensure that resider ROM programs are receiving the program on 4/19/2021. Facility N staff and CNA's were educated need to completed ROM on 4/23 DON or designee. Facility staff v	eir Iursing on the 8/2021 by	
	her room. R14 had fingers of her left h place; along with a the slightly closed 1 stated she was sup	I visible contractures of the and with an applied splint in rolled up washcloth present in fist of her right hand. R14 oposed to be on a ROM oper and lower extremities;		inserviced on 4/20/2021 in regar expectations with ensuring comp ROM programs. Monitoring will be accomplished an audit by DON or Designee fo residents per week x4 weeks. Th	ds to bletion of through r 3	
	however, it was no to poor staffing in t went to an offsite c exercises a couple needed the ROM p	t always getting completed due he facility. R14 voiced she ampus for other rehab times a week, however, still programs done at the nursing inther loss of her mobility. R14		resident's per month for 2 month Results will be reported to the fa QAPI committee for review and Deficient practices will be correct identification	is. cility follow-up.	
	expressed these or the nurses but they working on it." Furt fingers and joints for	oncerns had been reported to / just always tell her "we're her, R14 voiced she felt her elt tighter in the past weeks the lack of her ROM programs		Allegation of compliance is 4/28	2021.	
	nursing assistant (I exercises she was including a NuStep program; however, NA-C voiced she w her upper extremiti	on 3/24/21, at 10:04 a.m. NA)-C stated R14 had several supposed to be doing and "standing frame" these would often be refused. vas aware R14 wore braces on ies and acknowledged hearing M exercises weren't being				
	completed adding, about it]." NA-C sta to be done "when s voiced she was un program was care	"She does a lot [complain ated R14's ROM was supposed she wakes up," however, then aware a lower extremity ROM planned adding, "As far as I ave to [do the lower ROM]."				

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STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED		
	U CORRECTION			NG		C		
		245361	B. WING _		03/25/2021			
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP C 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	ODE	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE		
F 688	NA-C expressed R getting done consist staff members to c complete the progri however, verified s explained R14 had increased pain, no tightening or stiffer past months. Furth or completed exerce programs, would b the PointClickCare During interview or stated she routinel she had heard R14 contraction" was "k not feel R14 had se overall ROM in the R14 had mentione her upper and lowe completed adding complaint "maybe NA-F expressed sh responsible to corr adding, "I want to se R14's Documentatt 2/2021, identified to This included, "Flo 15 reps also Be [si evening her hands week this needs to there is no restoral recorded as being February 2021, on remainder of the a	14's exercises may not be stently as R14 favors certain are for her and others may not rams "the way she wants," the was unsure. NA-C not really complained about r had NA-C observed more ning in R14's extremities in the her, NA-C stated any attempted cises, including ROM e recorded by the NA staff in	F 68	38				

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ID PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1 (V2) MILLT			I(X3) DA		
IAME OF PI	245361	IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED	
							С	
NAME OF P		245361	B. WING			03	/25/2021	
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			0 SOUTH DAVIS AVENUE TCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 688	Continued From pa	age 57	F 68	88				
		ther task which read, "Floor	1.00	00				
	Aides: Passive ROM U/E ROM 5x/wk 10 reps."							
	This was recorded	as being completed only once						
		on 2/1/21. The remainder of						
		the exercise minutes and eft blank, or had "NA [not						
	applicable]."	er blank, of had the flot						
	R14's Documentati	ion Survey Report v2, dated						
		asks to be completed for R14.						
	This included, "Floo	or Aides: L/E exercise 2x/wk						
		re do ROM daily on evening						
		nd legs, 7 days per week this						
		laily by the CNA's if there is no c]." This was recorded as being						
		ee times in March (so far) on						
	3/9/21, 3/10/21, and	d 3/15/21. R14 was recorded						
		ercises only three times, on						
		nd 3/24/21. The remainder of the exercise minutes and						
		eft blank, or had "NA [not						
		d. There was no evidence R14						
	had been provided	or offered her LE ROM						
		c of 3/1/21 to 3/6/21. In						
		outlined a task which read, ve ROM U/E ROM 5x/wk 10						
		o recorded as being						
		times in March (so far) on						
	3/9/21 and 3/15/21	. R14 was recorded as						
	5	ses only four times, on 3/10/21,						
		nd 3/24/21. The remainder of the exercise minutes and						
		eft blank, or had "NA [not						
		dictated. Further, R14's						
	medical record was	s reviewed and lacked any						
		nonstrating when R14's ROM						
	exercises had beer	n completed and/or refused.						

Facility ID: 00775

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DA	TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					MPLETED
							С
		245361	B. WING			03	/25/2021
NAME OF F	PROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	Ē	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			SOUTH DAVIS AVENUE CHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE
F 688	Continued From pa	age 58	F 6	88			
	registered nurse m a previous spinal c extensive assistant as a result. RN-A re- including the record exercise, and verifi- being completed of be; nor was there e ROM exercises we expressed there was voiced she was not getting done or not exercise programs documented as car	anager (RN)-A voiced R14 had ord injury and required ce with her mobility and ADLs eviewed R14's medical record, ded minutes and reps for each ed the exercises were not r documented as they should evidence to demonstrate the ere offered and refused. RN-A as "room for improvement" and t sure if the exercises were . RN-A stated R14's ROM should be completed and re planned to help prevent and promote strengthening					
	dated 10/2010, dire for a resident which physician's order w and reviewing the o any "special needs then outlined speci complete various F with directing appro- recorded in the me other information ir and professional st Free of Accident H CFR(s): 483.25(d)( §483.25(d) Accider The facility must er §483.25(d)(1) The	nts.	F 6	89			4/28/21

Facility ID: 00775

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		AND HUMAN SERVICES			FORM	04/29/2021 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245361	B. WING _		03/25/2021		
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	supervision and ass accidents. This REQUIREMEI by: Based on observat review the facility fa related to potential higher hot water ter accessible location addressed by main (R4, R8, R10, R19, R48, R50, R52, R5 communicated the faucets were too ho to ensure assessed interventions were a fall in order to mir injury for 1 of 1 resi Further the facility f supervision to preve residents (R40) rev Findings include: HOT WATER On 3/22/21, from 1 resident room bath amongst all four fac resident rooms (R4 R34, R37, R47, R4 R556) were found t the bathroom fauce pull hand away afte getting burned. When interviewed of had initially verbaliz	NT is not met as evidenced tion, interview, and record ailed to ensure concerns burn hazards surrounding mperatures in resident s were communicated and tenance for 15 of 15 residents R23, R29, R34, R37, R47, 05, R555, R556) who hot water in their bathroom ot. In addition, the facility failed	F 6	<ul> <li>Free of Accidents and Super The facility must ensure that §483.25(d)(1) The resident e remains as free of accident h possible; and §483.25(d)(2)Each resident r adequate supervision and as devices to prevent accidents. R4, R8, R10, R19, R23, R29, R47, R556 all had room wate temperature adjustments on R48, R50, R52, R505, R555 discharged from the facility. H room water adjustments occu 4/8/2021. Resident 55 passed away on Resident 40's care plan was reflect independent in room v and mobility on 4/15/2021. Re expected to discharge home 4/24/2021.</li> <li>Facility wide water temperatu adjusted on 4/8/2021 and low contracted service provider. I director and assistant mainte director were educated to pro temperature regulation and e if a resident voices a concerr grievance should be filed and investigation initiated on 4/21 Facility wide audit of falls occu last 30 days was completed b 4/15/2021 to ensure all fall's identified intervention and fall interventions are in place. Fa</li> </ul>	- nvironment azards as is eceives sistance R34, R37, r 4/8/2021. all have dowever, urred on 12/2/2020. updated to vith transfers esident is on res were vered by a Maintenance nance oper water nsuring that that a /2021. urring in the by NHA on have an		

Facility ID: 00775

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STATEMENT	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245361	B. WING _			03/2	C 25/2021
NAME OF I	PROVIDER OR SUPPLIER	1	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 689	asked permission t water temperature. burned by the hot v she does not put he water faucet stream water to her for mo confirmed staff had getting hot when it staff wet the washo "a little bit" to ensur hot before they gav During interview on stated she had felt hot. R10 explained cold [water] when I When interviewed of denied she had even used the water; how noticed "it [the water that day while she I R37 explained 3/22 had noted the water 3/21/21 she stated using the water "an On 3/22/21, at 6:36 maintenance (DOM thermometer to ass water temperatures rooms after he had surveyors' findings. 120 degrees Fahre check, the DOM sta	o check the bathroom sink R47 denied having been vater; however, R47 explained er hands directly under the n as staff brought a basin of rning and evening cares. R47 I knowledge about the "water is running." R47 explained doth from the basin and waited re the washcloth was not too re the washcloth to her. a 3/22/21, at 2:57 p.m. R10 the hot water had been too due to this, "I have to use the wash my hands." on 3/22/21, at 3:28 p.m. R37 er burned herself while she wever, R27 stated she had er temperature] was too hot" had been washing her hair. 2/21 had been the first day she re to be "that hot; however, on she had witnessed a nurse ad it was steaming." 6 p.m. the director of 1) used an analog spike sess the bathroom sink hot is in eight of the 15 resident been updated on the . None were verified to be over nheit. During the hot water ated he had not been aware of	F 6	89	inserviced on 4/20/2021 on the neereport resident concerns of hot wat using gait belts when applicable for transfers and ensuring fall intervent are initiated timely. Monitoring of water temperatures w completed through weekly audits of rooms by the maintenance director designee for 6 weeks. Results will 1 reported to the facility QAPI commi- review and follow-up. Deficient prac- will be corrected upon identification Monitoring of fall interventions will the completed by the DON or designeer- residents weekly for 4 weeks then residents monthly for 1 month. Res- be reported to the facility QAPI com- for review and follow-up. Deficient practices will be corrected upon- identification Monitoring of staff assisted transfer- be completed through 3 transfer- observations weekly for 4 weeks the staff assisted transfer observations months. Results will be reported to facility QAPI committee for review a follow-up. Deficient practices will be corrected upon identification Allegation of compliance is 4/28/20	er, tions vill be f 15 or be ttee for ctices e for 10 10 sults will mmittee rs will en 5 for 2 the and e	
	120 degrees Fahre check, the DOM sta any staff hot water During interview on	nheit. During the hot water ated he had not been aware of					

		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245361	B. WING				C 25/2021
NAME OF I	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	water temperatures where the temperatures where the temperatures to her. Further, NA- residents' hands wh "close" to them when make sure it was no had concerns about since she started et and a half months a had been unsure if concern to a nurse. When interviewed of stated when she wo the hot water had b the cold, she had be under the water stres she provided care t wet washcloth out s hot on R47's body. were concerns with started employmen two months ago; ho not communicated which she added "b [concerns with the fer During interview on stated, "If you put it the hottest setting if explained, "You hav it (the water temper centerthere is a tr on this concern he temperatures for th burn themselves." communicated this	were hot and had periods ture had been "uncomfortable" A stated the water could burn hich prompted her to stay en they used the water to ot too hot. NA-A explained she t the hot water temperatures mployment with the facility one ago; however, she voiced she she had communicated this on 3/22/21, at 6:47 p.m. NA-I orked with the residents and een turned on by itself, without een unable to put her hands eam. NA-I confirmed when o R47 she had to "shake" the so it became cooler and not so NA-I stated she had felt there the water since she had t at the facility approximately owever, she voiced she had this concern to anyone, in out most everybody knows not water temperatures]." 3/23/21, at 3:12 p.m. NA-J [hot water knob] all the way to t is going to burn." NA-J ve to play around until you get	F	\$89			

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI	דופי ר	CONSTRUCTION		TE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				· · ·	MPLETED	
			1				С	
		245361	B. WING			03/25/202		
NAME OF	PROVIDER OR SUPPLIER	-		STR	REET ADDRESS, CITY, STATE, ZIP CODE	CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			0 SOUTH DAVIS AVENUE FCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 689	Continued From pa	age 62	F 6	89				
		nurse (LPN)-C denied						
		ent or staff hot water concerns						
	•	w; however, LPN-C explained e "library area" had been "a little						
		when she had turned on just the						
		had denied she felt this had						
		the time as she had added						
		ot 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						
		tant (MA)-A were interviewed						
		A checked designated						
		e water temperature locations						
		stated acceptable hot water Id be 115 degrees Fahrenheit						
		te regulations and 120 degrees						
		to meet federal regulations.						
		d he had adjusted the water						
		t two months ago" due to						
		eratures having been reported a result of lower temperatures						
		vever, the DOM and the MA-A						
		owledge of staffs' current hot						
		ne DOM stated after he						
		ly water temperature logs						
		v that he had not been ware of the temperatures that						
		hen 115 degrees Fahrenheit.						
		d he would expect MA-A to						
		se elevated readings with an						
		nt, "but with me running						
		bed through the cracks." The expected all staff to bring						
		him or the MA-A "right away"						
		was a top priority and water						
	temperature's outs	ide the regulations had the						
		injure the residents. The DOM						
	and the MA-A deni	ed knowledge of a facility						

Facility ID: 00775

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		TE SURVEY MPLETED
		245361	B. WING		С	
NAME OF	PROVIDER OR SUPPLIER	240001	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		8/25/2021
		ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	_	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 689	policy which directer resident accessible a policy had been p During interview on coordinator (LPN)-I residents or staff ha not experienced an personally. LPN-B to report issues witt "maintenance super other staff of the pol A Logbook Docume Temps, Eye Washer report, dated 2/23/2 designated facility I monitoring which in Lane 1, Lane 2, Lai and Lane 1, Lane 2, Lai	ad them on how to check water temperatures; however, provided after the interview. 3/25/21, at 10:11 a.m. care B denied any knowledge that ad hot water concerns and had y concerns with the hot water explained she expected staff h hot water to the ervisor right away" and alert otential risks. entation: Air Temps, Water es temperature monitoring 21 through 3/23/21, identified ocations for water temperature included individual headings for ne 3, and Lane 4 "Resident" 2, Lane 3, and Lane 4 eport indicated water checks d on 2/23/21, 3/1/21, 3/9/21, entified all documented n on these four days showed esident 2 Lane checks had n ranged from 116 and 119 t. On 3/23/21, the hot water these same areas identified n ranged from 103 to 112	F 68			

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COM	E SURVEY IPLETED
		245361	B. WING				C 25/2021
NAME OF	PROVIDER OR SUPPLIER		·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	and "Note any discr heater settings as r necessary." The po "dial thermometer" which should be ca FALL INTERVENTI R55's quarterly Min 10/14/20, identified communication abil indicated R55 requi mobility and most a in which R22 had in transitions and walk had been free of fal assessment and ha hypotension (abnor pressure when star (failure of lungs to f used at that time. R55's care plan, rev R55 had been a fall weakness, and ass R55's fall goal had falls. The care plan 11/24/20 which ider been placed, along added to R55's whe to identify any further R55's Fall Review B identified R55 had r months in which he medications and ha evaluation indicated	repancies," "Adjust water required," and "Retest as olicy instructs staff to use a to test water temperatures librated on a regular basis.	F 6	89			

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DAT COM	0938-0391 E SURVEY IPLETED
		245361	B. WING				C 25/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	vision was impaired and hands-on assis in which he had bee come to a standing interventions at the follows: proper foot kept clear of clutter and call light within A progress note, en p.m. indicated R55 floor after he had be wheelchair with a si head and a raised si eye. The progress of fall prevention inter- support a reason for interventions in resp A Fall Scene Invest indicated R55 had I to get weak after di- did not have his oxy that R55 had been identified weakness saturations had app the fall and directed when his blood oxy 90%. An Incident Review 11/24/20, at 3:09 p. 11/16/20, at 12:10 p indicated dietary sta R55 had been foun had not known wha incident report iden dialysis that day wit	and required use of a device to move from place to place en unable to independently position. Care plan time of the evaluation were as wear at all times; room to be and debris; personal items reach. tered on 11/16/20, at 12:44 had been found lying on the een previously noted in his mall laceration on top of his swollen area above the right note did not identify any new ventions or documentation to or no new fall prevention	F	\$89			

Facility ID: 00775

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245361	B. WING				C <b>25/2021</b>
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	Staff had applied op low oxygen saturati later was on floor." indicated R55 had r limitations and requi- fall signs were place the fall. A progress note, en p.m. indicated at ap- had been found lyin left elbow skin tear. R55 stated he fell a had dropped on the wheelchair. A fork h when staff assisted had been incontine progress note did n prevention interven support a reason fo interventions in resp R55's electronic me evidence of a Fall S related to R55's 11/2 R55's EMR lacked Review and Analysi 11/28/20 fall. An Inc V-3 had been reque fall; however, none R55's record lacked notified of the fall. On 3/24/21, informa support R55's 11/28 the interdisciplinary	xygen after they obtained the ion reading and "5 minutes Further, the incident report not always been aware of his uired assist of one. Call don't ed on 11/24/20 in response to hered on 11/28/20, at 4:11 proximately 2:45 p.m. R55 ng on the floor with a sustained . The progress note identified after he reached for a fork he e floor while seated in his had been found under him I him up off of the floor and he nt during the incident. The not identify any new fall tions or documentation to or no new fall prevention ponse to the fall. edical record (EMR) lacked Scene Investigation Form	F	589			

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						<u>). 0938-039</u> TE SUBVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	TE SURVEY MPLETED
			, a boilebillt			С
		245361	B. WING		03	8/25/2021
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 689	surveyor on 3/24/2 information R55 ha 11/28/20 at 4:11 p.t had been free of in fall were "TBD [to b note on the piece of pulled from daily cl on 11/30/2020 (Mo injuries are reviewed hosp [hospital] on 7 When interviewed of LPN-B stated staff "immediate intervent fall which would he falls. The intervent fall would then be r meeting for any ne stated staff always they required assis making at the time staff were also exp Review and Analys Management repor During interview or manager registered were expected to p place after a reside would have looked "maybe Dycem (no other intervention a something." RN-An acknowledged R55 however, she confi information that ide	1, which indicated typed ad been found on the floor on m. Further, this indicated R55 jury and intervention(s) for the be determined]." A hand written of paper indicated, "This is inical morning meeting report nday) where falls/interventions, ed. (patient was admitted to		9		

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		AND HUMAN SERVICES					FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245361	B. WING					C 25/2021
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD	E	•	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			0 SOUTH DAVIS AVENUE TCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
F 689	staff should have co management for fo been trained" on fac	ge 68 vas done." RN-A explained ommunicated the fall to llow up as staff "should have cility expected fall procedures. on 3/25/21, at 11:07 a.m. the	F	589				
	director of nursing ( the nursing assistan "initiate something." interventions were ' and she would expe documented. Further reviewed falls in wh effectiveness of the reviewed R55's EM	(DON) stated the nurse and nts would talk after a fall and "The DON explained fall "usually done immediately" ect the interventions to be er, the DON explained IDT nich staff discussed the e fall interventions. The DON R and confirmed the lack of entions after his 11/28/20 fall.						
	revised 2/2021, indi policy was to identifi implement fall preve provide guidelines f assessment and fal policy directs staff p medical provider and time frame, to comp analysis, and record interventions taken addition, the policy interventions if a re- evaluate the chain of preceding the fall, a by the IDT daily.	ation and Management, icated the purpose of the fy residents at risk for falls, to ention interventions, and to for post-fall resident Il root cause identification. The post-fall to notify the resident's and family in an appropriate plete an incident review and d in the EMR "appropriate to prevent future falls." In directs staff to re-evaluate fall sident continues to fall, to of events or circumstances and that falls will be reviewed						
	USE	RVISION AND GAIT BELT IDS) dated 2/16/21, identified						

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		& MEDICAID SERVICES				0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245361	B. WING _		03	C 6/ <b>25/2021</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 689	moderately impaire needed for bed mo use, and personal I person physical as medical diagnoses vascular accident ( indwelling urinary c last month. R40's Visual/Bedsid dated 2/19/21, iden one and front whee ambulate short dist R40's care plan da related to history of failure, and DM2 (d (physical therapy) a instructions for mol mobility related to 0 DM2, CKD [chronic weakness; follow P and FWW ambulat movement in bed a and FWW with trar to CVA, polyarthritis and weakness; as personal hygiene. R40's fall review ew identified history of to two times; medic may contribute to fa to increase urine pp (nonsteroidal anti-in standing in one spo while make a turn e	age 69 ed cognition, extensive assist bility, transfers, dressing, toilet hygiene. R40 also required one sistance to walk in room. R40's included arthritis and cerebral CVA) (stroke) with an atheter, and a fall within the de Kardex Report document tified R40 required assist of eled walker (FWW) to cances and to walk in room. ted 3/4/21 identified fall risk falls, weakness, CVA, heart liabetes mellitus); follow PT and OT (occupational therapy) oility functional; alteration in CVA polyarthritis, heart failure, c kidney disease], and T instructions; assist with one ion; assist one to two with and in/out of bed; assist one hefers; self-care deficit related s, heart failure, DM2, CKD, sist one with dressing and valuation dated 2/10/21, falls in the last six months one cation use and diagnoses that alls: diuretics (water pills used roduction in kidneys), NSAIDS inflammatory drugs); gait while ot, walking straight forward and exhibits loss of balance while res wide base support. Fall	F 68	39		

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245361	B. WING				C 25/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEP	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	risk for fall r/t (relate history of falls, med diagnosis of CVA; r and bladder and ha neurogenic bladder transfers and currer Review of R40's oc recertification, prog plan dated 3/12/21, [stand by assistanc balance, toileting tra assistance of one p R40's progress note identified R40 requi stroke, received PT assist of one. Review of R40's ph encounter notes da "discussed and inst [R40] that PT would with all transfers du stress to pt [R45] to mobility, transfer tra During an observati R40 sat on toilet in wheel chair placed had gotten herself of wheelchair, and pus wheel herself back of water.	ed to) age, decreased mobility, lication listed above, and resident is continent of bowel as indwelling Foley for r; assist of one and FWW for ntly does not self transfer. ccupational therapy ress report & updated therapy identified R40 needed SBA re] with FWW for standing ansfer with SBA, and current	F 6	89			

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245361	B. WING			( 03/2	25/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	pivoted herself into front of her without and unhooked indw placed it on her lap to request help with catheter bag. During an observati nursing assistant (N and placed gloves of pushed herself up of position and took he NA-G provided peri pants up while R40 bathroom wall. R40 wheelchair. The fac with the use of a ga During an observati dietary aid knocked waited for a respon knocked again and observed to open th herself in the wheel the same blue sweat wore yesterday. R4 herself dressed and myself." During an interview p.m. stated she was now. R40 stated, "I I am supposed to." know it, as she is m getting there somel be careful, wheel m the bar on the wall the states of the same blue sweat wore weat the somel be careful, wheel m	the wheel chair located in assistance. R40 bent down velling urinary catheter bag and . R40 pushed the call light on a the indwelling urinary ion on 3/24/21, at 7:45 a.m. NA)-G entered R40's bathroom on. R40, without a gait belt on, off the toilet to a standing old of the bar on the wall. neal cares and pulled her hung onto the bar on the pivoted herself into the cility staff failed to transfer R40	Fé	689			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 04/29/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245361	B. WING				C 25/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 72	Fe	689			
	trained medication a was toileted about e with assist of one. T really transfer by he transfer belt is place one is needed to st backwards and we also indicated R40 hang onto the bar of During an interview NA-K identified R40 bathroom. NA-K als help R40 to the bat but I have not seen placed the wheelch forty-five degrees, F her own, and I have wheel chair to bed. boost R40 up more of the wheelchair. N on R40 indicated sh transfer. During an interview NA-G indicated a g the transfer with F4 7:45 a.m. NA-G ide used when R40 trans in the room becaus coming to this facili make sure R40 doe she is aware R40 transfer	on 03/23/21, at 3:19 p.m. ) was one assist to go to the so stated we have rarely had to hroom, she has taken herself that. NA-K indicated she air next to the bed at a R40 grabs the bed railing on also transferred her from the NA-K verified she had helped times than not to get her out IA-K also verified the charting he should have assist of one to y on 03/24/21, at 8:04 a.m. ait belt was not used during 0 in her bathroom today at ntified a gait belt should be hsferred and staff need to be she had fallen prior to ty. NA-G stated staff need to be not fall. NA-G also stated and indicated they had also sfer. NA-G identified she had					

		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245361	B. WING	i			C <b>25/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER		ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	LPN-E identified R4 to transfer. LPN-E is self transfer regular by herself. LPN-E in call for help. LPN-E in formed PT so the indicated R40 shout transfers. LPN-E st her this morning" da quick and does not transfer gait belt is falls. During an interview identified R40 shout assistance of one d walking and transfe should have superv toilet from the whee transfer belt should R40. OT stated she transferring in the re During an interview identities every time R40 she would be a are entered every to stated R40 should r put on the call light, help her. PT indicat aware R40 had self Facility policy titled Management [MHN Program last revise belts must be used indicated in the pati	y on 3/24/21, at 8:47 a.m. 40 required assistance of one stated she had caught R40 rly and going to the bathroom indicated she reminded R40 to also indicated she had by are well aware of it. LPN-E and have on a gait belt during all cated "I did not place a belt on uring a transfer R40 is too like it. LPN-E identified the used for safety to help prevent on 3/24/21, at 12:42 p.m. OT ald be provided with stand by due to being unsteady with ers. OT also identified R40 vision with transfers onto the el chair. OT also verified a gait be used anytime you transfer e heard R40 had been self ehabilitation meeting today. on 03/24/21, at 01:45 p.m. PT e physical therapy worked with assessed, then progress notes en days or on tenth visit. PT not be self-transferred, should , and wait for staff to arrive to ted she had not been made		589			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION (X3)	DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED
					С
		245361	B. WING		03/25/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
NEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETIO DATE
F 689	support and stabiliz	ge 74 e the resident when walking. A be used during a stand pivot	F 68	9	
		guidance to the resident, when			
F 697 SS=D	0		F 69	7	4/28/21
	provided to residen consistent with prof the comprehensive and the residents' g This REQUIREMEN by: Based on observat review the facility fa management for 1 complained of foot intervention. Findings include: R26's face sheet da	sure that pain management is ts who require such services, ressional standards of practice, person-centered care plan, goals and preferences. NT is not met as evidenced tion, interview, and document alled to provide timely pain of 1 residents (R26) who pain and did not receive timely ated 3/24/21, indicated Parkinson's disease (disorder		Pain Management The facility must ensure that pain management is provided to residents w 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	vho
	that affects movem disorder, anxiety dis disorder, dementia elsewhere with beh (impairment of mer muscle weakness. R26's MDS dated 2 cognitive impairment assist with transfers	ent), major depressive sorder, post-traumatic stress in other diseases classified avioral disturbances nory and functioning), and 2/3/21, indicated severe nt and required extensive two s and bed mobility. R26's assistance with activities of		<ul> <li>Resident 26 was assessed for pain on 4/9/2021 and pain care plan was reviewed.</li> <li>To ensure other residents assessment related to pain are completed per the F all facility residents were assessed for pain and interventions were placed with the plan of care and MD's updated as necessary with completion date of 4/25/2021.</li> <li>Staff education was initiated on 4/20/20 to the facility practice for pain assessments to be completed timely p</li> </ul>	RAI, nin D21

Facility ID: 00775

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION		E SURVEY PLETED	
		245361	B. WING _			C 25/2021	
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 697	R26's care plan rev alteration in skin int turn and reposition heels off the bed, fo to keep blankets of under legs as tolera wearing shoes. Not concerns. Review of care plan idenified risk for pa pain management of Review of Medicatid dated 3/1/21-3/31/2 medications: -Gabapentin Capsu (mg) by mouth two -Acetaminophen Ta mouth every 4 hour discomfort. -Morphine Sulfate ( solution 20mg/ML ( mouth every 4 hour (shortness of breat R26's progress not "Hospice Note Text arrived. VS stable. clear throughout. B Dressing changed to denies pain initially shows nonverbal si staff to use PRN (a medication) for pair Moments (hospice	rised on 2/10/21, Risk for regrity interventions to include every 2-2.5 hours. Elevate bot cradle added to foot of bed f resident's toes, place pillow ated. Heel protectors when not ify hospice of any skin in despite R26's receiving daily medications. on Administration Record 21, indicated the following alle 100 mg give 300 millegram times a day for anxiety/pain. ablet 325 mg give 2 tablet by 's as needed for general concentrate) (pain medication) milliliters). Give 5 mg by 's as needed for pain/SOB h) 5mg=0.25 ml. es dated 3/9/2021, at 14:52 : [R26] was lying in bed when I No edema noted. Lung sound owel sounds present x 4. to wound on right heel. Patient , during dressing change gns of discomfort, encouraged s needed) morphine (pain in control and to notify provider) if ineffective. Staff erns at this time. No changes	F 69	<ul> <li>the RAI also on practice to treat notification when observed. Far were educated on 3/31/2021 of policy. Monitoring will be accomplished an audit by center administratic effectiveness of current pain minterventions 5 residents per wweeks, then 10 residents monindicated by QA committee to resident interventions for pain managed.</li> <li>Results will be reported to the QAPI committee for review an Deficient practices will be correidentification</li> <li>Allegation of compliance is 4/2</li> </ul>	acility nurses on pain ed through on of nanagement veek for 4 thly or as ensure control are facility d follow-up. ected upon		

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	. <u> </u>				. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		e survey Ipleted
			A. DUILDI	ING	·	,	с
		245361	B. WING				25/2021
NAME OF F	PROVIDER OR SUPPLIER		[	S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
MEEKER	MANOR REHABILIT	ATION CENTER. LLC			600 SOUTH DAVIS AVENUE		
				L	LITCHFIELD, MN 55355		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI)	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	^	CROSS-REFERENCED TO THE APPROF		DATE
	1				DEFICIENCY)		
F 607		70		~ 7			
F 697		•	F 6	97			
		and interview on 3/23/21, at ng in Broda chair with feet					
	· ·	of chair. R26 made a moaning					
	sound. R26 was as	ked if he was having pain.					
		oot is killing him". Nursing					
		alked into room and notified of					
		NA-A adjusted R26's right was better. R26 stated "No".					
		as going to notify the nurse.					
		oservation on 3/23/21, at 3:24					
	p.m. NA-A walked o room.	down hallway into another					
	100111.						
	-at 3:26 p.m. NA-A	walked down hallway with					
		dropped them off into another					
		en proceeded to the nurses					
		nse practical nurse (LPN)-C e room in back of nurses					
	station.	100mm back of hurses					
		left nurses station, walked					
		nd answered another call light					
	passing LPN-C.						
	-3:30 p.m. NA-A wa	alked back up 300 wing, NA-A					
	standing at nurses	station desk grabbing					
		and proceeded down the wing.					
	LPN-C was sitting a computer.	at nurses station on the					
	computer.						
	-3:34 p.m. NA-A sa	nitized hands, grabbed					
		in passing LPN-C and					
		another residents snack. NA-A					
	returned to nursing	station.					
	-3:37 p.m. LPN-C s	sitting at nurses station on					
		anding at nurses station					
	grabbing another re	esidents snack and proceeded					

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PRINTED: 04/29/2021

		AND HUMAN SERVICES				FORM	): 04/29/2021 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245361	B. WING_			03	C / <b>25/2021</b>
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 697	Continued From pa	ige 77	F 69	97			
	to walk down the ha	allway.					
		m. NA-A reported that another was having pain to LPN-C.					
	minutes after R26 r stated no staff had LPN-A stated all sta having pain immedi	3/23/21, at 3:40 p.m. (20 reported pain to NA-A) LPN-C reported R26 having any pain. aff should report if a resident is iately so they can assess why n and get the pain relief.					
	LPN-C asked R26 i stated yes. LPN-C	on 3/23/21, at 3:49 p.m. if he was having pain. R26 gave R26 acetaminophen lief and told him she would be ne pain.					
	hospice registered should be monitore nonverbal cues of v changes. RN-B stat comfortable and fre goal with hospice is as possible. During p.m. LPN-A stated medication if he is h would expect staff t within 5 minutes bu	3/24/21, at 12:54 p.m. nurse (RN)-B stated R26 ed for pain as he does have wincing during dressing ted important to keep R26 ee of pain. RN-B stated their s to keep R26 as comfortable interview on 3/24/21, at 1:08 R26 does have as needed having pain. LPN-A stated she to report a residents pain it should be right away so the he pain and treat it as soon as					
	stated if a resident should report it imm	3/25/21, at 9:24 a.m. LPN-B reports pain to a staff they nediately to the nurse. LPN-B nt to give residents relief of ssible.					

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION		(X3) DAT COM	E SURVEY IPLETED
		245361	B. WING					25/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODI	Ξ		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 697	Continued From pa	ge 78	F	697				
	stated she forgot to as she forgot. NA-A	3/25/21, at 9:43 a.m. NA-A report R26's pain to the nurse stated it was important to nediately to give the resident						
	of nursing (DON) st the staff watch him stated it looked like missing and should keep him comfortat either use the walki	3/25/21, at 9:52 a.m. Director rated R26 is vulnerable and carefully for pain. DON further the care plan for pain is be part of R26's plan to help ble. DON stated staff should e talkie or tell a nurse ident is having pain.						
F 761 SS=E	ensure that residen have an effective pay with individualized in consistent with the "Pain management alleviating the resid acceptable to the re- her clinical condition goals. The nursing of interventions whe resident's pain may wound care, ambula Label/Store Drugs a		F	761				4/28/21
	Drugs and biological labeled in accordan professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be ace with currently accepted ales, and include the ory and cautionary e expiration date when						

Facility ID: 00775

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		AND HUMAN SERVICES			F	FORM /	04/29/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED C	
		245361	B. WING	i			, 25/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From pa	ge 79	F7	761			
	§483.45(h) Storage	of Drugs and Biologicals					
	Federal laws, the fa biologicals in locked temperature contro personnel to have a						
	locked, permanentl storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected	facility must provide separately y affixed compartments for d drugs listed in Schedule II of e Drug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can NT is not met as evidenced					
	Based on observat review, the facility f medication were dis of 4 medication car 26 residents on tho failed to ensure res were discarded after residents (R2 and F Findings include: Review of the facility Medication Cart Au	ty's Medication Room or dits form dated 2/11/21, by			Label/Store Drugs Biologicals Drugs and biologicals used in the fact must be labeled in accordance with currently accepted professional princi and include the appropriate accessor and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with Sta and Federal laws, the facility must sto all drugs and biologicals in locked compartments under proper temperation	iples, y ate	
	medication located Lane 2 No was circ and Lane 4 No was	aide (TMA)-B Lane 1 expired in the cart: No was circled. led. Lane 3 No was circled, circled. ion tour of the 300 Wing on			controls, and permit only authorized personnel to have access to the keys §483.45(h)(2) The facility must provid separately locked, permanently affixe compartments for storage of controlle drugs listed in Schedule II of the	de ed	

Facility ID: 00775

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	-	AND HUMAN SERVICES			0		APPROVE 0938-039
TATEMEN	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245361	B. WING			( 03/2	C 25/2021
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	00/1	-0/2021
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		60	00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 761	3/22/21, at 5:20 p.r (LPN)-A multiple ex observed in the me concerns were ider R2's Phillips colon movement) take or date of 2/2021. Stock medication of (supplement) 100 t 2/2021. During interview or stated the medication not be given to resis sick and they are n the medication after medications should expiration. LPN-A s gone through on a During medication 3/23/21, at 1:00 p.r medications were of	n. with licensed practical nurse cpired medication were edication cart. The following ntified: health (help promote bowel he capsule daily with expiration one daily multivitamin ablets with expiration of a 3/22/21, at 5:25 p.m. LPN-A cons are expired and should idents as it could make them ot sure off the effectiveness of er they expire. LPN-A stated all d be removed from cart after stated medication carts are	F 7(	61	Comprehensive Drug Abuse Preve and Control Act of 1976 and other of subject to abuse, except when the uses single unit package drug distr systems in which the quantity store minimal and a missing dose can be readily detected. INTENT §483.45(g) Labeling of Dru and Biologicals and §483.45(h) Sto Drugs and Biologicals Resident 2 medications were audite 3/31/2021 and no expired medication remain. Resident 24 medications were audite 3/31/2021 and no expired medication remain. To ensure other residents are free f administration of expired medication facility medication carts were audite 3/31/2021 and all expired medication facility medication carts were audite 3/31/2021 and all expired medication facility medication carts were audite 3/31/2021 and all expired medication facility medication carts were audite administration of expired medication facility medication carts are audited and expired medication carts are audited and expired for the provest of the provide of the provest of the pr	drugs facility ibution d is ugs rage of ed on ons ited on ons from ns all 4 ed on ons to	
	take one tablet by expiration date of 1 Stock medication F (supplement) open expires 3 months a				medications are removed. Clinical leadership was educated to the pol medication storage and handling or 4/21/2021. Monitoring will be accomplished thr an audit by center DON or designer weekly for 4 weeks, and monthly or indicated by QA committee to ensu expired medications are on the card	icy of n rough e as re no ts.	
	(supplement) open expires 3 months a 15 grams of protein cherry flavor. During interview or	on 10/29/20 label stated fter opening. 30 fluid ounce,			an audit by center DON or designed weekly for 4 weeks, and monthly or indicated by QA committee to ensu	e ras re no ts. ty ow-up.	

Facility ID: 00775

						. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
						С
		245361	B. WING		03/	/25/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
MEEKEF	MANOR REHABILI	TATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 761	Continued From pa	age 81	F 76	1		
		d from cart immediately if they		identification.		
		y are not effective. TMA-A s have not been used on 		Allegation of complia	nce is 4/28/2021.	
	registered nurse (F are gone through of night shift. RN-A st medications as the effectiveness of the expiration date. RN there could be issue not be used past 3 stated it is a proble expired and left on During interview of medication carts a sheet is completed expired medication stated if any reside they would notify the effects.	e medication past the N-A stated with the prostat ues with bacteria and should months from opening. RN-A em that the medications were				
	of nursing (DON) s gone through on a even twice a month not to give expired last time the medic	stated expired medications are monthly basis and sometimes h. DON stated it is important medications. DON stated the cation carts were gone through /21 and would be due again at				
	pharmacist stated go through the me sends her the form	n 3/25/21, at 10:55 a.m. the DON are having the nurses dication carts and then she ns. However, in the next few will be back in and auditing				

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TATEMEN	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	). 0938-039 TE SURVEY MPLETED
		245361	B. WING		03	C 6/25/2021
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
	give medications per have not been stud Storage of medicat indicated "Discontin drugs or biologicals dispensing pharma Routine/Emergenc CFR(s): 483.55(b)( §483.55 Dental Sen The facility must as routine and 24-hou §483.55(b) Nursing The facility- §483.55(b)(1) Must outside resource, in of this part, the foll the needs of each n (i) Routine dental s under the State pla (ii) Emergency den §483.55(b)(2) Must assist the resident- (i) In making appoin (ii) By arranging for dental services loca §483.55(b)(3) Must residents with lost of dental services. If a 3 days, the facility n	stated it is important to not ast the expiration date as they lied past that dated. ion policy revised 04/2019 hue, outdated, or deteriorated a are returned to the cy or destroyed." y Dental Srvcs in NFs 1)-(5) rvices asist residents in obtaining r emergency dental care. g Facilities. t provide or obtain from an n accordance with §483.70(g) owing dental services to meet resident: ervices (to the extent covered n); and tal services; t, if necessary or if requested, ntments; and transportation to and from the	F 76			4/28/21

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		AND HUMAN SERVICES					APPROVE 0938-039
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION () UILDING		DATE	SURVEY LETED
		245361	B. WING	·		C 03/25/2021	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/2	0/2021
MEEKEF	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIOI DATE
F 791	led to the delay; §483.55(b)(4) Must circumstances whe dentures is the facil charge a resident for dentures determine policy to be the faci §483.55(b)(5) Must eligible and wish to reimbursement of or medical expense un This REQUIREMEN by: Based on observat review, the facility fa concerns were add 2 residents (R37) re Findings include: R37's admission Mi 2/18/21, identified F required extensive a of daily living (ADLs broken teeth or like Census list, printed resided at the nursi source as Medicaid R37's MHM (Monar Oral/Dental Evaluat R37 had observed her teeth along with	have a policy identifying those n the loss or damage of lity's responsibility and may not or the loss or damage of ed in accordance with facility lity's responsibility; and assist residents who are participate to apply for lental services as an incurred nder the State plan. NT is not met as evidenced tion, interview, and document ailed to ensure voiced dental ressed and acted upon for 1 of eviewed for dental care. inimum Data Set (MDS), dated R37 had intact cognition and assistance with her activities s), and had no obviously ly cavities. Further, R37's 3/24/21, identified R37 ng home and listed her payer l. rch Health Management) tion, dated 2/11/21, identified plaque or debris present on n, " several missing teeth."	F 7	791	Routine/Emergency/Dental Services The facility must assist residents in obtaining routine and 24-hour emergend dental care. §483.55(b) Nursing Facilities. The facility— §483.55(b)(1) Must provide or obtain fro an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of ear resident: i. Routine dental services (to the exter 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;	om ו ch nt	
	required set-up for	not wearing any dentures and oral cares. Further, the d, "Staff will assist resident to			Resident 37 has a dental appointment of 9/22/2021 and resident is agreeable to date of service.	on	

Facility ID: 00775

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU		E CONSTRUCTION		0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	• •				PLETED
							2
		245361	B. WING			03/2	25/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 791	Continued From pa	ige 84	F 7	91			
	set up dental appoi needed." The comp dictation regarding refused a dental ap dictation on when F had been prior to he home. When interviewed of voiced she had com "they're [her teeth] to teeth to the surveyor several missing teet palate. R37 stated and get them addressed helped her arrange her missing teeth m about her smile and not smile at people teeth] as much as p her teeth had, at tim pain when eating. R37's care plan, pri had a self-care defi conditions and low directed R37 requir complete personal care plan lacked ar statements, goal(s) R37 maintained goa assessed as needin to ensure dental can numerous missing to When interviewed of	ntments and transportation as obleted assessment lacked any if R37 had been offered and/or opointment at the time; nor any R37's last dental appointment er admission to the nursing on 3/22/21, at 3:33 p.m. R37 ocerns with her dentition as falling out." R37 showed her or and was observed to have eth on both the top and lower she needed to see a dentist to d; however, nobody had those services. R37 voiced nade her feel self-conscious d, as a result, she would often and "try to hide it [missing possible." Further, R37 voiced nes, caused her to have some inted 3/23/21, identified R37 icit related to respiratory back pain. The care plan red assistance of one to hygiene tasks; however, the ny identified problem b, or interventions to ensure od oral hygiene despite being ng oversight and/or assistance re was completed and having teeth.			A facility wide audit to ensure a ne assessment is in place was compl clinical leadership on 4/12/2021 ar ensure that if they would like to se dentist it has been offered. No new residents were identified as reque- see dental sooner than the next da onsite visit. Staff inservice was completed on 4/20/2021 to ensure that residents request to see dentist are added to and reported to clinical leadership further follow up. Monitoring will be accomplished th an audit by DON or designee x1 d 1 week, weekly for 4 weeks, and r or as indicated by QA committee to ensure that any resident with conc elated to dentition are followed up timely. Results will be reported to facility QAPI committee for review follow-up. Deficient practices will b corrected upon identification. Allegation of compliance is 4/28/20	eted by nd to e a v sting to ate of who o the list for arough aily for nonthly o erns on the and pe	

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	RS FOR MEDICARE	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION		<u>NO. 0938-039</u> DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		COMPLETED
		245361	B. WING		_	C 03/25/2021
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STA	TE, ZIP CODE	
MEEKEI	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 791	expressed she was doing her own oral recalled R37 makin dentition and, as a her mouth closed" missing teeth. NA-0 had reported comp due to her teeth; ho had reported not sn hates her smile." R37's medical reco any evidence R37's dentition had been with a dental provid assessed as missin reporting to the dire smile" due to her d On 3/24/21, at 8:47 manager (RN)-A we explained residents admission for their recalled completing 2/11/21) which four teeth. RN-A review stated R37 had ele upon her admission recall ever hearing about her teeth at t not aware" R37 had the direct care staff due to her dental co follow-up or appoin help R37. RN-A ex should have been n acted upon and ad as there were option	s unsure if R37 was actually cares or not. NA-C stated she og comments about her poor result, she would try to "keep so people didn't see her C stated she was unaware R37 laints of pain when chewing owever, again reiterated R37 miling at others because "she ord was reviewed and lacked s reported concerns with her acted upon and addressed ler for resolution despite being ng numerous teeth, and ect care staff she "hates her	F 7	91		

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	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:				TE SURVEY
				IG		С
		245361	B. WING _		03	/25/2021
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE
F 791	self-esteem and ma added unresolved o big problem." A provided Dental S	e addressed to help a person's aintain their weight. RN-A dental issues could become "a Services policy, dated 12/2016,	F 79	91		
	would be provided including referral(s) Further, the policy of department would h transportation or ap policy lacked any d the facility would en were addressed or resolution.	nd emergency dental care through various avenues to community dentists. butlined the social services help coordinate any needed opointments. However, the ictation or guidance on how hsure voiced dental complaints acted upon to ensure Preferences, Substitutes 4)(5)	F 80	06		4/28/21
	§483.60(d)(4) Food allergies, intolerand §483.60(d)(5) Appe nutritive value to re food that is initially different meal choid This REQUIREMEN	ives and the facility provides- I that accommodates resident ees, and preferences; ealing options of similar sidents who choose not to eat served or who request a ce; NT is not met as evidenced				
	review, the facility f allergen was not se (R505) reviewed wh reaction (a severe,	tion, interview, and document ailed to ensure a known food erved to 1 of 1 residents no had a listed anaphylactic potentially life threatening fish. This resulted in the re allergic reaction.		Allergies, preferences, intoleran Each resident receives and the provides— §483.60(d)(4) Food that accommodely resident allergies, intolerances, preferences;	acility nodates	

Facility ID: 00775

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		AND HUMAN SERVICES				FORM	04/29/202 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	Сом	E SURVEY PLETED C
		245361	B. WING	i			_ 25/2021
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 806	Continued From pa	ge 87	F٤	306		- 10004	
	dated 3/8/21, indica intact, was able to u himself understood with eating. Further 3/1/21, identified R related to an allergy R505's allergy flows R505 was allergic t flow sheet listed R "Severe." When interviewed of stated he had an al two Fridays (3/12/2 facility staff. R505 e and voiced he need contamination. R50 (used to alert staff t 3/12/21 and 3/19/2 listed allergy to fish During interview an 01:32 p.m. assista surveyor the white	sheet, dated 3/10/21, identified o fish and epinephrine. The 505's reaction to fish as, on 03/22/21, at 1:24 p.m. R505 lergy to fish and was given fish 1 and 3/19/21) in a row by expressed concern about this led to be careful with cross 05 provided his meal slips to allergies and diets), dated 1, which outlined R505 had a			Resident 505 Discharged on 3/23 To ensure other residents food al are adhered to a facility wide aud conducted on 4/20/2021 by facilit Tray tickets are now printed in or paper for resident with a food alle ensure staff have a visual remind allergy while serving meals. Staff education was completed o 4/20/2021 regarding the importan following a resident listed allergy staff were educated to the food al policy on 4/23/2021 by CDM. Monitoring will be accomplished an audit of meals by CDM or des daily for 1 week, weekly for 4 we monthly or as indicated by QA co to ensure resident food allergies served. Results will be reported t facility QAPI committee for review follow-up. Deficient practices will corrected upon identification Allegation of compliance is 4/28/2	lergies it was y CDM. colored ergy to ler of the n cce of Culinary llergy through ignee x1 eks, and mmittee are not o the v and be	
	<ul> <li>diet orders, allergies, special equipment, etc. will be on the board for at about a week so all culina staff can reference the information.</li> <li>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</li> </ul>						

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			pleted C
		245361	B. WING				25/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 806	and supervision to renvironment. Review of Allergy R allergy. Additional a allergies to Shellfish and Onion, and Mu record review and in identified. When interviewed of facility culinary direct grievance on her de allergy and him bein despite the known a family called in on 3 middle of completion would talk with her education to help pi R505 being served culinary director con listed upon admissi was a communicati that listed allergies card. The culinary how staff would ma not delivered. When interviewed of licensed practical n resident had an alle having an anaphyla the medication list f was nothing availab provider, on call pro-	maintain a safe meal Report identified R505 had Fish 5 residents were listed with n, Milk, Pistachio, Milk, Corn shrooms. Based on further interviews, no concerns were on 03/25/21, at 10:47 a.m. ctor stated there was a esk regarding R505's fish ng served fish products allergy. She stated R505's 8/19/21, and she was in the ng the grievance process but cook and provide staff revent ongoing episodes of the known food allergen. The nfirmed R505's allergy was on on 3/1/21, and voiced there on board posted in kitchen along with R505's dietary director confirmed that was ke sure a specific food was on 03/25/21, at 11:19 a.m. urse (LPN)-D stated if a ergy to epinephrine and was notic episode, she would check for something else and if there ole, she would call primary ovider, or 911 if needed.	F 8	06			
	RN-A stated resider	on 03/25/21, at 11:22 a.m. nt allergies are put in the cord when admitted to the					

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PRINTED: 04/29/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COM	E SURVEY PLETED
		245361	B. WING				C 25/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 806	facility and put on the got a call from R503 stated R505 received Fridays in a row. RI culinary director rigil grievance. Further, ingested fish, she w to him to the hospite would not do anythin needed to call 911. When interviewed of director of nursing ( were listed on medi- seen by the staff in The DON confirmed and dietary staff delivered The DON was away the delivery of the fi- back to the dietary of would need to see w The DON confirmed he had an allergy to stated if R505 had of call would be placed with an assessmen hands on deck and would start swelling cart." DON stated to equipped, although for R505 due to his stated there was a able to answer for t that the dietary staff administrator. The	The dietary slip. She stated she bis brother on 3/19/21 and he ed fish on his meal tray two N-A stated she talked to the ht away and gave her the she stated if R505 would have yould have expected to send al. RN-A stated Benadryl ng, and that the facility on 03/25/21, at 12:01 p.m. the DON) stated resident allergies cation sheets and can been the electronic health record. d that the nursing assistants mmunicated daily. She stated ed meal trays to residents. re of R505's fish allergy and ish to him. She stated it went department. She stated she what R505's reactions were. d it was anaphylaxis and that o epinephrine. Further, she contact with the fish, then a d to 911 immediately, along t. DON stated it would be "all anaphylaxis meant his throat and he would need the crash the crash cart was well confirmed it was not equipped allergy of epinephrine. DON grievance filed and was not he dietary department, and f had to answer to the DON confirmed a pharmacy ted and did not have anything	Fε	306			

Facility ID: 00775

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		AND HUMAN SERVICES				I	FORM	04/29/2021 APPROVED 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	()		E SURVEY PLETED		
		245361	B. WING					_ 25/2021		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD B		(X5) COMPLETION DATE		
F 806	administrator stated grievance filed relat stated dietary staff ticket to make sure served to the reside When interviewed of R505 stated cross of to him. He stated hi watch for any items have fish hidden in allergic to epinephri even more complex Record review reve initiated by RN-A. F take time to review plating." Two separ surveyor, both com dietary staff delivero 3/19/21. Facility policy "Food revised August 201 food allergies and/o upon admission and similar appeal and t taken to prevent res allergen(s)." Furthe residents with seve prepared so that cro allergens does not o intolerance's and an assessment notes a	on 03/25/21, at 12:21 p.m. the d she was aware of a ted to R505's fish allergy. She needed to follow the meal tray the food allergy was not ent. on 03/25/21, at 01:07 p.m. contamination was very scary is wife was usually with him to a, such as salads, that would them. R505 stated he was ine, which made his situation c. Paled grievance dated 3/19/21, Resolution listed, "cook will allergy section of menu before ate incidents were provided to pleted on 3/25/21 confirmed ed fish to R505 on 3/12/21 and d Allergies and Intolerance's," 7, indicated "residents with or intolerance are identified d offered food substitutions of nutritional value. Steps are sident expose to the r identified, meals for re food allergies are specially oss-contamination with occur and allergies and re documented in the and incorporated into the	Fε	806						
	residents care plan Infection Preventior CFR(s): 483.80(a)(	n & Control	F 8	80				4/28/21		

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		AND HUMAN SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245361	B. WING_					C 25/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP	CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			0 SOUTH DAVIS AVENUE TCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 91	F 88	80				
	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based conducted accordin accepted national s §483.80(a)(2) Writte procedures for the p but are not limited t (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh	Atablish and maintain an and control program a safe, sanitary and ament and to help prevent the ransmission of communicable tions. In prevention and control atablish an infection prevention in (IPCP) that must include, at owing elements: atem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ing to §483.70(e) and following standards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other						
	to be followed to pro	ansmission-based precautions event spread of infections; isolation should be used for a but not limited to:						

If continuation sheet Page 92 of 100

PRINTED: 04/29/2021

		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SUR COMPLETE C		
		245361	B. WING				25/2021	
_	PROVIDER OR SUPPLIER	ATION CENTER, LLC		600	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH DAVIS AVENUE CHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 880	<ul> <li>(A) The type and dudepending upon the involved, and</li> <li>(B) A requirement t least restrictive poscircumstances.</li> <li>(v) The circumstance must prohibit emploid isease or infected contact with resider contact will transmi (vi)The hand hygier by staff involved in §483.80(a)(4) A system if involved in §483.80(a)(4) A system if involved in staff involved in the corrective actions to staff involved in the staff involved in the staff involved in the staff involved in the staff involved in staff involved in the staff invo</li></ul>	uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility.	F 8		DPOC F880 3/25/2021 Equipment/Environment LPN-E was re-educated and competency checked to catheter b on 3/24/2021 and educated on cle catheter bags on 4/22/2021. The facility identified that a tot residents have the ability to be imp by this practice. Catheter bag competencies were initiated for all Licensed nurses and CNA's on 3/3	aning of al of 3 bacted		

Facility ID: 00775

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				NG	0	C
		245361	B. WING		•	25/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC		600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 880	Continued From pa	ge 93	F 88	30		
	personal hygiene, a with eating. R40's of included CVA (strok disease), and type a arthritis. R40's care plan dat a self-care deficit re- heart failure, DM2, noted as: assist of of During an observat licensed practice no R40's room, applied urinary collection le the floor of R40's of connection site on the with an alcohol swa leg and placed a to of the large urinary R40. LPN-E then w the large urinary co swab, pulled tubing urinary collection ba bathroom sink. LPN collection leg bag to bathroom for the vin closet on the floor. mixture of fifty perc water in a container unmeasured amount plastic container. LI with this type of cat than I have seen." A her gloves, washed be right back" and of	obility, transferring, dressing, and toileting, and independent current medical diagnoses (e), CKD (chronic kidney 2 diabetes mellitus (DM2), and (ed 3/4/21, identified R40 had elated to CVA, polyarthritis, CKD, weakness. Interventions one with personal hygiene. (ion on 03/24/21, at 7:27 a.m. urse (LPN)-E entered resident d gloves, and removed a g bag from a basin located on oset. LPN-E wiped off the top the urinary collection leg bag (b). LPN-E rolled up R40's pant wel under the connection site collection bag attached to viped the connection site of llection bag with an alcohol apart, removed the large ag and placed it in the N-E then connected the urinary o R40. LPN-E looked in the negar and located it on the LPN-E stated they use a ent vinegar and mater into a PN-E stated "I am not familiar heter bag, it is totally different At 7:42 a.m. LPN-E removed I her hands, and stated "I will exited the room. At 8:00 a.m. R40's room applied gloves,		<ul> <li>Polices/Procedures/Syste</li> <li>The Director of Nur Preventionist reviewed policy on disinfecting car ensure they meet the s The policy/procedure we the facility QAPI Common the need to increase, d discontinue the audits. Training/Education</li> <li>Facility educated list CNA's to catheter bag of cleaning on 3/30/2021-</li> <li>Catheter bag componentiated for all Licenseed CNA's on 3/30/2021-4/1 nursing leadership tear to ensure facility staff c competence. Monitoring/Auditing</li> <li>The infection prever designee will audit staff catheter bag changing currently have catheter morning and at night wi be changed per MD or The audit results will dec in frequency, 100% cor audits will result in decr for staff providing direct and/or entering the residential</li> </ul>	rsing and Infection and revised the atheter bags to tandard of practice. ill be shared with ittee for input on ecrease or censed nurses and changing and 4/23/2021. betencies were a nurses and 23/2021. The n will work together ompliance and entionist or for residents who bags daily in the hen the bags are to ders for 7 days. etermine decrease inpliance on the rease of frequency t care to residents	

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
		245361	B. WING	i			C 25/2021
NAME OF	PROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	had mixed earlier. I collection bag over looped around her out. LPN-E attempt and tubing upwards with the syringe over solution drained into the urinary catheter attached to the cath the vinegar water solution placed a cap on the urinary catheter col and paced it on the her gloves, washed room. LPN-E failed collection bag and to bacteria. During an interview LPN-E indicated the the floor of the closs leg bag hung on the LPN-E identified sh the vinegar water s collection leg bag fr LPN-E also indicated bag should be flush connects to the bag unable to connect to had used the botton During an interview ADON stated the up be rinsed out with fi percent vinegar mix a syringe that would	LPN-E held the urinary the toilet with the tubing hand and did not straighten it ted to flush the catheter bag s from the bottom drain port er the toilet 3 times. The o the toilet and did not go into r collection bag. The tubing heter bag was not flushed with colution. LPN-E dumped the nately fifty percent of the ion into the toilet. LPN-E e end of the tubing of the llection bag, laid it in the basin, e closet floor. LPN-E removed d her hands, and exited the to properly sanitize the urinary tubing to prevent growth of e towel rack in the bathroom. he had taken 2 full syringes of colution and flushed the urinary rom the bottom drain port. ed the urinary collection leg hed through the top port that g. LPN-E stated she was the syringe to the top port so	F	380			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245361	B. WING				C 25/2021
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 880	Continued From particle urinary bag systep to bottom and the drain out from the beg to prevent the i identified nursing startegarding this compared by the nursing staff. During an interview director of nursing (skills competency fathe nursing staff. Dure covered and in check list for the cata and DON was unabed DON indicated staff contact her if they how to complete cata little bit of vinegar at together in a paper urinary drainage baa and the vinegar wat with a syringe into the from the top to botter tubing first and ther bag. DON also indicated staff contact her is all contact her is all contact her is all contact her is the paper urinary drainage baa and the vinegar wat with a syringe into the should be filled half make sure it is all contact contamination of the sanitation of the sanitatio	ge 95 tem should be cleansed from ne cleansing solution should pottom port of the collection ntroduction of bacteria. ADON aff had received education	1	380			
	Review of a facility Catheter Leg & Beo Purpose: To preven catheter bags, that the catheter drainag	and prevent infections. document titled Sanitation of lside Bags undated identified at growth of bacteria in are not currently connected to ge system. Procedures: Place at was just disconnected from					

Facility ID: 00775

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TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	3		PLETED
		245264	B. WING			C
		245361		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	25/2021
NAME OF F	PROVIDER OR SUPPLIER			600 SOUTH DAVIS AVENUE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC		LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 880	Continued From pa	ae 96	F 88	n		
1 000	•	ean wash basin. Make sure the	F 00			
		is covered with alcohol				
	packet and drainag	e port is clamped. Take				
		eter bag in basin to soiled utility				
		negar with 3 parts water (1/2 ½ cups water). Remove				
		insertion end of catheter bag				
	tubing and instill so	lution into catheter tubing, into				
		ition around inside the bag for				
		nute. Empty solution from the				
		r tubing/bag with tap water. om bag. Allow to air dry, in				
		Store in resident's room on top				
	shelf of closet.					
F 921 SS=F	Safe/Functional/Sa CFR(s): 483.90(i)	nitary/Comfortable Environ	F 92	1		4/28/21
		nvironmental Conditions				
		ovide a safe, functional,				
	residents, staff and	ortable environment for				
		NT is not met as evidenced				
	by:					
		tion, interview and document		483.90(i) Other Environmental Co	onditions	
		ailed to ensure potentially orn toilet equipment was		The facility must provide a safe, functional, sanitary, and comfortal		
		after resident-involved events		environment for residents, staff ar		
		f the resident room toilet(s).		public.		
		g, routine monitoring and				
		se toilets had potential to affect residing in the nursing home.		All facility toilets were braced with piping and caulked by the mainter		
		estaing in the nursing nome.		department by 4/2/2021.		
	Findings include:			To ensure compliance with this the		
				engineer Rex Stromquist was con	tacted	
		imum Data Set (MDS), dated		and approved of this method on 4/13/2021.		
		45 had intact cognition and assistance with toileting.		4/13/2021. Staff education was initiated on 4/	20/2021	
	Further, the MDS o			to the facility practice for reinforce		

Facility ID: 00775

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		AND HUMAN SERVICES					FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		(X3) DATI COM	E SURVEY PLETED
		245361	B. WING					C 25/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CO	DE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 921	and/or admission. When interviewed of stated he had susta approximately three was sitting on the to R45 did not obtain a change rooms as a was embarrassing a When interviewed of licensed practical n worked at the facilit verified she was wo broken resulting in found R45 laying or water and broken to Further, LPN-E stat the first time such e explained she recal incidents like it whe from the wall causir	since the previous assessment on 03/22/21, at 4:49 p.m. R45 ained a fall in his bathroom e or four months ago when he bilet and it broke beneath him. a major injury but did have to result. R45 added the ordeal	FS	921	in in place and any issues neareported to maintenance for f Monitoring will be accomplish an added preventative mainter program to facility toilets to ch cracks and the placement of piping by the maintenance dir designee. Results will be report facility QAPI committee for re follow-up. Deficient practices corrected upon identification. Allegation of compliance is 4/	ollow ed thr enance neck for the PN rector prted t view a will be	up. ough or /C or co the and	
	maintenance (DON explained the facilit which could suppor (Ibs) and had to, at pipe underneath of residents' who weig had not been tracki had this PVC bracin A short time later, D document identifyin facility had assessed	p.m. the director of I) was interviewed. He y used wall-mounted toilets t weight up to 500 pounds times, place pieces of PVC the toilet bowl to support ghed more. DOM voiced he ng or monitoring which toilets ng placed underneath of them. DOM provided surveyor with g 15 of 54 resident toilets the ed to required PCV bracing. on 3/24/21, at 1:14 p.m.						
	had not been tracki had this PVC bracin A short time later, D document identifyin facility had assessed When interviewed of	ng or monitoring which toilets ng placed underneath of them. OOM provided surveyor with ig 15 of 54 resident toilets the ed to required PCV bracing.						

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245361	B. WING				C 25/2021
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 921	the floor as a result stated R45 did not y of the event and did any injuries as a re- reviewed R45's con- the time and verifie obtained. Further, R45's weight (less to toilet to fail and bre- to ask for support b During the recertific 3/25/21, documenta demonstrate the far assessment of their toilets to ensure sat R45 sustained a fail no documentation pro- the toilets had beer cracks or disrepair continued use. Furt documentation pro- any, toilets had beer facility to ensure sat On 3/25/21, at 9:34 was held with DOM current toilets in us- placed underneath he was unsure whic R45's had been rep no system in place the toilets and repla DOM stated he was involving a broken to few months prior. On 3/25/21, at 10:0	t of the toilet breaking. RN-A weigh over 300 lbs. at the time d not recall if he had sustained sult of the incident. RN-A then mpleted skin assessment at d no major injuries had been RN-A stated she did not think than 300 lbs.) would cause the ak and added she was aware oraces for larger residents. cation survey, from 3/22/21 to ation was requested to cility had complete an r remaining wall-mounted fety with resident use after II when one broke. There was provided which demonstrated n observed or assessed for to ensure they were safe for ther, there was no vided which outlined which, if an replaced or repaired in the afe operating use. A a.m. a subsequent interview who provided a listing of e which had the PVC bracing of them. DOM acknowledged ch, if any, toilets outside of placed and verified there was to check the state of repair of ace them, if needed. Further, s only aware of the one fall toilet which was R45's fall a	F S	921			

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		AND HUMAN SERVICES				FORM	04/29/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245361	B. WING				_ 25/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEEKER	R MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 921	2019. She explaine R45's fall which inv breaking away from the current system toilet(s) with PVC p any larger residents she was unaware of being completed wi replacement) in the When interviewed of engineering departs nursing home record originally built in 19 construction project expressed installati including the use of sufficient to hold or toilet as such a toilet Further, all remaining which were installed	d at the nursing home since d she had been aware of only olved a toilet failing and in the wall, and acknowledged in place was to brace the iping or use a commode for s. The administrator expressed of any listings or monitoring ith the toilets (or their e nursing home. on 3/24/21, an MDH ment representative voiced the rds indicated the building was 78, and there were no other ts listed since 1988. He fon of support braces, f PVC piping, was not repair a cracked or defective et would require replacement. ng toilets in the nursing home d in 1978 should be replaced.	FS	921			

Facility ID: 00775

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Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
		00775	B. WING		03/2	C 25/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER. I	TH DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health 7 DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 04/22/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 62

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00775	B. WING		03/	25/2021
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IEEKEF	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, th corrected prior to el Minnesota Departm On 3/22/21 to 3/25/ Department's staff the following correct Please indicate in y correction that you and identify the data Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state stat listed in the "Summ column and replace the correction order the findings which a statute after the stat as evidence by." Fo are the Suggested Time period for Corr PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	21, surveyors of this visited the above provider and tion orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for he assigned tag number eff column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met blowing the surveyors findings Method of Correction and rrection.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00775	B. WING			C <b>25/2021</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
<b>IEEKE</b> F	MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE ELD, MN 5535	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	MINNESOTA STAT	E STATUTES/RULES.				
2 265	MN Rule 4658.0085 Resident Health Sta	5 Notification of Chg in atus	2 265			4/28/21
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, ar attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision t resident from the nu	o transfer or discharge the ursing home; or				
	E. expected an	d unexpected resident deaths				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		00775	B. WING			C 25/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
		600 SOU	TH DAVIS A			
MEEKEF	R MANOR REHABILIT	ATION CENTER, I LITCHFI	ELD, MN 55	355		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	age 3	2 265			
	This MN Requirement is not met as evidenced by:					
		and record review, the facility		Corrected		
		e medical provider was notified				
		dition for 1 of 1 residents (R55)				
		documented increased periods				
		saturations (sats) and an				
		ode which lasted approximately				
		was sent the following day to a is appointment. R55 had				
		admission directly from the				
		nt related to low O2 sats and				
		(BP), who subsequently				
	passed two days la	iter.				
	Findings include:					
		imum Data Set (MDS), dated				
		R55 had intact cognition and				
		lities. The MDS identified R55 Ils since the prior MDS				
		ad diagnosis of orthostatic				
		rmal decrease in BP when				
		ve heart failure (impaired heart	t			
		e renal disease which				
	required dialysis m	anagement, and chronic				
		failure of lungs to function				
		sed at that time; however, R55	5			
		to have a life-limiting				
	prognosis.	oxygen/gas exchange				
		are plan, dated 6/24/20,				
		periods of low blood O2 sats in				
		use to wear the O2 at times.				
		sist R55 with the goal of				
		hange" included the following:				
		ent respiratory status, monitor				
		l and as needed, keep medical				
		of changes. R55' care plan				
		5 had history of unresponsive				
	episodes or low BP R55's treatment ad	/. ministration record (TAR),				
	epartment of Health					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00775	B. WING			25/2021
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
<b>IEEKE</b> F	MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE ELD, MN 5535			
(X4) ID	-		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	ge 4	2 265			
	R55's O2 sats durir	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				
		two O2 sat readings of 89% or	1			
		) where the remainder of the m 90 to 98% and consistently				
		aily. The TAR lacked evidence				
	of documentation re	esponses for the day shift O2				
	•	26/20 - 11/30/20. In addition,				
		aff to monitor R55's BP after				
		, Wednesday, and Fridays.				
		om 103/64 to 108/60. The ce a BP reading after dialysis				
	on 11/27/20.	ce a Di Teading alter dialysis				
		rapid COVID-19 rapid test				
	had been negative.					
		stamped 6:53 p.m. a nursing				
		updated registered nurse				
	. , .	] BP was low." R55 had been				
		chair when RN-A entered				
		ad responded to verbal 'quickly fell asleep." R55's O2				
		been in his nares; however,				
		chine had been "off." R55 was	;			
		ard O2 machine and assisted				
		two person pivot transfer. R55				
		didn't feel good." RN-A had				
		ed medication aide (TMA) to				
		lodrine (medication used to				
		en standing) if he had not that day. The note indicated,				
		atch and reassess resident."				
		lacked documentation of BP of	r l			
		t the time of the entry or that				
		er had been contacted on				
	status.					
	R55 lacked evidence	ce of documented progress				

Minnesota Depa STATEMENT OF DEF AND PLAN OF CORF	ICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00775	B. WING			C 25/2021
NAME OF PROVIDER	OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MEEKER MANO	R REHABILIT	ATION CENTER. I	JTH DAVIS AVE ELD, MN 5535			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX (EA		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 265 Contin	ued From pa	age 5	2 265			
11/28/2 On 11/ fallen t he had he sat elbow inches person had be seeme now." the me status. R55 la from 1 a.m. On 11/ "went l approx assiste during again n 3.5L of which note in throug withou he had afebrik which to 4L.	20, at 4:11 p. 28/20, time s o the floor at attempted t in his wheel skin tear tha wide. R55 h , place, and en reported d to level ou The progress dical provide cked docum 1/28/20, at 4 30/20, time s imp and did imately one sd him into b cares the ev esponded to O2. R55 ha ne also felt of dicated R55 nout the night complaint." felt "tired ar e; however, I required the The progress dical provide ted and/or u 30/20, time s	stamped 4:11 p.m. R55 had t approximately 2:45 p.m. after o pick up a dropped fork while chair. R55 had sustained a lef t measured 2.6 inches by 3 had been alert and oriented to time. R55's blood pressure to be "up and down but has t within normal range as of s note lacked documentation er had been contacted on ented progress note entries :11 p.m. to 11/30/20, at 5:30 stamped 5:30 a.m. R55 had not respond to staff for minute" when two staff had ed with a mechanical stand liff vening prior. R55, once he o staff, had O2 sats at 89% on d stated he had felt cold in cold to touch. The progress had been checked on nt and he had rested "quietly That morning, R55 had stated of foggy." He had been his O2 sats had been 85% nurse to increase the O2 flow s note lacked documentation er or dialysis had been pdated on status. stamped 11:13 a.m. R55 had nergency room (ER) from the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		(X3) DATE SURVEY COMPLETED C	
		00775	B. WING		03/2	25/2021
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
IEEKER	MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE ELD, MN 5535			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLE DATE
2 265	Continued From pa	age 6	2 265			
	progress note lack medical provider ha On 12/2/21, the fact the St. Cloud Hosp passed away that of An Inpatient Discha 12/2/20, indicated F 11/30/20 with O2 st 80/40. Due to R55' BP, R55 had been evaluation and sub transfer hospital. R discharge diagnosi hypoxic respiratory COVID-19, with ad chronic systolic hea myocardial infarctio During interview on practical nurse (LP physician communi- status would depend If the change was " the doctor right awas significant" she wool either situation LPN document the med resident's record. L were to present as abnormally low O2 physician "right awas changes in condition When interviewed of coordinator LPN-B present with abnorm an unresponsive en doctor" and would in	arge Death Summary, dated R55 had arrived to dialysis on ats "in the 60's" and a BP of s low O2 sats and initial low sent to the local ER for sequently admitted to a .55's principle hospital s had been acute on chronic failure secondary to ditional diagnosis of acute on art failure and type II on (heart attack). n 3/25/21, at 9:25 a.m. licensed N)-C explained her mode of ication for resident changes in nd on the nature of the change. 'severe" she would "contact ay" and if it was "less uld fax the medical provider. In N-A stated she would ical provider follow-up in the .PN-C explained if a resident unresponsive or have sats she would contact the ay" due to these being				
nesota De		n 3/25/21, at 10:40 a.m. case d nurse (RN)-A confirmed				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ (	E SURVEY PLETED C
	00775		B. WING			25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEEKEI	R MANOR REHABILIT	ATION CENTER I	TH DAVIS AVE ELD, MN 5535			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLET DATE
2 265	Continued From pa	ge 7	2 265			
	too bad" and that R 69% had not been in explained staff had keep his O2 N/C in remove the N/C ind not been known to felt R55 had typical consequences whe acknowledged she 11/29/20 evening un RN-A reviewed R55 she stated she "woot confirmed she wout minimum" to contact R55's unresponsive the abnormal O2 sa Further, RN-A state refused any medica directions she woul documentation to s explained she woul vitals monitoring as have been COVID- was brewing" for R5 staff not updating m changes in conditio When interviewed of director of nursing ( expected staff to up on his unresponsive periods of lower O2 considered a change Further, the DON e	III drop on occasion but not 55's O2 sats on 11/16/20, of normal for him. RN-A educated R55 on the need to place as ordered as he would lependently; however, he had turn the O2 machine off. RN-A ly been free of adverse n he removed his O2. RN-A had been unaware of R55's nresponsive episode. After 5's 11/30/20 progress note, uld have sent him in." RN-A ld have expected staff "at a ct the medical provider after e episode and then again after ats on 11/30/20 for follow-up. d then if R55 would have al provider orders and/or d have expected upport the follow-up. RN-A d have also initiated increased her biggest concern would 19. RN-A stated "something 55. RN-A explained the risk of nedical providers on residents' ns was "this [death]." on 3/25/20, at 11:07 a.m. the (DON) stated she would have odate R55's medical provider e episode and increased sats as these would be ge in condition for R55. xplained she would have oporting documentation that				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS A. BUILDING:	TRUCTION		E SURVEY PLETED
		00775	B. WING			C 25/2021
	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE, Z	IP CODE		
		600 SOU	TH DAVIS AVENUE			
VIEERER	MANOR REHABILIT	LITCHFII	ELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 265	Continued From pa	ge 8	2 265			
		resident care delivery" around nresponsive episode had been ection control."				
	practitioner (NP)-A and "doing fairly we (GI) bleed in Septer R55 clinic notes du confirmed the only in had been related to results. NP-A voiced on 11/9/20 for a "reg acknowledged she updates which cond unresponsive episo abnormal O2 sats. I of R55 having had up past and she furthen not experienced iss despite R55's having at all times as prese have expected staff R55's changes in co done more of a wor included a COVID- explained, "We wou to monitor him due that time [in the fact During a telephone p.m. LPN-F stated of R55 had "went limp lift." LPN-F believed this in the past "but been unable to prov unresponsive episo LPN-F acknowledge typically "in the 90's	3/25/21, at 11:58 a.m. nurse stated R55 had been "stable" II" after his gastrointestinal mber. NP-A reviewed available ring the interview and notes present past 11/16/20 negative COVID-19 test d she had last examined R55 gulatory visit." NP-A had not been provided any cerned R55's 11/28/20 fall, the de on 11/29/20, or his NP-A denied any recollection unresponsive episodes in the r explained R55 typically had ues with lower O2 sats ig not wanted to wear the O2 cribed. NP-A stated she would to contact the clinic about ondition as she "would have kup" which would have fup test. In addition, NP-A uld have been fairly aggressive to COVID running rampant at ility]." interview on 3/25/21, at 12:20 on the evening of 11/29/20, " when staff "had him in the d he had similar episodes of not too frequent." LPN-F had vide further details about other des R55 may have had. ed R55's O2 sats were ;" however, they would drop to only with exertion. LPN-F had				

A. BUILDING:     C       00775     B. WING     03/25/2021		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00775         B. WING         O3/25/2021           AME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         600 500/111 ADVIS ASKENUE         COMPARED           AEEKER MANOR REHABILITATION CENTER, 1         E00 SOUTH DAVIS ASKENUE         E00 FORCE/ENCY         COMPARED           MEETA         ESCHARD EPRICENCING INSIDE PRECEDED BY FLUL.         In PRETX REGULATORY OR LSC IDENTERING INFORMATION         In PRETX TAG         PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLD BE CROSS-REFERENCING ACTION APPROPRIATE         COMPARED           2 265         Continued From page 9         2 265         Street Addition and the continued the medical provider about R55's unresponsive episode or overall status and further confirmed she had also not updated dialysis on 11/29/20 or 11/30/20. LPN-F confirmed she had not contacted the medical provider.         PRETX A policy Change in Resident Condition, dated for COMPARED and take "the proper steps" of monitoring their vitals and calling the medical provider.         A policy Change in Resident Condition, dated for COMPARED and calling their vitals and calling the medical provider.         A policy Change in Resident Condition, dated for COMPARED and the resident's physician/healthcare provider when there had been an accident or incident which involved the regrested at 10 policy or code in-service staff on policy and/or procedures for contacting medical provider(s) with any resident changes in condition. They could have resident to anogs in condition. They could in-service staff on policy and/or procedures for contacting medical provider(s) with any resident changes in condition. They could have resident to anospiala.         2 565         4/28/21<			BENTI IO/TION NOMBER.	A. BUILDING:			
Beeck wanner Rehabilitation center.1         Beeck Utter Provider Republic Control of Control contrul of Control of Control of Control of Control of Cont			00775	B. WING			
Matcher Rubbing         Summary statement of policities (M) ID Summary statement of policities (Resolution) of connective action should be resolution 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 fill 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 fill R55's unresponsive 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 mentioning their vitals and calling the medical provider. A policy Change in mesident Condition, dated 6/2019, directed staff to notify the resident's mental physicia or mental condition, and/or a need to transfer the resident to incident which involved the resident or incident which involved the resident or nursing, or designee, could in-service staff on policy and/or procedures for contacting medical provide(s) and/or resident condition. They could than audit resident records to ensure ongoing compliance.         2 565         MN Rule 4585.0405 Subp. 3 Comprehensive Plan of Care; Use         2 565	AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
Image         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTATORY OR LSC DENTIFYING INFORMATION)         Image         Description         Description <thdescription< th="" th<=""><th>IEEKER</th><th>MANOR REHABILIT</th><th>ATION CENTER 1</th><th></th><th></th><th></th><th></th></thdescription<>	IEEKER	MANOR REHABILIT	ATION CENTER 1				
PREFIX TAG       CEACH OPERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CEACH CORRECTIVE ACTIONS HOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMMENT DATE         2 265       Continued From page 9       2 265         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 fit 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 staft 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, adi/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 records to ensure ongoing compliance.       2 565       4/28/21         2 565       MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use       2 565       4/28/21       4/28/21		SUMMARY ST				CORRECTION	(X5)
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 mental 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 records to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	COMPLET
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.         SUGESTED 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 records to ensure ongoing compliance.       2 565         TIME PERIOD FOR CORRECTION: Twenty-one (21) days.       2 565       4/28/21	2 265	Continued From pa	age 9	2 265			
	2 565	11/30/20. LPN-F co the medical provide episode or overall s she had also not up regarding R55's sta stated she had felt had been a concer he had this type of monitored R55. LP condition were to c proper steps" of mo the medical provide A policy Change in 6/2019, directed sta physician/healthcan been an accident of resident, a significar mental physical or need to transfer the SUGGESTED MET director of nursing, staff on policy and/ medical provider(s) representative(s) w condition. They cou to ensure ongoing of TIME PERIOD FOI (21) days. MN Rule 4658.040 Plan of Care; Use Subp. 3. Use. A c must be used by al	onfirmed she had not contacted er about R55's unresponsive status and further confirmed podated dialysis on 11/30/20 atus that morning. LPN-F R55's unresponsive episode n; however, due to her belief episode in the past she only N-F explained if a resident's hange she would take "the onitoring their vitals and calling er. Resident Condition, dated aff to notify the resident's re provider when there had or incident which involved the ant change in the resident's mental condition, and/or a e resident to a hospital. THOD OF CORRECTION: The or designee, could in-service or procedures for contacting ) and/or resident <i>v</i> ith any resident changes in uld than audit resident records compliance. R CORRECTION: Twenty-one 5 Subp. 3 Comprehensive				4/28/21

	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	::		
	00775		B. WING			C 25/2021
	AME OF PROVIDER OR SUPPLIER STREET A			STATE, ZIP CODE	•	
	TROVIDER OR SOFFEIER					
MEEKER	MANOR REHABILIT	ATION CENTER. I	ELD, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
2 565	Continued From pa	age 10	2 565			
	This MN Requirem by:	ent is not met as evidenced				
		ion, interview, and document		Corrected		
	review, the facility f	ailed to develop a				
		e plan to include assessed				
		d subsequent interventions to				
		ygiene was maintained for 1 of eviewed for dental hygiene				
	care.	eviewed for dental hygiene				
	Findings include:					
		linimum Data Set (MDS), dated	k			
		R37 had intact cognition and				
	•	assistance to complete her				
		ring (ADLs). Further, the MDS o broken teeth and/or likely				
	cavities present.	o broken teeth and/or likely				
		rch Health Management)				
		tion, dated 2/11/21, identified				
		plaque or debris on her teeth				
		eral missing teeth." R37 was				
		earing dentures and required				
	set-up for oral care					
		on 3/22/21, at 3:33 p.m. R37				
		dental care as "they're [her R37 expressed she had				
		teeth which made her				
		er smile and, as a result, she				
	tried to "hide it as n	nuch as possible." R37				
		her teeth to the surveyor, and				
		ave several missing teeth on				
	both the top and lo					
		re plan, printed 3/23/21, was ed any identified problem				
		), or interventions to ensure				
		od oral hygiene despite being				
		ng oversight and/or assistance				
		are was completed and having				
	numerous missing					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		00775	B. WING			C 03/25/2021			
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE					
MEEKER MANOR REHABILITATION CENTER, I 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355									
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)			
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE			
2 565	Continued From pa	ge 11	2 565						
	When interviewed o	on 3/23/21, at 1:50 p.m.							
		IA)-C stated she noticed R37							
		teeth and, as a result, "tries							
		closed" as she "hates her							
		ned 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 don	e 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								
		arding R37's dental care or							
		ned since there had been no							
		R37's MDS, dated 2/18/21,							
		to care plan it." However,							
		as aware R37 had numerous							
		tated it should have been							
		lan to ensure staff were							
	-	e person" and getting care							
	completed.								
	•	anning policy, dated 6/2019,							
		ciplinary team (IDT) would							
		nent a comprehensive care 1 days after admission for							
		policy continued, "The goal of							
		d, individualized care plan is to							
		eas and their causes, and							
		ns that are targeted and							
	meaningful to the re								
		HOD OF CORRECTION: The	e						
		or designee, could audit all							
		ensure dental status							
		essed and care planned, and							
		are preferences are carried							
		en in-service staff to ensure							
		re in place and oral cares are							
						1			
	acted upon timely ti	nen audit to ensure ongoing							

Minneso	ta Department of He	ealth		·	ORM APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
					С
		00775	B. WING		03/25/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
MEEKER	MANOR REHABILIT	ATION CENTER I	TH DAVIS AV ELD, MN 553		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 565	Continued From pa	age 12	2 565		
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830		4/28/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident in bed.	1		
	by: Based on observat review the facility fa care planned interv immediately after a recurrent falls and/ (R55) reviewed for to ensure adequate	ent is not met as evidenced ion, interview, and record ailed to ensure assessed and rentions were implemented fall in order to minimize or injury for 1 of 1 residents falls. Further the facility failed e supervision to prevent residents (R40) reviewed for		Corrected	
	Findings include:				
	FALL INTERVENT	IONS			
		imum Data Set (MDS), dated R55 had intact cognition and			

Minnesota Department o STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00775	B. WING			C 03/25/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
<b>IEEKE</b> F	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE ELD, MN 5535				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
	indicated R55 requi mobility and most a in which R22 had ir transitions and walk had been free of fa assessment and ha hypotension (abnor pressure when star (failure of lungs to f used at that time. R55's care plan, rev	lities. Further, the MDS ired limited physical assist for activities of daily living (ADL's) hstability during surface king. The MDS identified R55 Ils since the prior MDS ad diagnosis of orthostatic mal decrease in blood hding) and respiratory failure function properly) with oxygen					
	weakness, and ass R55's fall goal had falls. The care plan 11/24/20 which ider been placed, along added to R55's whe	I risk related to history of falls, istance needed with transfers. been to be safe and free from indicated a revision on ntified call don't fall signs had with anti-roll back brakes eelchair. The care plan failed er revisions after 11/24/20.					
	identified R55 had n months in which he medications and ha evaluation indicated alert and had no iss vision was impaired and hands-on assis in which he had be come to a standing interventions at the follows: proper foot	Evaluation, dated 1/15/20, multiple falls in the prior six a took more than three fall risk ad fall risk diagnosis. The d R55 had been oriented and sues with his memory. R55's d and required use of a device st to move from place to place en unable to independently position. Care plan time of the evaluation were as wear at all times; room to be and debris; personal items reach.					
	p.m. indicated R55	ntered on 11/16/20, at 12:44 had been found lying on the een previously noted in his					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		C 03/25/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
NEEKER	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE ELD, MN 5535			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	Continued From page 14				
	head and a raised s eye. The progress of fall prevention inter support a reason for interventions in res A Fall Scene Invest indicated R55 had to get weak after di did not have his oxy that R55 had been identified weakness saturations had app the fall and directed	mall laceration on top of his swollen area above the right note did not identify any new ventions or documentation to or no new fall prevention ponse to the fall. tigation Form, dated 11/17/20, lost his strength and appeared alysis. The form identified R55 ygen on prior to the fall and "sleepy." Further, the form s and low blood oxygen beared to be the root cause of d staff to lay R55 down in bed gen saturations were below				
	11/24/20, at 3:09 p. 11/16/20, at 12:10 p indicated dietary sta R55 had been foun had not known wha incident report iden dialysis that day wit oxygen blood satur Staff had applied or low oxygen saturati later was on floor." indicated R55 had limitations and requ	and Analysis V-3, dated m. identified R55 had a fall on o.m. The incident report aff had heard a crash in which d on the floor in his room. R55 at happened; however, the tified R55 had returned from th his oxygen "off" and had ations of 69% at that time. xygen after they obtained the ion reading and "5 minutes Further, the incident report not always been aware of his uired assist of one. Call don't ed on 11/24/20 in response to				
	p.m. indicated at ap had been found lyir left elbow skin tear.	ntered on 11/28/20, at 4:11 oproximately 2:45 p.m. R55 ng on the floor with a sustained . The progress note identified after he reached for a fork he				

STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		С	
		00775			03/	25/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
MEEKER	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE ELD, MN 5535			
(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 ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 15	2 830			
2 830	Continued From page 15 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.					
	support R55's 11/2 the interdisciplinary undated piece of pa surveyor on 3/24/2 information R55 ha 11/28/20 at 4:11 p.1 had been free of in fall were "TBD [to b note on the piece of pulled from daily cl on 11/30/2020 (Mo injuries are reviewe hosp [hospital] on 2	ation had been requested to 8/20 fall had been reviewed by / team (IDT). An unnamed, aper had been provided to the 1, which indicated typed id been found on the floor on m. Further, this indicated R55 jury and intervention(s) for the be determined]." A hand writter of paper indicated, "This is inical morning meeting report nday) where falls/interventions ed. (patient was admitted to 11/30/20)."				
	LPN-B stated staff	on 3/25/21, at 10:11 a.m. were expected to put an ntion" in place after a resident				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Сом	E SURVEY PLETED C
		00775	B. WING			25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER I	ITH DAVIS AVE ELD, MN 5535			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 16	2 830			
	fall which would hel	p decrease further potential				
		on(s) put into place after the				
		eviewed during the next IDT				
		eded adjustments. LPN-B				
	,	have a nurse who is on-call if				
		t with fall intervention decision				
		of the fall. LPN-B explained				
		ected to fill out an Incident				
		is, along with a Risk t, after each resident fall.				
	Management repor					
	During interview on	3/25/21, at 10:40 a.m. care				
		manager registered nurse (RN)-A stated staff				
		ut "immediate interventions" ir	ו			
		nt fall. RN-A explained she				
		to see if R55 had a grabber,				
		n-slip material)," or some				
		s she "would have done eviewed R55's EMR and				
		's 11/28/20 fall progress note;				
		rmed the EMR lacked				
		ntified immediate fall				
		been implemented or that the				
		ed up on by facility				
		nich RN-A voiced, "Does not				
		as done." RN-A explained				
		ommunicated the fall to				
		llow up as staff "should have				
		cility expected fall procedures				
	When interviewed o	on 3/25/21, at 11:07 a.m. the				
		(DON) stated the nurse and				
		nts would talk after a fall and				
		" The DON explained fall				
	interventions were	"usually done immediately"				
		ect the interventions to be				
		er, the DON explained IDT				
		hich staff discussed the				
		e fall interventions. The DON				
	Teviewea K55'S EM	R and confirmed the lack of				1

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		C 03/25/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE ELD, MN 5535	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 17	2 830			
	documented interve	entions 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 SUPE USE	RVISION AND GAIT BELT				
	moderately impaire needed for bed mo use, and personal h person physical ass medical diagnoses vascular accident (	ADS) dated 2/16/21, identified of cognition, extensive assist bility, transfers, dressing, toilet hygiene. R40 also required one sistance to walk in room. R40's included arthritis and cerebral CVA) (stroke) with an atheter, and a fall within the	e 5			
	dated 2/19/21, iden one and front whee	de Kardex Report document tified R40 required assist of eled walker (FWW) to ances and to walk in room.				
		ted 3/4/21 identified fall risk falls, weakness, CVA, heart				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00775	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/25/2021	
	PROVIDER OR SUPPLIER	600 SOU	DDRESS, CITY, ST TH DAVIS AVE			
MEEKEF	R MANOR REHABILIT	ATION CENTER. I	ELD, MN 5535			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 18	2 830			
	(physical therapy) a instructions for mot mobility related to C DM2, CKD [chronic weakness; follow P and FWW ambulati movement in bed a and FWW with tran to CVA, polyarthritis	iabetes mellitus); follow PT and OT (occupational therapy) bility functional; alteration in CVA polyarthritis, heart failure, kidney disease], and T instructions; assist with one ion; assist one to two with nd in/out of bed; assist one usfers; self-care deficit related s, heart failure, DM2, CKD, ist one with dressing and				
	identified history of to two times; medic may contribute to fa to increase urine pr (nonsteroidal anti-ir standing in one spo while make a turn e standing and requir review summary ide risk for fall r/t (relate history of falls, med diagnosis of CVA; r and bladder and ha neurogenic bladder	aluation dated 2/10/21, falls in the last six months one cation use and diagnoses that alls: diuretics (water pills used roduction in kidneys), NSAIDS offlammatory drugs); gait while ot, walking straight forward and exhibits loss of balance while res wide base support. Fall entified R40 has the potential ed to) age, decreased mobility lication listed above, and esident is continent of bowel is indwelling Foley for "; assist of one and FWW for ntly does not self transfer.				
	plan dated 3/12/21, [stand by assistanc	ress report & updated therapy identified R40 needed SBA e] with FWW for standing ansfer with SBA, and current				
	identified R40 requi	e dated 3/23/21, at 10:55 a.m. ired daily skilled care for ¯ and OT and transfers with				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED C	
		00775	B. WING			03/25/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
MEEKER	R MANOR REHABILIT	ATION CENTER I	TH DAVIS AVE ELD, MN 5535				
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 19	2 830				
	assist of one.						
	encounter notes da "discussed and inst [R40] that PT would with all transfers du stress to pt [R45] to mobility, transfer tra During an observati R40 sat on toilet in wheel chair placed had gotten herself of wheelchair, and pus wheel herself back of water.	ysical therapy treatment ted 3/24/21, identified ructed/educated pt [patient] I like to to [sic] ask for assist e to fall risks. Continue to use call light for assist with aning wheelchair with SBA. on on 03/23/21, at 2:10 p.m. bathroom by herself with next to her. At 2:13 p.m. R40 off the toilet, back into her shed her feet on the floor to to the bedside table for a drink					
	R40 sat on the edge dressed and bent o stood up, held onto pivoted herself into front of her without and unhooked indw placed it on her lap.	on on 3/24/21, at 7:16 a.m. e of the bed completely ver to tie her shoes. R40 the bedside railing, and the wheel chair located in assistance. R40 bent down elling urinary catheter bag and R40 pushed the call light on the indwelling urinary	8				
	nursing assistant (N and placed gloves of pushed herself up of position and took ho NA-G provided peri pants up while R40 bathroom wall. R40	on on 3/24/21, at 7:45 a.m. IA)-G entered R40's bathroom on. R40, without a gait belt on, off the toilet to a standing old of the bar on the wall. neal cares and pulled her hung onto the bar on the pivoted herself into the ility staff failed to transfer R40 it belt.					

If continuation sheet 20 of 62

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	C (X3) DATE SURVEY	
		00775	B. WING			25/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE LD, MN 5535			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From pa	ige 20	2 830			
	dietary aid knocked waited for a respon knocked again and observed to open th herself in the wheel the same blue swea wore yesterday. R4 herself dressed and myself." During an interview p.m. stated she waa now. R40 stated, "I I am supposed to." know it, as she is n getting there somel be careful, wheel m the bar on the wall	ion on 03/25/21 08:18 a.m. a d on R40's closed door and se and heard nothing, she then opened door. R40 was he bathroom door and pushed lchair with her feet. R40 wore atshirt and tan slacks on she 0 verified she had gotten d stated "Yes, shoes and all by with R40 on 3/23/21, at 1:56 s headed to the bathroom right take myself and I don't know if R40 indicated the staff must ot asking them for help and is how. R40 also stated "I try to nyself to the bathroom and use to pull myself up. R40 also old her she was getting much				
	trained medication was toileted about e with assist of one. T really transfer by he transfer belt is place one is needed to st backwards and we also indicated R40 hang onto the bar of During an interview NA-K identified R40 bathroom. NA-K als help R40 to the bat	on 03/23/21, at 3:07 p.m. aid (TMA)-C indicated R40 every 2 hours and transferred TMA-C indicated R40 does not erself. TMA-C identified a ed on R40 and assistance of and because she may lean want to prevent a fall. TMA-C sometimes needed cues to on the wall. on 03/23/21, at 3:19 p.m. 0 was one assist to go to the so stated we have rarely had to hroom, she has taken herself that. NA-K indicated she				
	placed the wheelch	air next to the bed at a R40 grabs the bed railing on				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00775	B. WING		03/25/2021	
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S			
EEKER	MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE ELD, MN 5535			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE COMF THE APPROPRIATE DA	
2 830	Continued From pa	age 21	2 830	DEFICIENC	Y)	
	wheel chair to bed. boost R40 up more of the wheelchair. I on R40 indicated s transfer. During an interview NA-G indicated a g the transfer with F4 7:45 a.m. NA-G ide used when R40 tra in the room becaus coming to this facili make sure R40 do she is aware R40 t told her coworkers	e also transferred her from the NA-K verified she had helped e times than not to get her out NA-K also verified the charting he should have assist of one to w on 03/24/21, at 8:04 a.m. gait belt was not used during 40 in her bathroom today at entified a gait belt should be insferred and staff need to be se she had fallen prior to ity. NA-G stated staff need to es not fall. NA-G also stated ransferred herself and she had and indicated they had also nsfer. NA-G identified she had -H.				
	LPN-E identified Re to transfer. LPN-E self transfer regula by herself. LPN-E i call for help. LPN-E informed PT so the indicated R40 shou transfers. LPN-E st her this morning" d quick and does not transfer gait belt is falls. During an interview identified R40 shou	v on 3/24/21, at 8:47 a.m. 40 required assistance of one stated she had caught R40 rly and going to the bathroom ndicated she reminded R40 to E also indicated she had ey are well aware of it. LPN-E uld have on a gait belt during al tated "I did not place a belt on luring a transfer R40 is too t like it. LPN-E identified the used for safety to help prevent v on 3/24/21, at 12:42 p.m. OT uld be provided with stand by due to being unsteady with				

	ROVIDER OR SUPPLIER	00775	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IEEKER I (X4) ID PREFIX	ROVIDER OR SUPPLIER	00775			C 03/25/2021	
IEEKER I (X4) ID PREFIX			DDRESS, CITY, S	TATE, ZIP CODE	00/	20/2021
(X4) ID PREFIX		600 SOU	TH DAVIS AVE			
PRÉFIX	MANOR REHABILIT	LITCHFII	ELD, MN 5535	5		1
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 22	2 830			
1	R40. OT stated she	be used anytime you transfer heard R40 had been self ehabilitation meeting today.				
i         	identities every time R40 she would be a are entered every to stated R40 should r put on the call light,	on 03/24/21, at 01:45 p.m. PT e physical therapy worked with assessed, then progress notes en days or on tenth visit. PT not be self-transferred, should and wait for staff to arrive to ed she had not been made transferred.				
 	Management [MHN Program last revise belts must be used indicated in the pati employees to hold support and stabiliz gait belt must also b	Monarch Healthcare ] Safe Resident Handling d on 3/20/20, identified gait for ambulatory residents wher ent care plan to allow onto the belt to provide e the resident when walking. A be used during a stand pivot guidance to the resident, when e plan.				
	DON or designee, or residents and reside interventions are in help mitigate fall ris	HOD OF CORRECTION: The could audit all current fall risk ent falls to ensure care plan place and acted upon toto k. The DON or designee, ff on fall risk interventions and nation and audit for				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
	MN Rule 4658.0520 Proper Nursing Car	) Subp. 2 D Adequate and e; Shaving	2 850			4/28/21

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SU COMPLE	
				с	
		00775	B. WING	03/25/	2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NEEKEE	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVENUE		
		LIICHFI	ELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
2 850	Continued From pa	ige 23	2 850		
	proper care. The c adequate and prop D. Assistance	or determining adequate and criteria for determining er care include: with or supervision of shaving necessary to keep them clean			
	by: Based on observati review, the facility f grooming to 1 of 1 n activities of daily liv dependent on staff Findings include: R26's face sheet, d had Parkinson's dis movement), major disorder, post traum in other diseases of behavioral disturba and functioning), ar R26's MDS dated 2 cognitive impairment assistance with acti R26's care plan rev limited physical mo required 2 staff at ti care performance of living related to Par disorder, confusion requires 2 assist to personal hygiene w time and reproach. Review of R26's tas personal hygiene w from march 1st thro	lated 3/24/21, indicated R26 sease (disorder that affects depressive disorder, anxiety natic stress disorder, dementia lassified elsewhere with nces (impairment of memory nd muscle weakness. 2/3/21, indicated severe nt and required extensive ivities of daily living. <i>r</i> ised on 2/10/21, indicated bility related to weakness and imes for cares. R26 has self deficit with activities of daily rkinson's, post traumatic stress at time, personal hygiene tal dependence with all <i>r</i> hen he refuses care allow sked dated 3/2021, indicated <i>r</i> as signed off at least daily	5		

Minneso	ta Department of He	ealth				APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	E CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
						С
		00775	B. WING		03/2	25/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		600 SOU	TH DAVIS AVE	ENUE		
MEEKER	MANOR REHABILIT	ATION CENTER, I LITCHFI	ELD, MN 5535	55		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH		COMPLETI DATE
1/10		<b>,</b>	1/10	DEFICIENCY		
2 850	Continued From pa	age 24	2 850			
2 000	-	290 Z-T	2 000			
	shaved.					
		on 3/22/21, at 1:27 p.m. R26				
	had scruffy chin/ch					
		on 3/23/21, at 8:48 a.m. R26 air in day room. Mask in place				
		under chin and on cheeks.				
		er mask or upper lip due to				
	mask being in place					
		on 3/23/21, at 9:04 a.m. R26's				
		d by staff and noted $1/4-3/4$				
		and white hairs on chin, under				
		R26 stated staff shave him but				
	further stated not "f					
		on 3/23/21, at 2:06 p.m.				
		26's room. R26 continues to				
		ir 1/4-3/4 inch remains in				
		ed 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				
		h coarse, gray and white hairs				
	on chin, under chin					
		on 3/24/21, at 8:52 a.m. R26				
		a chair, continues to be				
	unshaved.					
		1 3/24/21, at 9:28 a.m. nursing				
	( )	ated she tried to shave R26				
		s razor is broken. NA-E stated				
		he resident every day if				
		ted she is not sure how long				
		een working, but appears he				
		d in a while. NA-E stated she to the social worker and try to				
	find another razor					
		n 3/24/21, at 12:54 p.m.				
		RN)-B stated she was only				
		broken shaver today and				
		ly a new one as they just got				
		ted as long as he wishes to be				
		be. RN-B stated that she				
naaata D	epartment of Health					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING			25/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
		ATION CENTER   600 SOU	TH DAVIS AVE	NUE		
	R MANOR REHABILIT	LITCHFIE	ELD, MN 5535	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 850	Continued From pa	ae 25	2 850			
	already is working of During interview on stated that R26 was some oil to his face R26 tolerated being stated that she four head to the razor and but not sure how lo NA-E stated if a res there is a spare on used and clean and the broken razor to During observation face appears smoo face or neck. During interview on stated she shaves in but some need to b grows fast. NA-B st broken for about a universal one on No NA-B further stated scruffy and hair was to the North end to stated R26 use to th however, now prefe During interview on licensed practical in requires staff assist the head of the razo still be able to use to or using the univers LPN-B stated R26 of sometimes will hit of however they shoul During interview on	on getting him a new one. 3/24/21, at 1:04 p.m. NA-E s now shaved and she applied as it was rough. NA-E stated g shaved well. NA-E further nd out that someone lost the nd that is why it is not working, ng it hasn't been working for. sidents razor is not working the North end that they can d that they should also bring the social worker. on 3/24/21, at 1:05 p.m. R26 th and without scruffy hair on 3/24/21, at 1:44 p.m. NA-B residents every week or so, be shaved daily if there hair tated R26's razor has been week or so and that there is a borth side that staff can use. I that if a resident looked s growing out they should go get the universal razor. NA-B nave really long facial hair,				
	according to the ca different in this exp	re plan and each resident is ectations. DON stated if broken they should use the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
			A. BUILDING.				
		00775	B. WING	B. WING		03/25/2021	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IEEKEF	MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	COMPLET	
2 850	Continued From pa	ge 26	2 850				
	should be reported stated it would not be unshaved. DON stat through to make su shaved. DON further under personal hyg with R26 should be behaviors during fir Shaving the resider indicated "The purp promote cleanliness The following inform the resident's medic that the procedure or title of the individual procedure, If and he the procedure or an ability to participate problems or compla- related to the proce the treatment, the re- intervention taken." person recording the supervisor if the resi- report other informa- facility policy and pr practice." SUGGESTED MET director of nursing, current residents fo- preferences are beit then in-service staff preferences are act ensure ongoing cor	nt policy revised 2/2018, hose of this procedure is to s and to provide skin care. nation should be recorded in cal record: the date and time was performed, the name and I who performed the ow the resident participated in hy changes in the resident's in the procedure. Any aints made by the resident edure, if the resident refused eason(s) why and the The signature and title of the he data. Reporting:notify the sident refuses the procedure. ation in accordance what rofessional standards of THOD OF CORRECTION: The or designee, could audit all or facial hair to ensure shaving ing carried out. They could f to ensure shaving ted upon timely then audit to	3				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	:		
		00775	B. WING		C 03/25/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		600 SOU	TH DAVIS AN			
	R MANOR REHABILIT	ATION CENTER, I LITCHFIE	LD, MN 553	355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
2 895	Continued From pa	age 27	2 895			
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			4/28/21
	that is directed tow through positioning implemented and r comprehensive res of nursing services development of a r provides that: B. a resident wir receives appropriation	motion. A supportive program and prevention of deformities and range of motion must be maintained. Based on the sident assessment, the director must coordinate the nursing care plan which th a limited range of motion te treatment and services to motion and to prevent further of motion.				
	by: Based on observat review, the facility f range of motion (R consistently implen reduce the risk of o (R14) reviewed for Findings include: R14's annual Minin 10/16/20, identified demonstrated no d Further, R14 requir complete most of h (ADLs); however, t limitation(s) to her record if any impain R14's Therapy Rec 6/11/19, identified a	tion, interview, and document failed to ensure care planned .OM) exercises were nented to prevent decline and contracture for 1 of 2 residents mobility and ROM. num Data Set (MDS), dated I R14 had intact cognition and lelusions or other behaviors. red extensive assistance to her activities of daily living he section to record functional ROM were dashed and did not rment existed. commendations sheet, dated a Restorative Nursing Program uded, "U/E [upper extremity]		Corrected		

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If continuation sheet 28 of 62

	ota Department of He	(X1) provider/supplier/clia	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00775	B. WING	B. WING		C 25/2021
	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST			
MEEKEF	R MANOR REHABILIT	ATION CENTER 1	ELD, MN 5535			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	HE APPROPRIATE	COMPLETI DATE
2 895	Continued From pa	ge 28	2 895			
	plan, dated 3/5/21, orientated to person plan outlined R14 h and directed to prov cares along with, "U Reps." On 3/22/21, at 2:10 her room. R14 had fingers of her left ha place; along with a the slightly closed fi stated she was sup program for her upp however, it was not to poor staffing in th went to an offsite ca exercises a couple needed the ROM p home to prevent fur expressed these co the nurses but they working on it." Furth fingers and joints fe and attributed it to t being completed. When interviewed of nursing assistant (N exercises she was including a NuStep program; however, NA-C voiced she w her upper extremition R14 voice her ROM completed adding, about it]." NA-C sta	15 reps." Further, R14's care identified R14 was alert and n, place and time. The care ad limited physical mobility vide gentle ROM daily with JE/LE ROM 7X/Week 10 p.m. R14 was observed in visible contractures of the and with an applied splint in rolled up washcloth present in ist of her right hand. R14 posed to be on a ROM per and lower extremities; always getting completed due he facility. R14 voiced she ampus for other rehab times a week, however, still rograms done at the nursing rther loss of her mobility. R14 oncerns had been reported to just always tell her "we're her, R14 voiced she felt her elt tighter in the past weeks he lack of her ROM programs on 3/24/21, at 10:04 a.m. NA)-C stated R14 had several supposed to be doing and "standing frame" these would often be refused. as aware R14 wore braces on es and acknowledged hearing A exercises weren't being "She does a lot [complain ted R14's ROM was supposed he wakes up," however, then				
	program was care	aware a lower extremity ROM planned adding, "As far as I				
	[knew] we didn't ha epartment of Health	ve to [do the lower ROM]."				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00775	B. WING			25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 29	2 895			
	getting done consis staff members to ca complete the progra however, verified sl explained R14 had increased pain, nor tightening or stiffen past months. Furtho or completed exerce programs, would be the PointClickCare During interview on stated she routinely she had heard R14 contraction" was "ki not feel R14 had su overall ROM in the R14 had mentioned her upper and lowe completed adding s complaint "maybe a NA-F expressed sh responsible to com adding, "I want to s R14's Documentatio 2/2021, identified ta This included, "Floo 15 reps also Be [sid evening her hands, week this needs to there is no restoration remainder of the ar- minutes and rep(s)	3/24/21, at 10:25 a.m. NA-F worked with R14 and voiced complain before that "her ind of stiff," however, NA-F did istained a decline in her past months. NA-F voiced I before her ROM programs to r extremities were not being she last heard her voice such a a week ago or so." Further, e believed the night shift was plete R14's ROM exercises ay nights do [them]." on Survey Report(s) v2, dated taks to be completed for R14. or Aides: L/E exercise 2x/wk c] sure do ROM daily on arms and legs, 7 days per be done daily by the CNA's if ve aids [sic]." This was completed only two times in 2/1/21 and 2/4/21. The eas to record the exercise were either left blank, or had " dictated. In addition, the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ (°СОМ	E SURVEY PLETED
		00775	B. WING		C 03/25/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER I	H DAVIS AVE LD, MN 5535			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 895	Continued From pa	ge 30	2 895			
	the areas to record rep(s) were either la applicable]." R14's Documentation 3/2021, identified ta This included, "Floot 15 reps also Be sur her hands, arms an needs to be done d restorative aids [sic completed only thre 3/9/21, 3/10/21, and as refusing the exe 3/19/21, 3/20/21, ar the areas to record rep(s) were either la applicable]" dictated had been provided exercises the week addition, the report "Floor Aides: Passiv reps." This was also completed only two 3/9/21 and 3/15/21. refusing the exercises 3/19/21, 3/20/21, ar the areas to record rep(s) were either la applicable]" or "No" medical record was other evidence dem exercises had been When interviewed or registered nurse material	an 2/1/21. The remainder of the exercise minutes and eft blank, or had "NA [not on Survey Report v2, dated asks to be completed for R14. or Aides: L/E exercise 2x/wk re do ROM daily on evening ad legs, 7 days per week this aily by the CNA's if there is no c]." This was recorded as being be times in March (so far) on d 3/15/21. R14 was recorded rcises only three times, on nd 3/24/21. The remainder of the exercise minutes and eft blank, or had "NA [not d. There was no evidence R14 or offered her LE ROM of 3/1/21 to 3/6/21. In outlined a task which read, ve ROM U/E ROM 5x/wk 10 or ecorded as being times in March (so far) on R14 was recorded as ses only four times, on 3/10/21, nd 3/24/21. The remainder of the exercise minutes and eft blank, or had "NA [not dictated. Further, R14's a reviewed and lacked any nonstrating when R14's ROM a completed and/or refused. on 3/24/21, at 1:29 p.m. anager (RN)-A voiced R14 had ord injury and required				
	as a result. RN-A re including the record	e with her mobility and ADLs eviewed R14's medical record, led minutes and reps for each ed the exercises were not				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		с	
		00775	B. WING			25/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
IEEKER	MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE			
			ELD, MN 5535		000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 31	2 895			
2 900	be; nor was there e ROM exercises were expressed there way voiced she was not getting done or not. exercise programs documented as car further contracture a adding, "They need A provided Range of dated 10/2010, dire for a resident which physician's order way and reviewing the c any "special needs" then outlined specific complete various R with directing appro- recorded in the med other information in and professional sta SUGGESTED MET director of nursing of residents receiving to ensure range of no upon and then audi compliance. TIME PERIOD FOF (21) days. MN Rule 4658.0528 Ulcers	of Motion Exercises policy, cted how to complete ROM a included ensuring a as in place for such procedure are plan prior to starting for ' of the resident. The policy fic physical step(s) on how to OM exercises and concluded opriate documentation was dical record, and, "Report accordance with facility policy andards of practice." THOD OF CORRECTION: The or designee, could audit all range of motion programming motion is being provided as d then in-service staff to obtion programming is acted t to ensure ongoing R CORRECTION: Twenty-one 5 Subp. 3 Rehab - Pressure sores. Based on the	2 900			4/28/21
						1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C 03/25/2021	
		00775	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
		600 SOU	TH DAVIS AV			
IEEKER	MANOR REHABILIT	ATION CENTER 1	ELD, MN 553			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE						(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI		COMPLET DATE
				DEFICIENCY	()	
2 900	Continued From pa	ge 32	2 900			
	of nursing services	must coordinate the				
		ursing care plan which				
	provides that:					
		o enters the nursing home				
		ores does not develop				
		ess the individual's clinical				
		ates, and a physician				
	authenticates, that	they were unavoidable; and				
	R a resident w	ho has pressure sores				
		y treatment and services to				
		revent infection, and prevent				
	new sores from dev					
		ent is not met as evidenced				
	by:	ent is not met as evidenced				
		ion, interview, and document		Corrected		
		ailed follow pressure ulcer		-		
	interventions for 2 of	of 2 residents (R4 and R26)				
	identified at risk for	pressure ulcers.				
	Findings include:					
		um data set (MDS) dated				
		severe cognitive impairment				
	mobility and transfe	extensive assistance with bed				
		ed 3/24/21, indicated				
		unspecified dementia with				
		nces (Brain impairment in				
	memory and judger	ment), peripheral vascular				
		(difficulty with sleeping),				
		with late onset (a progressive				
		ys memory and other				
	important mental fu					
		s dated 12/23/20, indicated er blanket when resident is in				
		sure on feet/toes. Monitor				
		oes every shift discontinue				

Minnesota Department of Health STATE FORM

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00775	B. WING	B. WING		25/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IEEKER	R MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	ge 33	2 900			
	apply to first and se	econd toes topically every				
		Itime for wound care.				
		ce evaluation and skin risk				
		21, indicated moderate risk for				
	skin breakdown.					
		ised 3/4/21, indicated ADL's				
		e with dressing, showering,				
	bed mobility and personal hygiene. R4's care plan		ו			
		Inerable with mobility				
	limitation, communi	ications, staff will provide daily				
	cares as per care p	lan and will notify nursing				
	when plan needs updating for accuracy. Risk for					
	skin integrity with interventions of monitoring skin					
		with cares and on bath days,				
	apply lotion to dry s					
		y 2-3 hours and as needed				
		n indicated risk for skin				
		ed any information about the				
	foot cradle.					
		ssessment dated 3/17/21,				
		remains discolored ongoing.				
		essment dated 3/10/2,				
		great toe and second digit				
	scabbed areas ong	on 3/22/21, 1:15 p.m. R4				
		bed with blankets on top of				
		body. Foot cradle was				
		the floor next to the wall unde	r			
	the tray table.					
		on 3/23/21, at 1:59 p.m. R4				
		<i>i</i> th blankets covering body				
		toes, foot cradle was again				
		the floor, next to the wall				
	5	. No concave mattress was				
	observed in use.					
		3/23/21, at 2:35 p.m. nursing				
		ated being unaware of R4				
		e foot cradle while in bed but				
		cradle should be kept on her				
		prevent further break down of				

Minneso	ta Department of He	alth	-			APPROVE	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	or contraction		A. BUILDING:				
		00775	B. WING	B. WING		C 03/25/2021	
	PROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, ST	TATE ZIP CODE			
	Novibel ( of coll ) eleft						
MEEKER	MANOR REHABILIT	ATION CENTER 1	LD, MN 5535				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETI DATE	
2 900	Continued From pa	ae 34	2 900		- ,		
	-	-					
		ed R4 had scabs on her toes					
		monitoring. NA-A stated she					
		foot cradle on R4's bed. NA-A ollows the Kardex which tells					
		the residents and did not see					
	this listed on there.	the residents and did not see					
	Immediately following interview, at 2:42 p.m.						
		n, without implementing foot					
		down the hallway into another					
		continues to lay on left side					
		r feet/toes and foot cradle on					
	the floor.						
		on 3/24/21, at 7:24 a.m. R4					
		lying in bed toes/feet have blankets on them and					
		n floor, next to wall and under					
	the tray table.						
		3/24/21, at 7:24 a.m. NA-B					
		s on her right great toe and					
		ght foot which the trained					
		urse will treat before getting					
		NA-B stated since she has					
		has never seen the foot					
	cradle being used v						
		months and would look to the					
		tions for the residents.					
	During interview on	3/24/21, at 9:19 a.m.					
	Licensed practical r	nurse (LPN)-A stated R4					
	should have the foo	ot cradle on the bed if there					
	was an order for it.	LPN-A stated R4 has scabs					
	-	at are being monitored and					
		er order. LPN-A further stated					
		care plan/Kardex when caring					
		ould think that those					
	interventions should						
		3/24/21, at 9:21 a.m. LPN-B					
		Ild be using the foot cradle due					
		toes. LPN-B stated it is					
		radle to prevent further break					
		pressure to her toes. LPN-B					
	stated all intervention	ons should be on the care plan					

TATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION			
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		00775	B. WING	B. WING		C 03/25/2021	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
			TH DAVIS AVE				
NEEKEF	R MANOR REHABILIT	ATION CENTER 1	ELD, MN 5535				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	ge 35	2 900				
	for staff to follow as	this indicated how to care for					
	the resident.						
		3/25/21, at 9:56 a.m. Director					
		tated R4's foot cradle should					
		event pressure on her feet and	k				
	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						
		ated 3/24/21, indicated					
		Parkinson's disease (disorder ent), major depressive					
		sorder, post traumatic stress					
		in other diseases classified					
		avioral disturbances					
		nory and functioning), and					
	muscle weakness.	nory and runctioning), and					
		2/3/21, indicated severe					
		nt and required extensive two					
		s and bed mobility. R26's					
		assistance with activities of					
	daily living.						
	, ,	ary report dated 3/24/21,					
		eel- remove pressure by					
		pillow under calf and applying					
	a heel cushion boo	t. Heel protectors to both feet.					
	Offload heels in be	d. Position blankets over bed					
	frame. Monitor righ	t lateral heel bruise					
	non-blanchable as	well as left heel and left toes					
		ruise on top of right great toe					
	every shift.						
		ressure wound evaluation are					
	as follows:						
		pressure length 2.5 x 2.5 0					
	depth unstageable.						
		pressure length 3.0 x 1.2 0					
	depth unstageable.						
		ressure length 2.5 x 1.0 0					
	depth unstageable.						
	R26's care plan rev	rised on 2/10/21, Risk for					

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TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
ND FLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:	······	COMPLETED		
		00775	B. WING	B. WING		C 03/25/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
		600 SOU	TH DAVIS AVE				
IEEKER	R MANOR REHABILIT	ATION CENTER 1	ELD, MN 5535				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	ige 36	2 900				
	alteration in skin int	tegrity interventions to include					
		every 2-2.5 hours. Elevate					
		pot cradle added to foot of bed					
	to keep blankets of	f resident's toes, place pillow					
		under legs as tolerated. Heal protectors when not					
	wearing shoes. Notify hospice of any skin						
	concerns.						
		on 3/23/21, at 2:06 p.m. R26					
		ts are tucked under mattress					
	•	dents feet, no elevation of					
	bilateral feet on a p						
		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					
		it the interventions to follow					
	and how to transfer						
		on 3/24/21, at 8:52 a.m. R26					
		chair. LPN-A removed old					
		l serosanguinous drainage					
		t, cleansed with wound					
	cleanser and dried	with gauze. Wound was noted					
	to be eschar in the	center with pink surrounding					
		nchable. LPN did not measure					
		pilex with boarder. R26					
		-A stated hospice measures					
	and provides wound						
		3/24/21, at 9:28 a.m. NA-E					
		have pressure boots on at all					
		s are to be elevated, has not					
		e in a long time, but thinks it o the air mattress and					
		IA-E stated R26 has a sore on					
	1 0	as a dressing on it. NA-E					
		e Kardex which is at the desk					
	to know how to car						
		3/24/21, at 12:54 p.m.					
		nurse (RN)-B stated R26 was					
	kicking the foot cra						
		should be having feet up on a					

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
	of contraction	IDEINTI IORTION NOMBER.	A. BUILDING:		COMPLETED	
	00775 B. WING			- C 03/25/202		
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
		600 SOU	TH DAVIS AVE			
NEEKER	R MANOR REHABILIT	ATION CENTER 1	ELD, MN 5535			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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TAG	REGULATORT OR E		TAG	DEFICIENC		Ditte
0.000		07	0.000			
2 900	Continued From pa	ige 37	2 900			
	of skin.					
	During observation	on 3/24/21, at 1:02 p.m. R26				
	lying in bed with bla	ankets over bedrail and				
		ed on a pillow. NA-E stated				
		et up on a pillow to reduce				
		she knows it needs to be done.				
		3/24/21, at 1:08 p.m. LPN-A				
		oot cradle was removed from				
	his care plan by the	e care manager since being				
		was still in place by state				
		her stated staff should be				
		orders to elevate R26's feet to				
		akdown. LPN-A stated care				
	manager updates t	he care plan/Kardex and this				
	should reflect the p	lan 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 F	R26 wears heel protects as				
	well. LPN-B stated	blankets should be folded over	•			
	the rail of the bed to	o relieve pressure and prevent				
	further break down	to resident's skin. LPN-B				
	stated staff should	be following R26 interventions				
	that were ordered b					
		on 3/25/21, at 9:36 a.m. R26				
		blanket covering bilateral arms				
		protects on his feet.				
		n 3/25/21, at 9:52 a.m. DON				
		s should be pulled off of his				
		sure injury or add to skin				
		stated heel floating was				
		pressure of R26's heels.				
		it is expected for staff to				
	follow the plan of ca					
		nd wound management policy				
		ated " Wound care will be				
		g or provider order. Procedure				
		tilizing safe and sanitary				
		t to prevent contamination or				
	I the spread of infect	tion. Document treatment or				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00775 B. WING			C 03/25/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEEKEF	R MANOR REHABILIT	ATION CENTER I	H DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 900	refusal of treatment record." SUGGESTED MET director of nursing, current residents to physician orders ha then audit to ensure are being implement in-service staff to en- care planned intervent then audit to ensure	ge 38 t in the resident's medical THOD OF CORRECTION: The or designee, could audit all ensure pressure ulcer related we been care planned and care planned interventions nted. They could then nsure physician orders and entions are being carried out e ongoing compliance.	2 900			
21325	Emergency Oral He Subpart 1. Routine home must provide resource, routine de needs of each resid include dental exan fillings and crowns, oral surgery, bridge orthodontic procedu that are provided fo community at large reimbursement poli This MN Requireme by: Based on observati review, the facility fa	e dental services. A nursing e, or obtain from an outside ental services to meet the lent. Routine dental services ninations and cleanings, root canals, periodontal care, s and removable dentures, ures, and adjunctive services r similar dental patients in the , as limited by third party	21325	Corrected		4/28/21

Minnesota Department of Health STATE FORM

64LU11

If continuation sheet 39 of 62

TATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	00775		B. WING		С	
		00775			03/	25/2021
NAME OF P	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
<b>MEEKER</b>	MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE			
		LITCHFIE	LD, MN 5535			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21325	Continued From pa	ge 39	21325			
	required extensive a of daily living (ADLs broken teeth or like Census list, printed resided at the nursi source as Medicaid R37's MHM (Monar Oral/Dental Evaluat R37 had observed her teeth along with R37 was recorded of required set-up for assessment outline set up dental appoin needed." The comp dictation regarding refused a dental ap dictation on when F had been prior to he home. When interviewed of voiced she had com "they're [her teeth] f teeth to the survey several missing tee palate. R37 stated s get them addressed helped her arrange her missing teeth m about her smile and not smile at people	R37 had intact cognition and assistance with her activities s), and had no obviously ly cavities. Further, R37's 3/24/21, identified R37 ng home and listed her payer l. rch Health Management) tion, dated 2/11/21, identified plaque or debris present on n, " several missing teeth." not wearing any dentures and oral cares. Further, the ed, "Staff will assist resident to ntments and transportation as bleted assessment lacked any if R37 had been offered and/or pointment at the time; nor any R37's last dental appointment er admission to the nursing on 3/22/21, at 3:33 p.m. R37 incerns with her dentition as falling out." R37 showed her or and was observed to have th on both the top and lower she needed to see a dentist to d; however, nobody had those services. R37 voiced nade her feel self-conscious d, as a result, she would often and "try to hide it [missing possible." Further, R37 voiced				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00775		B. WING	B. WING		C 25/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE ELD, MN 5535			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
21325	Continued From pa	ige 40	21325			
	care plan lacked ar	ny identified problem				
		, or interventions to ensure				
		od oral hygiene despite being				
		ng 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					
		however, she often refuses				
		oice she did it herself. NA-C				
		s unsure if R37 was actually				
		cares or not. NA-C stated she				
		ig comments about her poor				
		result, she would try to "keep				
		so people didn't see her				
	missing teeth. NA-C stated she was unaware R37		7			
		laints of pain when chewing				
		due to her teeth; however, again reiterated R37 had reported not smiling at others because "she				
	hates her smile."	ming at others because she				
		rd was reviewed and lacked				
	-	s reported concerns with her				
		acted upon and addressed				
		ler for resolution despite being				
		ng numerous teeth, and				
		ect care staff she "hates her				
	smile" due to her de					
		a.m. registered nurse				
		as interviewed. RN-A s were assessed upon				
		dental condition(s), and she				
		R37's assessment (dated				
		nd R37 was "missing many"				
		ed R37's medical record and				
	stated R37 had ele	cted to receive dental services				
		n; however, was unable to				
		"any specific complaints"				
		he time. RN-A voiced she "was	6			
		been making comments to				
	i the direct care staff	about not wanting to smile				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		с	
	00775		B. WING			25/2021
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
IEEKER	MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE			
		LITCHFIL	ELD, MN 5535			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21325	Continued From pa	ge 41	21325			
21385	follow-up or appoint help R37. RN-A exp should have been r acted upon and add as there were optio despite the COVID- concerns should be self-esteem and ma added unresolved of big problem." A provided Dental S identified 24-hour a would be provided t including referral(s) Further, the policy of department would h transportation or ap policy lacked any di the facility would en were addressed or resolution. SUGGESTED MET The director of nurs all current residents needs are being me staff to ensure reside communicated to th dental needs are fo ensure ongoing cor TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one	21385			4/28/21
21385	Staff assistance Subp. 3. Staff assi	) Subp. 3 Infection Control; stance with infection control. assigned to assist with the	21385			4/28/21

	ota Department of He	ealth (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION (	X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	00775		B. WING		C 03/25/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY	STATE, ZIP CODE	
		600 SOU			
MEEKEF	R MANOR REHABILIT	ATION CENTER 1	ELD, MN 55		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
21385	Continued From pa	ige 42	21385		
	the residents and n	ogram, based on the needs of ursing home, to implement ocedures of the infection			
	by: Based on observati review, the facility fi infection control pra (R40) reviewed for procedures. Findings include: R40's admission M 2/16/21, identified r indwelling urinary c needed with bed m personal hygiene, a with eating. R40's c included CVA (strok	ent is not met as evidenced ion, interview and document ailed to ensure proper actice for 1 of 1 residents urinary catheter cleaning inimum Data Set (MDS) dated noderately impaired cognition, atheter, extensive assistance obility, transferring, dressing, and toileting, and independent current medical diagnoses (e), CKD (chronic kidney)		Corrected	
	arthritis. R40's care plan dat a self-care deficit re heart failure, DM2, noted as: assist of During an observat licensed practice nu R40's room, applied urinary collection le	2 diabetes mellitus (DM2), and ted 3/4/21, identified R40 had elated to CVA, polyarthritis, CKD, weakness. Interventions one with personal hygiene. ion on 03/24/21, at 7:27 a.m. urse (LPN)-E entered resident d gloves, and removed a g bag from a basin located on loset. LPN-E wiped off the top			
innegato D	connection site on t with an alcohol swa leg and placed a to of the large urinary R40. LPN-E then v the large urinary co swab, pulled tubing	the urinary collection leg bag ab. LPN-E rolled up R40's pant wel under the connection site collection bag attached to viped the connection site of illection bag with an alcohol apart, removed the large ag and placed it in the			

STATEMEI	o <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00775		B. WING			25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE ELD, MN 5535			
(X4) ID	SI IMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLET DATE
21385	Continued From pa	ge 43	21385			
	collection leg bag to bathroom for the vir closet on the floor. mixture of fifty perc water in a container unmeasured amoun plastic container. Li with this type of cat than I have seen." A her gloves, washed be right back" and of LPN-E re-entered F filled a syringe with had mixed earlier. I collection bag over looped around her out. LPN-E attempt and tubing upwards with the syringe over solution drained inter the urinary catheter attached to the cath the vinegar water solution placed a cap on the urinary catheter col and paced it on the her gloves, washed room. LPN-E failed collection bag and to bacteria. During an interview LPN-E indicated the the floor of the closs leg bag hung on the LPN-E identified sh	A-E then connected the urinary or R40. LPN-E looked in the negar and located it on the LPN-E stated they use a ent vinegar and fifty percent r. LPN-E poured an nt of vinegar and water into a PN-E stated "I am not familiar heter bag, it is totally different At 7:42 a.m. LPN-E removed I her hands, and stated "I will exited the room. At 8:00 a.m. R40's room applied gloves, the vinegar water solution she _PN-E held the urinary the toilet with the tubing hand and did not straighten it ed to flush the catheter bag s from the bottom drain port er the toilet 3 times. The the toilet and did not go into collection bag. The tubing neter bag was not flushed with olution. LPN-E dumped the nately fifty percent of the ion into the toilet. LPN-E e end of the tubing of the lection bag, laid it in the basin, closet floor. LPN-E removed I her hands, and exited the to properly sanitize the urinary tubing to prevent growth of a on 03/24/21, at 8:47 a.m. e wash basin was located on et and the urinary collection to and flushed the urinary tubing and flushed the urinary				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		СОМ (°СОМ	E SURVEY PLETED C
		00775	B. WING			25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVEN ELD, MN 55355			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
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21385	Continued From pa	ge 44	21385			
	bag should be flush connects to the bag unable to connect t had used the bottor During an interview ADON stated the un be rinsed out with fip percent vinegar mix a syringe that would be used for this pro- the urinary bag syst top to bottom and the drain out from the b bag to prevent the i identified nursing st regarding this comp During an interview director of nursing ( skills competency fit the nursing staff. D were covered and i check list for the ca and DON was unab DON indicated staff contact her if they h how to complete ca little bit of vinegar at together in a paper urinary drainage ba and the vinegar war with a syringe into the from the top to botto tubing first and ther bag. DON also indiv should be filled half make sure it is all completed to the syringe into the top to botto tubing first and ther	on 3/25/21, at 11:12 a.m. rinary collection leg bag should ifty percent water and fifty ked solution. ADON identified d fit the tubing was expected to cess. ADON also identified tem should be cleansed from the cleansing solution should bottom port of the collection ntroduction of bacteria. ADON taff had received education				

A. BUILDING:     C       00775     B. WING     03/25/202       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     03/25/202       MEEKER MANOR REHABILITATION CENTER, I     600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355     500 SOUTH DAVIS AVENUE       (X4) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL     ID PREFIX     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE     (comparing)	STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		E SURVEY
00775         B. WING	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COM	PLETED
600 SOUTH DAVIS AVENUE LTCHFIELD, MN 55355           (M) ID TAG         SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEIBED BY FULL (EACH DEFICIENCY MUST BE PRECEIBED BY FULL TAG         ID PREFIX (EACH DEFICIENCY MUST BE PRECEIBED BY FULL (EACH DEFICIENCY MUST BE PRECEIBED BY FULL TAG         PREFIX (EACH ADRECTOR YOR LSC IDENTIFYING INFORMATION)         PAREFIX TAG         PREFIX (EACH ADRECTOR YOR LSC IDENTIFYING INFORMATION)         PREFIX TAG         PREFIX (EACH ADRECTOR YOR LSC IDENTIFYING INFORMATION)         PREFIX TAG         PREFIX (EACH ADRECTOR YOR LSC IDENTIFYING INFORMATION)         PREFIX TAG           21385         Continued From page 45         21385         21385         21385           21385         Continued From page 45         21385         21385           reductor to prevent growth of bacteria in catheter bags, that are not currently connected to the catheter bag in basin. Make sure the end of catheter bag in clamped. Take disconnected catheter bag in basin to solled utility room. Mix 1 part vinegar with 3 parts water (11/2 cup vinegar with 1½ 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 you water, Cempve affect had give the preceed affect of parts; SUGGESTED METHCDO OF CORRECTION: The director of nursing, or designee, could audit resident who assist with toileting care to ensure resident hand hygiene is performed after toileting procedures are being followed. They could then in-service saff to ensure infection control practices are being carried out then audit to <th></th> <th colspan="2">00775</th> <th colspan="2">B. WING</th> <th colspan="2">C 03/25/2021</th>		00775		B. WING		C 03/25/2021	
WEEKER MANOR REHABILITATION CENTER, 1         LITCHFIELD, MN 55355           (X4) ID PREFX 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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PREFIX PREFIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG         D PREFIX (EACH DEFICIENCY)         (COM DEFICIENCY)           21385         Continued From page 45         21385         21385           21385         Continued From page 45         21385           catheter bags, that are not currently connected to the catheter bags, that are not currently connected to the catheter bag is covered with alcohol packet and drainage system. Procedures: Place the catheter bag is covered with alcohol packet and drainage port is clamped. Take disconnected catheter bag in basin to solled 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 procedures are being followed. They could then in-service saff to ensure infection control practices are being car	NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
CMUD PREEX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL)       ID PREEX TAG       PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       construction of the transmission of transmissi transmission of transmissi transmission o			ATION CENTER I 600 SOU	TH DAVIS AV	/ENUE		
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       construction         21385       Continued From page 45       21385         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 bag that are not currently connected to the catheter bag is covered with alcohol packet and drainage port is clamped. Take disconnected catheter bag in basin to solled utility room. Mix 1 part vinegar with 3 parts water (1/2 cup vinegar with 1 ½ cups water). Remove alcohol packet from insettion 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 resident hand hygiene is performed after toileting processes, along with ensuring catheter toileting processes, along with ensuring catheter toileting processes along with ensuring catheter toileting procedures are being followed. They could then in-service saff to ensure infection control			LITCHFIE	ELD, MN 553	55		
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 solled utility room. Mix 1 part vinegar with 3 parts water (1/2 cup vinegar with 1½ 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 tolleting 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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
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 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 solled 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	21385	Continued From pa	ge 45	21385			
TIME PERIOD FOR CORRECTION: Twenty-one (21) days.21435214354/2821435MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing214354/28	21435	clean to dirty, to try Review of a facility Catheter Leg & Beo Purpose: To preven catheter bags, that the catheter bags, that the catheter bag that catheter into the clean end of catheter bag packet and drainag disconnected cather room. Mix 1 part vir cup vinegar with 1 1 alcohol packet from tubing and instill so bag. Swish the solu 30 seconds to 1 mi bag. Rinse catheter Empty tap water from clean wash basin. Sign shelf of closet. SUGGESTED MET The director of nurses residents who assiss resident hand hygics processes, along w procedures are being ensure ongoing cor TIME PERIOD FOF (21) days. MN Rule 4658.0900 Recreation Program	and prevent infections. document titled Sanitation of dside Bags undated identified at growth of bacteria in are not currently connected to ge system. Procedures: Place at was just disconnected from ean wash basin. Make sure the j is covered with alcohol e port is clamped. Take eter bag in basin to soiled utility negar with 3 parts water (1/2 ½ cups water). Remove n insertion end of catheter bag lution into catheter tubing, into ition around inside the bag for nute. Empty solution from the r tubing/bag with tap water. om bag. Allow to air dry, in Store in resident's room on top THOD OF CORRECTION: sing, or designee, could audit st with toileting care to ensure ene is performed after toileting rith ensuring catheter cleaning ng followed. They could then nsure infection control carried out then audit to mpliance. R CORRECTION: Twenty-one				4/28/21

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775		B. WING		C 03/25/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
MEEKER	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AV		
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
21435	Continued From pa	ge 46	21435		
	recreation program based on each indi- strengths, and need meet the physical, i well-being of each i comprehensive res comprehensive pla 4658.0400 and 468 provided opportunit	an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and			
	by: Based on observati review, the facility f assess and develop activities of interest reviewed who comp meaningful activitie and evening hours. to ensure activities provided to promote resident (R7) obser Findings include: R37's admission M 2/18/21, identified F required extensive of daily living (ADLs was, "Very important activities while in th	ent is not met as evidenced on, interview, and document ailed to comprehensively o interventions to promote for 1 of 2 residents (R37) olained about a lack of s in the facility on weekend In addition, the facility failed of interest were consistently e quality of life for 1 of 1 ved to not attend activities. inimum Data Set (MDS), dated R37 had intact cognition and assistance with her activities s). Further, the MDS outlined it nt," to R37 to do her favorite e nursing home. The MDS		Corrected	
	to, being around an groups of people al When interviewed ov voiced she enjoyed in the nursing home	idered having music to listen imals, and doing activities with so as, "Very important." on 3/22/21, at 3:16 p.m. R37 going to the activity programs and attended "every one of ever, R37 expressed there			

AND PLAN OF CORRECTION		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMI	E SURVEY PLETED
		00775	B. WING			25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE ELD, MN 5535			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
21435	Continued From pa	ge 47	21435			
	or evening hours ac stated she just sits television then. Fur mentioned to the st activities on the we just told "we're work R37's most recent I Management) Ther dated 2/15/21, iden oriented to person, reading, "wants to a assessment outline which included card walking or wheeling gardening or plants activities, besides r being enthusiastic a at the nursing homo prompts to engage section labeled, "Pr enjoyed bingo, mus along with one-to-o section item labeled required," had writte comment."	MHM (Monarch Health apeutic Recreation Evaluation tified R37 was alert and place and time with dictation attend all activities." The ed R37's activity preferences ds, other games, crafts or art, g outdoors, trips or shopping, a, and, "would like all the eading." R37 was listed as and willing to try the activities e; and needed minimal cues o in group-based activities. A rogram Plan," outlined R37 sic, church, crafts, and games; ne activities and cards. A final d, "Resources / Interventions en dictation which outlined, "no ted 3/4/21, identified R37 was	, r			

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING			25/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER I	TH DAVIS AVE ELD, MN 5535			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21435	Continued From pa	ge 48	21435			
	repeatedly heard R	37 voice there was "nothing to				
		ce." NA-C explained R37 had				
		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					
		ing through her belongings. on 3/23/21, at 2:02 p.m. NA-G				
		y involvement seemed to				
		od" but acknowledged she did				
		various group-based activities				
	such as bingo. NA-G stated she had heard R37					
		t of a lack of things to do in				
		nd ask staff repeatedly, "Wha	t			
		at is there to do?" NA-G				
		was offered activities				
		but added she "can't say				
	100%."	rd was reviewed and leaked				
		rd was reviewed and lacked nad been comprehensively				
		activity desire and/or				
		despite repeated complaints				
		lack of activities of being				
		o evidence the facility had				
		ny, options were available to				
	include or provide F	R37 with additional activities				
		ure her quality of life while				
	residing in the nurs					
		p.m. therapeutic recreation				
		as interviewed and verified she	•			
		37 throughout her stay at the				
		A explained R37 did attend the nd would often "share her	7			
		which were "both good and				
		/ attended activities such as				
		ancy Fingers" which TR-A				
		g typically receptive to most				
		offered to her. TR-A stated				
		had voiced there "could be				

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STATEMEI	o <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	- (X3) DATE SURVE COMPLETED	
	00775		B. WING	· · · · · · · · · · · · · · · · · · ·	03/	25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVEN ELD, MN 55355			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
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21435	Continued From pa	ige 49	21435			
	evenings and adde to her "everyday I w she brought R37 do therapeutic recreati them discuss the is actions or the asse been making such had approached the her to "come to wha ability to change the R37's POC (Point of Activity flowsheet, of identified all the act during the period. T days (3/11/21, 3/12 was recorded as had during the evening sheet recorded R37 table game and gro (Saturday), and the game on 3/13/21 (S (Saturday) R37 atte event, and the relig 3/21/21 (Sunday). T provided demonstra personal or group a attempted with R37 On 3/23/21, at 3:03 and verified knowle with a lack of activit evening hours. TRI with an activities ca there was "somethi do" adding these pr been able to offer " census and staffing	of Care) Response History - dated 3/10/21 to 3/23/21, divities R37 had attended This identified only four (4) /21, 3/16/21, and 3/18/21) R37 aving an activity completed hours (after 5:00 p.m.). The 7 as attending the provided oup movie on 3/13/21 ereligious service and table Sunday). Further, on 3/20/21 ended the table game and food ious service and a 1:1 visit on There was no other evidence ating what, if any, other activities had been offered or 7 on these weekend days. 6 p.m. TRD was interviewed edge R37 had voiced concerns ties on the weekends and D voiced she provided R37 allendar and explained to her ng every single day" for her to rograms were what they had at this time" given the low g needs of the department. d she had not comprehensively	4			

STATEME	<u>ota Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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		00775	B. WING			25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MEEKEP	R MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE ELD, MN 5535			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF (	CORRECTION	(X5)
PRÉFIX TAG	· ·	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET
21435	Continued From pa	ge 50	21435			
	grievance process were addressed. The ensure residents were at the nursing home A provided "Docum dated 6/2018, ident ensure appropriate was maintained, and assessments would record. However, the steps or procedures concerns with the are addressed and/or are quality of life. R7's admission min 12/24/21, identified required total assist extensive assistance living (ADLs). The full considered listening religious services and Review of R7's More identified activities: her room for her vise of the activities were refuse this offer of a R7's care plan last independent to choo like to attend while she is feeling up to participate or receiv offer. The care plan help R7 meet this g calendar in room for pleasure" and, "F	entation, Activities" policy, iffied TRD was responsible to departmental documentation ad any completed activity d be recorded in the medical ne provided policy lacked any s on ensuring voiced issues or activity department were assessed to ensure resident" himum data set (MDS) dated severely impaired cognition, tance with transfers, and ce with her activities of daily MDS also identified R7 g to music, the news, and lso as very important. ments Hospice document Keep a current calendar in ewing and choosing pleasure offer. Respect her right to activities. revised 1/11/21, identified R7 ose the activities she would here. We will encourage, once it if she would like to ve the 1:1 activities that we n listed two interventions to poal: "Keep a current activity or their viewing and choosing Respect the residents right to activities, but make all we have				

STATEME	<u>ota Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		C 03/25/2021	
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NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
MEEKEF	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE ELD, MN 5535			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21435	Continued From pa	ige 51	21435			
	evidence R7 had be reassessed for her involvement in the f R7's activity assess not received. During observations 2:44 p.m., 3:34 p.m. Broda chair awake game show "passw 3:52 p.m., R7 state Review of the Meel events calendar for to 9:30 a.m. spa ha 11:15 a.m. devotior visiting with everyor p.m. matching gam 7:30 p.m. Dominoe activity flow sheet of 11:09 a.m. and 3:16 R7's POC response dated 3/11/21 to 3/2 the activities R7 ha The flowsheet ident 3/18/21, and 3/21/2 an activity complete attending the group reading/local paper (Thursday), and rel (Sunday). Further, of for the scheduled a fingernails) as not a activity flowchart ide R7 was not availab approached. During an interview licensed practical n activities included r	2) through 3/23/21 lacked any een comprehensively activity interest and/or facility offered activities sment was requested however s on 3/23/21, at 1:41 p.m., h., and 3:52 p.m. R7 sat in the while watching the television vord puzzle." When asked at d, "I like talk shows." (ker Manor March activity '3/23/21, indicated 8:15 a.m.) and massages, 9:30 a.m. to hal readings, room to room 1:1 ne, 9:30 a.m. to 11:15 a.m., 2 the chapel, and 6:45 p.m. to s. The POC response history - lated 3/23/21, identified R7 at 6 p.m. as unavailable. e history - activity flow sheet, 23/21 (13 days), identified all d attended during the period. tified only three days (3/12/21, 21) R7 was recorded as having ed. The sheet recorded R7 as o movie on 3/12/21 (Friday), //library cart/book club 3/18/21 igious service 3/21/21 on 3/11/21 R7 was recorded ictivity ([Manicure/painting applicable. Additionally, the entified twenty-one (21) times le out of twenty-nine (29) times and a the hospice aids spends a				

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	of connection	·····				
		00775	B. WING		C 03/25/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
		600 SOU	TH DAVIS AVE			
MEEKER	R MANOR REHABILIT	ATION CENTER, I LITCHFII	ELD, MN 5535	5		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	HE APPROPRIATE	COMPLET DATE
				DEFICIENC	()	
21435	Continued From pa	ige 52	21435			
	identified R7 really	enjoys a manicure.				
		on 3/24/21, at 12:09 p.m.				
	recreation director	(RD) identified the				
		d POC Response History				
		navailable. RD verified				
		ed R7 maybe in the bathroom,				
		er, or sleeping in her room. RE				
		t wake residentis up when we				
		ng. RD also identified R7 taff assistance and was very				
	happy to get to play					
		,. interview on 3/25/21, at 9:47				
		ed R7 attended only three				
		y period of time. RD indicated				
		prepared for a large group				
	activity they did not	have time to complete				
		h R7. RD also verified R7 did				
		one time activity on the POC				
		n a 13 day period of time				
		RD stated we certainly could				
		-to-one time with R7. RD also				
		es from the newspaper had read however RD was not				
		to read them independently.				
		ty staff checked with R7 once				
		lable, they moved on to check				
		; they are unable to check				
	more than once. RI	D identified R7 did not have				
	any one-to-one acti	ivity visits and needed to be				
		nine what changes could have				
		d more time with her. At 10:45				
		hed surveyor and identified				
		History Document did not				
		-one activities were not being				
		R7 resident was unavailable.				
		ocument will be changed to resident's situation and				
	provide more indivi					
	SUGGESTED MET	HOD OF CORRECTION: The				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		E SURVEY PLETED	
		00775	B. WING			C 03/25/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
		600 SOU	TH DAVIS AV				
MEEKEI	R MANOR REHABILIT	ATION CENTER, I LITCHFI	ELD, MN 553	55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
21435	Continued From pa	ge 53	21435				
21665	and needs have be planned for meanin hour activity involve in-service staff to en being offered then a compliance. TIME PERIOD FOF (21) days.	ensure activity preferences en assessed and care gful weekend and evening ement. They could then nsure activity preferences are audit to ensure ongoing R CORRECTION: Twenty-one D Physical Environment ust provide a safe, clean,	21665			4/28/21	
	functional, comforta environment, allowi personal belonging This MN Requireme	able, and homelike physical ng the resident to use s to the extent possible. ent is not met as evidenced					
	review the facility fa related to potential higher hot water ter accessible locations addressed by main (R4, R8, R10, R19, R48, R50, R52, R50 communicated the faucets were too ho Findings include: On 3/22/21, from 1: resident room bath amongst all four fac resident rooms (R4 R34, R37, R47, R47 R556) were found to the bathroom fauce	on, interview, and record hiled to ensure concerns burn hazards surrounding mperatures in resident s were communicated and tenance for 15 of 15 residents R23, R29, R34, R37, R47, 05, R555, R556) who hot water in their bathroom bt. 10 p.m. to 6:57 p.m. several room sink faucets were tested cility' units. 15 occupied , R8, R10, R19, R23, R29, 8, R50, R52, R505, R555, o have hot running water in the which required surveyor to r only a few seconds to avoid		Corrected			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:	A. BUILDING:			
		00775	B. WING	B. WING		C 03/25/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
MEEKEF	R MANOR REHABILIT	ATION CENTER 1					
			ELD, MN 5535	PROVIDER'S PLAN OF C		(275)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21665	Continued From pa	age 54	21665				
	had initially verbalized bathroom sink] carries asked permission to water temperature. burned by the hot water faucet stream water to her for more confirmed staff had getting hot when it staff wet the washed "a little bit" to ensure hot before they gave During interview or stated she had felt hot. R10 explained cold [water] when I When interviewed denied she had even used the water; hore noticed "it [the water that day while she R37 explained 3/22 had noted the water "arr On 3/22/21, at 6:36 maintenance (DON thermometer to assistant (NA)-A st	on 3/22/21, at 3:28 p.m. R37 er burned herself while she wever, R27 stated she had er temperature] was too hot" had been washing her hair. 2/21 had been the first day she er to be "that hot; however, on she had witnessed a nurse nd it was steaming." 5 p.m. the director of <i>A</i> ) used an analog spike sess the bathroom sink hot s in eight of the 15 resident I been updated on the . None were verified to be over enheit. During the hot water ated he had not been aware of					

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00775	B. WING	B. WING		25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER. I	TH DAVIS AVE ELD, MN 5535			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	ge 55	21665			
	to her. Further, NA- residents' hands wh "close" to them whe make sure it was no had concerns about since she started et and a half months a had been unsure if concern to a nurse. When interviewed of stated when she wo the hot water had b the cold, she had b under the water stru- she provided care to wet washcloth out sho hot on R47's body. were concerns with started employmen two months ago; ho not communicated which she added "b [concerns with the I During interview on stated, "If you put it the hottest setting if explained, "You hav it (the water temper centerthere is a tr on this concern he temperatures for th burn themselves." communicated this When interviewed of	on 3/22/21, at 6:47 p.m. NA-I brked with the residents and een turned on by itself, withou een unable to put her hands eam. NA-I confirmed when to R47 she had to "shake" the so it became cooler and not so NA-I stated she had felt there the water since she had t at the facility approximately owever, she voiced she had this concern to anyone, in but most everybody knows hot water temperatures]." 3/23/21, at 3:12 p.m. NA-J [hot water knob] all the way to t is going to burn." NA-J ve to play around until you get rature knob] in the rick to it." NA-J stated based will usually adjust the water e residents so "they do not NA-J denied he had	t			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ (	E SURVEY PLETED	
		00775	B. WING			3/25/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
MEEKER	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE ELD, MN 5535				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
21665	Continued From pa	ige 56	21665				
	hot water. LPN-C h	ad denied she felt this had					
		the time as she had added					
		ot and thus she had not					
		initial hotness to other staff.					
		a.m. the DOM and the					
	· ·	maintenance assistant (MA)-A were interviewed					
	and confirmed MA-	A checked designated					
	resident accessible	water temperature locations					
		stated acceptable hot water					
		ld be 115 degrees Fahrenheit					
		e regulations and 120 degrees					
		to meet federal regulations.					
		d he had adjusted the water					
		t two months ago" due to					
		eratures having been reported					
		a result of lower temperatures vever, the DOM and the MA-A					
		owledge of staffs' current hot					
	-	e DOM stated after he					
		ly water temperature logs					
		<i>i</i> that he had not been					
		vare of the temperatures that					
		nen 115 degrees Fahrenheit.					
		d he would expect MA-A to					
		e elevated readings with an					
		nt, "but with me running					
		bed through the cracks." The					
	•	expected all staff to bring					
		him or the MA-A "right away"					
		vas a top priority and water					
	•	ide the regulations had the					
		injure the residents. The DOM					
		ed knowledge of a facility					
		ed them on how to check					
		water temperatures; however,					
		provided after the interview.					
		3/25/21, at 10:11 a.m. care					
		B denied any knowledge that ad hot water concerns and had					
		ad not water concerns and had					
	epartment of Health	y concerns with the not water					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING			C 25/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AVE ELD, MN 5535			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	ge 57	21665			
	to report issues with "maintenance supe other staff of the po A Logbook Docume Temps, Eye Washe report, dated 2/23/2 designated facility lo monitoring which in Lane 1, Lane 2, Lar and Lane 1, Lane 2, Lar and Lane 1, Lane 2, Lar and Lane 1, Lane 2, Lar and Jane 1, Lane 2, Lar and 3/17/21 and ide temperatures taken all Resident and Re temperatures taken all Resident and Re temperatures which degrees Fahrenheit documentation for t temperatures which degrees Fahrenheit An undated policy V Hot Water Tempera patient room water 105 [degrees] and as specified by stat had not been identifi- requirements. Furth record the results in and "Note any discr heater settings as r necessary." The po "dial thermometer" which should be ca SUGGESTED MET director of maintena hot water temperatu- bathing fixtures to e of 105-115 degrees	rvisor right away" and alert tential risks. entation: Air Temps, Water is temperature monitoring 11 through 3/23/21, identified ocations for water temperature cluded individual headings for he 3, and Lane 4 "Resident" , Lane 3, and Lane 4 eport indicated water checks d on 2/23/21, 3/1/21, 3/9/21, entified all documented on these four days showed esident 2 Lane checks had n ranged from 116 and 119 these same areas identified n ranged from 103 to 112				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED	
					С	
		00775	B. WING		03/25/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER 1	TH DAVIS AV ELD, MN 553			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	COMPLET DATE	
21665	Continued From pa	age 58	21665			
	audit to ensure ong and hot water temp of nursing (DON) o in-service staff to e hazards as directed compliance.	g Water Temperatures and joing compliance with testing perature ranges. The director r designee, could then nsure staff report facility d then audit to ensure ongoing R CORRECTION: Twenty-one				
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685		4/28/21	
	including walls, floc systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, brs, ceilings, all furnishings, oment must be kept in a good repair and operation health, comfort, safety, and esidents according to a written be and repair program.				
	by: Based on observatives of the facility of defective and/or work assessed for safety caused by failure of the lack of ongoing assessment of thes 39 of 54 residents of Findings include: R45's quarterly Min 3/1/21, identified Reference of the function of the safety of	ent is not met as evidenced ion, interview and document ailed to ensure potentially orn toilet equipment was y after resident-involved events f the resident room toilet(s). g, routine monitoring and se toilets had potential to affect residing in the nursing home. himum Data Set (MDS), dated 45 had intact cognition and assistance with toileting. putlined R45 had sustained since the previous assessment		Corrected		

If continuation sheet 59 of 62

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00775		B. WING			C 25/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, I	TH DAVIS AVE ELD, MN 5535			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21685	Continued From pa	ige 59	21685			
	When interviewed of	on 03/22/21, at 4:49 p.m. R45				
		ained a fall in his bathroom				
		e or four months ago when he				
		pilet and it broke beneath him.				
		a major injury but did have to				
	change rooms as a	result. R45 added the ordeal				
	was embarrassing	and scary to him.				
	When interviewed of	on 03/23/21, at 3:12 p.m.				
		urse (LPN)-E voiced they had				
		ty 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				
		ere the toilet had broken away				
		ng the resident to fall.				
	-	•				
		maintenance (DOM) was interviewed. He				
	explained the facility used wall-mounted toilets which could support weight up to 500 pounds					
		times, place pieces of PVC				
		the toilet bowl to support				
		phed more. DOM voiced he				
		ing or monitoring which toilets				
		ng placed underneath of them.				
		OOM provided surveyor with				
		ig 15 of 54 resident toilets the				
		ed to required PCV bracing.				
		on 3/24/21, at 1:14 p.m.				
		N)-A recalled when R45 fell to				
		of the toilet breaking. RN-A				
		weigh over 300 lbs. at the time				
		d not recall if he had sustained				
		sult of the incident. RN-A then				
		npleted skin assessment at				
		d no major injuries had been				
	obtained. Further.	RN-A stated she did not think				

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
			B. WING			25/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE			
MEEKER	R MANOR REHABILIT	ATION CENTER 1	H DAVIS AVE LD, MN 5535				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLET DATE	
		,		DEFICIENCY)			
21685	Continued From pa	ige 60	21685				
	R45's weight (less t	than 300 lbs.) would cause the					
		ak and added she was aware					
		praces for larger residents.					
		cation survey, from 3/22/21 to					
	3/25/21, documentation was requested to						
	demonstrate the facility had complete an						
		r remaining wall-mounted					
	toilets to ensure sa	fety with resident use after					
	R45 sustained a fal	Il 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.						
		a.m. a subsequent interview					
		who provided a listing of					
		e which had the PVC bracing of them. DOM acknowledged					
	•	•					
	he was unsure which, if any, toilets outside of R45's had been replaced and verified there was						
		to check the state of repair of					
		ace them, if needed. Further,					
		s only aware of the one fall					
		toilet which was R45's fall a					
	few months prior.						
	On 3/25/21, at 10:0	4 a.m. the facility					
		nterviewed and verified she					
	had been employed	d at the nursing home since					
	2019. She explaine	d she had been aware of only					
		olved a toilet failing and					
		n the wall, and acknowledged					
		in place was to brace the					
		iping or use a commode for					
		s. The administrator expressed					
		of any listings or monitoring					
		ith the toilets (or their					
	replacement) in the						
	when interviewed (	on 3/24/21, an MDH					

Minnesota Department of Health STATE FORM

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If continuation sheet 61 of 62

## PRINTED: 04/29/2021 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00775	B. WING			C 25/2021	
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
			H DAVIS AVE				
EEKEF	R MANOR REHABILIT	ATION CENTER, I LITCHFIE	LD, MN 5535	5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
21685	Continued From pa	age 61	21685				
	nursing home recoloriginally built in 19 construction project expressed installation including the use of sufficient to hold or toilet as such a toile Further, all remaining which were installed A facility' policy on the maintenance was received. SUGGESTED MET The director of main visually inspect all re defects and repair develop a plan for of auditing. The direct designee, could the compliance.	ment representative voiced the rds indicated the building was 78, and there were no other ts listed since 1988. He ion of support braces, f PVC piping, was not repair a cracked or defective et would require replacement. ng toilets in the nursing home d in 1978 should be replaced. toilet repair and/or equested, however, was not THOD OF CORRECTION: ntenance, or designee, could resident toilets for any obvious as needed. They could then ongoing inspection and for of maintenance, or en audit to ensure ongoing R CORRECTION: Twenty-one					

		AND HUMAN SERVICES & MEDICAID SERVICES				MAPPROVED D. 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DA	TE SURVEY		
245361			B. WING _		03	3/24/2021		
	PROVIDER OR SUPPLIER	ATION CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
K 000	INITIAL COMMENT	ſS	K 00	00				
	FIRE SAFETY							
	Minnesota Departm Fire Marshal Divisio Meeker Manor was with the requiremer Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing THE FACILITY'S P ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM VERIFICATION OF UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA ACCORDANCE WI IF OPTING TO USI OF THE PLAN OF REQUIRED. PLEASE RETURN	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. E AN EPOC, A PAPER COPY CORRECTION IS NOT						
	( K-TAGS) TO: Health Care Fire In:	spections						
ABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE		

F5361031

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

04/22/2021

PRINTED: 04/23/2021

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.

**Electronically Signed** 

		AND HUMAN SERVICES				FORM	04/23/2021 APPROVED
			(X2) MU				0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	· · /	PLETED
		245361	B. WING			03/2	24/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER. LLC			00 SOUTH DAVIS AVENUE		
	1			L	ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	ae 1	κo	000			
	State Fire Marshal	-					
	445 Minnesota St., St Paul, MN 55101-	Suite 145					
	By email to: FM.HC	.Inspections@state.mn.us					
	THE PLAN OF CO	RRECTION FOR EACH					
		T INCLUDE ALL OF THE					
		cription of the corrective action or correct the deficiency.					
		easures that will be put in deficiency does not reoccur.					
		e facility plans to monitor to ensure solutions are					
	4. Identify who is r actions and monitor	responsible for the corrective ring of compliance.					
	5. The actual or p the remedy.	roposed date for completion of					
	partial basement. T constructed in 1978 constructed in 1979 building and both bu	one-story building with a The original building was 3, with building additions 9 and 1988. The original uilding additions are fully fire , and were determined to be of uction.					
	detection in the corr	re alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion.					

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

PRINTED: 04/23/2021

	OF DEFICIENCIES	& MEDICAID SERVICES		LE CONSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY	
		. ,	01 - MAIN BUILDING 01	COMPLETED		
	245361				03/24/2021	
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER, LLC	-	00 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		
K 000	Continued From pa	ige 2	K 000			
		apacity of 75 beds and had a				
	NOT MET as evide	The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:				
K 351 SS=D	Sprinkler System - CFR(s): NFPA 101	Installation	K 351		4/15/21	
	construction type, a approved automatic accordance with NF Installation of Sprin In Type I and II con measures are perm sprinkler protection or local regulations In hospitals, sprinkl closets of patient sl of the closet does r sprinkler coverage required by NFPA 1 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9 This REQUIREMEN by: Based on observat facility failed to inst accordance with the (NFPA 101), section of NFPA 13, The S Sprinkler Systems, condition could cau	d hospitals where required by are protected throughout by an c sprinkler system in FPA 13, Standard for the kler Systems. struction, alternative protection nitted to be substituted for in specific areas where state prohibit sprinklers. lers are not required in clothes leeping rooms where the area not exceed 6 square feet and covers the closet footprint as 13, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5,		K 351- Sprinkler System- Installation Sprinkler head located in PPE stor room was moved on 4/15/2021 Sprinkler heads will be maintained monthly preventative maintenance program.	l by	

		AND HUMAN SERVICES				FORM /	04/23/2021 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				E CONSTRUCTION ( 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245361	B. WING	;		03/2	24/2021
	PROVIDER OR SUPPLIER	ATION CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 351	on 03/24/2021, obs head is in the PPE soffit than the allow	between 9:00 AM to 1:30 PM servations revealed a sprinkler Storage room is closer to a vable 4 inches.	K	351	Facility will monitor though monthly r of documentation in PM system. Facility is alleging compliance on 4/15/2021.	eview	

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

If continuation sheet Page 4 of 4