DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: MCDQ Facility ID: 00390

| 1. MEDICARE/MEDICAID PROVID (L1) 245367 2.STATE VENDOR OR MEDICAID II (L2) 346314100 | | 3. NAME AND AI (L3) MEADOW I (L4) 210 EAST G | MANOR RAND AVEN | | OX 365 (L6) 55936 | 4. TYPE OF ACT 1. Initial 3. Termination | 2. Recertification 4. CHOW |
|---|-----------------|--|---|--------------------------|---|--|---------------------------------|
| 5. EFFECTIVE DATE CHANGE OF (L9) | OWNERSHIP | 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual | | GORY 09 ESRD 10 NF | 02 (L7) 13 PTIP 22 CLIA 14 CORF | 5. Validation 7. On-Site Visit 8. Full Survey A | |
| 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | (L10) | 03 SNF/NF/Distinct 04 SNF | 07 X-Ray 08 OPT/SP | 11 ICF/III 12 RHC | D 15 ASC 16 HOSPICE | FISCAL YEAR EN | DING DATE: (L35) |
| 11. LTC PERIOD OF CERTIFICATIO | N | 10.THE FACILITY | | AS: | And/Or Approved Waivers O | f The Following Pequir | amante. |
| From (a): To (b): | | | equirements e Based On: | | 2. Technical Personne 3. 24 Hour RN | | Services Limit |
| 12.Total Facility Beds | 43 (L18) | 1. A | cceptable POC | | 4. 7-Day RN (Rural S) 5. Life Safety Code | | oom Size |
| 13.Total Certified Beds | 43 (L17) | | npliance with Prog ents and/or Appli | | * Code: A | (L12) | |
| 14. LTC CERTIFIED BED BREAKDO |)WN | | | | 15. FACILITY MEETS | | |
| 18 SNF 18/19 SNF 43 | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | | |
| 16. STATE SURVEY AGENCY REM Post certification revisit (1 | , | | | , | pleted on April 21, 2014 | . Refer to CMS f | form 2567B. |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY | Y APPROVAL | Date: |
| Gary Nederhoff, Unit Su | pervisor | | 05/1/2014 | (L19) | Kamala Fiske-Downing, 1 | Enforcement Spe | cialist 06/20/2014 (L20) |
| PA | RT II - TO BE | COMPLETED I | BY HCFA RE | EGIONA | L OFFICE OR SINGLE S | STATE AGENCY | |
| 19. DETERMINATION OF ELIGIBI | | | IPLIANCE WITH HTS ACT: | H CIVIL | 21. 1. Statement of Fina2. Ownership/Contr | ancial Solvency (HCFA- rol Interest Disclosure St | |
| X 1. Facility is Eligible to I 2. Facility is not Eligible | - | | | | 3. Both of the Abov | ee : | |
| 22. ORIGINAL DATE | 23. LTC AGREE | MENT 24 | 4. LTC AGREEN | MENT | 26. TERMINATION ACTION | ſ: | (L30) |
| OF PARTICIPATION 12/01/1986 | BEGINNING | G DATE | ENDING DA | TE | VOLUNTARY 01-Merger, Closure | | UNTARY to Meet Health/Safety |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburs | | to Meet Agreement |
| 25. LTC EXTENSION DATE: (L27) | • | n of Admissions: | (L44) | | 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal | OTHE | vider Status Change |
| | B. Rescind Si | uspension Date: | (L45) | | | | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY | | | 30. REMARKS | | |
| | (L28) | 03001 | | (L31) | Posted 07/02/201 | 4 Co. | |
| 31. RO RECEIPT OF CMS-1539 | 32 | 2. DETERMINATION 04/21/2014 | OF APPROVAL | L DATE | | | |
| | (L32) | - · -, | | (L33) | DETERMINATION APP | ROVAL | |



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245367

June 20, 2014

Mr. James Ingersoll, Administrator Meadow Manor 210 East Grand Avenue, PO Box 365 Grand Meadow, Minnesota 55936

Dear Mr. Ingersoll:

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 15, 2014 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File=



Protecting, Maintaining and Improving the Health of Minnesotans

May 1, 2014

Mr. James Ingersoll, Administrator Meadow Manor 210 East Grand Avenue, PO Box 365 Grand Meadow, Minnesota 55936

RE: Project Number S5367024

Dear Mr. Ingersoll:

On April 1, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 6, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 21, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 15, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 6, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 6, 2013, effective April 15, 2014 and therefore remedies outlined in our letter to you dated April 1, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kumala Fiske Downing

Licensing and Certification Program, Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number 245367 | (Y2) Multiple Construction A. Building B. Wing | | (Y3) Date of Revisit 4/21/2014 |
|--|--|---|-----------------------------------|
| Name of Facility | | Street Address, City, State, Zip Code | |
| MEADOW MANOR | | 210 EAST GRAND AVENUE, PO GRAND MEADOW, MN 55936 | O BOX 365 |

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

| (Y4) Item | | (Y5) | Date | (Y4) Item | | (Y5) Date | (Y4 | Item | | (Y5) | Date |
|----------------------------|-------------------------|-----------------|--|----------------------------|--------------------|-----------------------------------|---------|---------------------|--------------------|-------|---------------------------------------|
| ID Prefix | F0250 | | Correction Completed 04/15/2014 | ID Prefix | F0280 | Correctio Complete 04/15/20 | ed | ID Prefix | F0281 | | Correction Completed 04/15/2014 |
| Reg. # LSC | 483.15(g)(1) | | | Reg. # LSC | 483.20(d)(3), 483. | 10(k)(2) | | | 483.20(k)(3)(i) | | _ _ _ |
| ID Prefix Reg. # LSC | F0282 483.20(k)(3)(i | i) | Correction Completed 04/15/2014 | ID Prefix Reg. # LSC | F0309 483.25 | Correctio Complete 04/15/20 | ed | | F0315 483.25(d) | | Correction Completed 04/15/2014 |
| | F0329 483.25(I) | | Correction Completed 04/15/2014 | | F0428 483.60(c) | Correctio Complete 04/15/20 | ed | ID Prefix Reg. # | F0441 483.65 | | Correction Completed 04/15/2014 |
| ID Prefix Reg. # LSC | | | Correction Completed | | | Correctio Complete | | ID Prefix | | | Correction Completed |
| ID Prefix Reg. # LSC | | | | ID Prefix Reg. # LSC | | | | Reg. # | | | |
| Reviewed I | су | Reviewed GN/ | KFD | Date: 05/01/20 | 014 | of Surveyor: | 1016 | 0 | | | 1/21/2014 |
| CMS RO | o Survey Con | Reviewed | | Date: | | of Surveyor: Uncorrected D | eficien | ties Was | Summary of | Date: | |
| • | 3/6/2 | - | | | | d Deficiencies (| | | | YES | NO |

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) | Provider / Supplier / CLIA / Identification Number 245367 | (Y2) Multiple Con A. Building B. Wing | IN BUILDING 01 | (Y3) Date of Revisit 4/15/2014 |
|------|---|---|---|-----------------------------------|
| Nam | e of Facility | | Street Address, City, State, Zip Code | |
| MI | EADOW MANOR | | 210 EAST GRAND AVENUE, PO GRAND MEADOW, MN 55936 | D BOX 365 |

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

| (Y4) Item | | (Y5) | Date | (Y4) Item | | (Y5) | Date | (Y4) | Item | (| Y5) | Date |
|---------------|--------------|----------|-----------------------------|------------------|----------|---------------|----------------------|--------|---------------|---------------|-------|-------------|
| | | | Correction | | | | Correction | | | | | Correction |
| ID Prefix | | | Completed 03/21/2014 | ID Prefix | | | Completed 03/27/2014 | | ID Prefix | | | Completed |
| | NFPA 101 | | | | NFPA 101 | | = | | . | | | |
| • | K0062 | | | | K0147 | | - | | LSC | | | <u> </u> |
| | | | Correction | | | | Correction | | | | | Correction |
| 10.0 (| | | Completed | 15.5 (| | | Completed | | | | | Completed |
| | | | | | | | - | | | | | <u> </u> |
| Reg. # LSC | | | | Reg. # LSC | | | = | | Reg. # LSC | - | | <u> </u> |
| | | | Correction | | | | Correction | | | | | Correction |
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| Reg. # LSC | | | | Reg. # LSC | | | - | | Reg. # LSC | | | |
| | | | Correction | | | | Correction | | | | | Correction |
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| Reg. # | | | | Reg. # | | | = | | | | | |
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| | | | Correction | | | | Correction | | | | | Correction |
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| Reg. # | | | | Reg. # | | | _ | | Reg. # | | | |
| | | | | | | | - - | | | | | |
| | | | | | | | | | | | | |
| Reviewed I | Ву | Reviewed | | Date: 05/01/2 | Sig | nature of Su | rveyor: 25 | 222 | | | Date: | |
| State Agen | су | GS/K | FD | 05/01/2 | U 14 | | 200 | | | | | 4/15/2014 |
| Reviewed I | Ву Г | Reviewed | Ву | Date: | Sig | nature of Su | rveyor: | | | | Date: | |
| CMS RO | | | | | | | | | | | | |
| Followup t | o Survey Com | - | : | | Check | for any Unco | rrected Defi | cienci | ies. Was a | Summary of | | |
| | 3/5/20 | 14 | | | unc | orrected Defi | ciencies (Cl | 113-23 | or) Sent to | ine racility? | YES | NO |

Form CMS - 2567B (9-92) Page 1 of 1 Event ID: MCDQ22

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

| | | | | | TE SURVEY AGENCY | | ID: MCDQ Facility ID: 00390 |
|--|--|---|---|--|--|---|---|
| 1. MEDICARE/MEDICAID PROVIDI (L1) 245367 2.STATE VENDOR OR MEDICAID N (L2) 346314100 | | 3. NAME AND AE (L3) MEADOW M (L4) 210 EAST G (L5) GRAND ME | MANOR RAND AVEN | | OX 365 (L6) 55936 | 4. TYPE OF A 1. Initial 3. Terminati 5. Validation 7. On-Site V | 2. Recertification on 4. CHOW 6. Complaint |
| 5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 03/06 8. ACCREDITATION STATUS: 0 Unaccredited 1 TIC | 5/2014 (L34) (L10) | 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | OPPLIER CATEO 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP | GORY 09 ESRD 10 NF 11 ICF/III 12 RHC | 02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE | 8. Full Surve | ey After Complaint ENDING DATE: (L35) |
| 2 AOA 3 Other 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 43 (L37) (L38) | 43 (L18) 43 (L17) | Complianc1. Ac1. Y B. Not in Com | nce With equirements e Based On: cceptable POC | gram | And/Or Approved Waivers O 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): | 6. Scope 7. Medi | e of Services Limit cal Director nt Room Size /Room |
| 16. STATE SURVEY AGENCY REM See Attached Remarks 17. SURVEYOR SIGNATURE Michele McFarland, | | Date : | A/15/2014 | | 18. STATE SURVEY AGENC Kamala Fiske-Downing | | Date: Speciali st 04/21/2014 (L20 |
| PA 19. DETERMINATION OF ELIGIBIL 1. Facility is Eligible to F 2. Facility is not Eligible | JTY Participate | 20. COM | BY HCFA RI | EGIONAI | 21. 1. Statement of Fin 2. Ownership/Cont 3. Both of the Abov | ancial Solvency (HCl rol Interest Disclosur | CY |
| 22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24) 25. LTC EXTENSION DATE: (L27) | 23. LTC AGREEN BEGINNING (L41) 27. ALTERNATT A. Suspension | DATE | LTC AGREEN ENDING DA (L25) (L44) (L45) | | 26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbur 03-Risk of Involuntary Terminat 04-Other Reason for Withdrawa | 0 INV 05-1 Sement 06-1 OT-1 1 OT-1 | (L30) COLUNTARY Fail to Meet Health/Safety Fail to Meet Agreement HER Provider Status Change Active |
| 28. TERMINATION DATE: 31. RO RECEIPT OF CMS-1539 | (L28) | . INTERMEDIARY/ 03001 . DETERMINATION | CARRIER NO. | (L31) | 30. REMARKS Posted 04/21/20 | 14 CO. | |
| 2 Ro RECHI I OI CMD*1337 | (L32) | . DETERMINATION | JI MI KO VAI | (L33) | DETERMINATION APP | PROVAL | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00390

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN-24-5367

At the time of the standard survey on March 6, 2014 the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8262

April 1, 2014

Mr. Jim Ingersoll, Administrator Meadow Manor 210 East Grand Avenue, PO Box 365 Grand Meadow, Minnesota 55936

RE: Project Number S5367024

Dear Mr. Ingersoll:

On March 6, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Meadow Manor April 1, 2014 Page 2

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904 Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 15, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its

effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Meadow Manor April 1, 2014 Page 4

occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 6, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 6, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

Meadow Manor April 1, 2014 Page 5

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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections, State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kumalu Fiske Downing

Licensing and Certification Program, Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 03/25/2014 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | AREKONSTRUCTION MN Dept of Health | | E SURVEY PLETED. |
|---------------|---|---|----------------|---|---|---|
| 1 | | 245367 | B. WING _ | Rochester | 03/0 | 06/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | A | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/1 | 30/2014 |
| MEADO\ | W MANOR | | | 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | | |
| (X4) ID | SUMMARY STA | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECT | ON | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | COMPLÉTION DATE |
| F 000 | INITIAL COMMEN | TS | F 00 | 00 | · | |
| | as your allegation of Department's acce | of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance. | | | | |
| F 250 SS=D | revisit of your facilit validate that substa regulations has bee your verification. | acceptable POC an on-site by may be conducted to untial compliance with the en attained in accordance with SERVICE | F 25 | 50 | | AL VIVIA EDAVED TO ESTATE ANY EDA |
| | services to attain o | ovide medically-related social r maintain the highest I, mental, and psychosocial resident. | | The preparation of the following correction for this deficiency doe constitute and should not be into | s not erpreted | |
| | by: Based on interview facility failed to provide services to attain or practicable, physical well-being for 1 of 1 | NT is not met as evidenced and document review, the vide medically-related social maintain the highest al, mental and psychosocial resident (R10) with limited e English language spoken or | | as an admission nor an agreement facility of the truth of the facts a conclusions set forth in the state deficiencies. The plan of correction prepared for this deficiency was solely because it is required by pof State and Federal law. Without the foregoing statement, the fact states that with respect to: | leged on ment of on executed rovisions t waiving | |
| | with diagnosis that hemorrhage due to dysphasia due to ce | on to the facility on 12/12/13 included intracerebral cerebrovascular disease and erebrovascular disease, | 4/10/14 GPN | 1. Interpreter services were of R10, family declined services been discharged from the nu facility. TILLE | . R10 has | S X6) DATE |

Any defigency 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: 03/25/2014 FORM APPROVED OMB NO. 0938-0391

| | | = & MEDICAID SERVICES | | | C | MB NO | . 0938-0391 |
|--------------------------|---|--|--------------------------|------|---|----------|---|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | | CONSTRUCTION U / 2014 MN Dept of Health | (X3) DAT | E SURVEY MPLETED |
| | | 245367 | B. WING | | Rochester | 03/ | /00/004 <i>/</i> I |
| NAME OF | PROVIDER OR SUPPLIER | <u> </u> | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | 03/ | 06/2014 |
| MEADO' | W MANOR | | | | EAST GRAND AVENUE, PO BOX 365 | | |
| | | | | | AND MEADOW, MN 55936 | | ** |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | DBE . | (X5) COMPLETION DATE |
| F 250 | Continued From pa | age 1 | F 250 | 0 | | | |
| (1974). A. | 1 | cian orders dated 2/27/14. | | ! | All residents were reviewed to | - 500 if | |
| Jayriki Tarihin | | 44 | | ۷. | | o see ii | |
| fort. | H10's admission will 12/18/13 indicated | inimum Data Set (MDS) dated "Yes" to the question R10 | İ | | there are language barriers. | | in the second |
| 1 | needed or wanted a | an interpreter to communicate | ı | - | Completion date: 3/28/14 | | |
| 1 | with a doctor or hea | alth care staff. Identified | I | 3. | Staff to be educated on revise | | |
| I | preferred language | as Cambodian, had unclear er makes self-understood and | I | | facility policy. Completion da | te: | |
| | rarely/never unders | ar makes sen-understood and stands others. | I | | 4/8/14 | | - 1: |
| | | | | 4. | Social Service will determine, | upon | - 10 10 10 10 10 10 10 10 10 10 10 10 10 |
| | | ted 12/24/14 identified a | | | each admission, if there is a la | • | |
| | | Cambodian was primary n interventions read, "Provide | | | barrier and initiate policy whe | | • |
| <u> </u> | translator as availab | ble to communicate. Daughter | | | needed. | 311 | |
| | or son will assist wh | nen they are present. Use | | r. | | ا داد م | . A |
| | communication tech | nniques which enhance dequate time to respond, | | Э. | Upon admission of a resident | | |
| | Repeat as necessar | ry, Do not rush, Request | | | language barrier, Social Servic | | 3 |
| | feedback, clarification | on from the resident to ensure | | | audit 2x per week for a month | | ere many merce a company |
| | | e when speaking and make ff TV/radio as needed to | | | then 1x per month to ensure t | that | N. A. |
| | reduce noise, Ask y | | | | residents who have a limited | | 1 |
| | appropriate, Use sin | mple, brief, consistent | | | understanding of the English I | anguag | e |
| | | remative communication tools | | | spoken or written needs are n | | · |
| | | munication book, gestures, " However, the facility did not | | 6, | The data collected will be pres | | |
| | provide interpreter s | services and staff were not | | | to the QA committee. The data | | , |
| | observed to use pict | ture communication tools to | | | | | |
| | communicate with re | esident. | | | be reviewed at the quarterly C | | |
| | During an interview | on 3/4/14 at 2:46 p.m. | | | Assurance meeting. At this tir | ne the | |
| | registered nurse (RN | N)-D stated there are times | | | QA committee will make a | • | |
| | | ea what she needs. We use | | | decision/recommendation re | egarding | g |
| | watch what she is do | ng toileting, food, drink and oing to see if we can | | | any necessary follow-up stud | | |
| | determine what she | needs. R10 was observed | | 7. | | for this | 1/15/14 |
| | while interviewing RN | N-D to wheel self over to a | | | area of compliance. | 101 65 | 1. 14 |
| * | rocking chair and sta | arted rocking the empty chair. | | | area of compliance. | egel | HXTT 1 |

RN-D excused self from the interview and

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | PR 07 2014 | | TE SURVEY MPLETED |
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| | | 245367 | B. WING _ | MN Dept of Health | 03. | /06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | STREET ADDRESS, CTY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | 1 00. | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE. |
| F 250 | room. RN-D kneele as R10 spoke to he (possibly Cambodia informed writer, sor resident to talk to st changed during the room. R10 started t sounded sad said F sorry" to R10 and F no English words. E and RN-D no pictur other communication asked RN-D where tools were kept, RN was unable to locate During an observation nursing assistant (Not kneeling down by R area of the facility. I language and not use R10 to her room an she was speaking pattempted to communication she was speaking pattempted to communication she was speaking pattempted to communication she was speaking pattempted to communicate she word "Bed" are continued to speak Cambodian. NA-D hallway close to the R10 yogurt to eat. No sure that was what its continued to speak sure | d wheeled her back to her d down by R10 and listened r in a different language an.) RN-D smiled at R10 and netimes it works to just allow aff. R10's tone of voice interaction with RN-D in her or cry and tone of her voice interaction with RN-D in her or cry and tone of her voice interaction with RN-D in her or cry and tone of her voice interaction with RN-D in her or cry and tone of her voice interaction with RN-D then stated, "I'm 10 continued to speak using ouring the dialog between R10 er communication sheets or in tools were. When surveyor the picture communication -D stated in R10's room but the them at this time. In on on 3/4/14 at 3:44 p.m. In on on | F 25 | 50 | | |
| | offer her some wate took a drink of her w then took another dr poured the water on | nack and thought she would r. R10 ate her yogurt and vater. R10 became tearful, ink of the water and then her hands. NA-D asked R10 sh her hands. NA-D verified | | | | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILE | _TIPI DING | LE CONSTRUCTAPR 0 7 2014 | | TE SURVEY MPLETED |
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| | | 245367 | B. WING | i | MN Dept of Health Rochester | 02 | 2/06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | 1 03 | 3/06/2014 |
| (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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 250 | while communication picture communication | ige 3 ring their interaction. Again on with R10 NA-D did not use tion sheets or tools to assist it R10 was attempting to | F2 | 250 | | | |
| | stated R10 knows s toileting, food, thirty was able to say " Y the meaning for the facility used to have sheets to use to con However, NA-F state | on 3/5/14 at 11:12 a.m. NA-F some words in English such as the tired/sleep and stated R10 es or No " and understand most part. NA-F stated the epicture flashcards, and paper municate with R10. and R10's family (F)-A took words in her language on | | | | | ************************************** |
| | them and didn't thin facility. This was so home. NA-F verified staff were unable to stated staff provided frequently for R10. I interpreter services NA-F stated, "I wish to interpreter] becaushe is saying. I wish to be unable to undereally in. She might realize. An interpreter | k they ever got back to the me time ago F-A took them d when R10 became agitated tell why R10 was upset. NA-F d one to one supervision quite NA-F was unaware of any available to use with R10. we did have one [reference use we can't understand what we could have an interpreter erstand how much pain she is be in more pain than we er would help us to know what er able to provide for her." | · | | | | |
| | stated staff used ha sleepy. We have fla are kept in top draw the nurses' station. I used those since R1 wing about a month thought the flashcar | on 3/5/14 at 2:36 p.m. NA-G nd singles for, drink, eat, shcards, to use with R10 that er of her nightstand and at NA-G stated she had not 0 had a room on the west ago. NA-G stated she ds " frightened her when she was in a new place and you | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILE | | CONSTRUCTION APR 0 7 2014 | (X3) DA | TE SURVEY MPLETED |
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| | | 245367 | B. WING | | MN Dept of Health | 0.3 | 3/06/2014 |
| | PROVIDER OR SUPPLIEF W MANOR | | • | 210 | REET ADDRESS, CITY, STATE Y P CODE DEAST GRAND AVENUE, PO BOX 365 RAND MEADOW, MN 55936 | 1 00 | 700/2014 |
| (X4) ID PREFIX CAS TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 250 | could tell she was first got here. I wou would shake her h she gets agitated. her, in a place that nobody understand any interpreter ser communicate with nice if they did hav During an interview director of nursing staff to use the corworking with R10. was unable to have because R10 spok stated when R10 b facility staff would despeak to her in the relay to staff what is she needed. The D | scared and anxious when she ald hold up a flashcard and she ead. I totally understand why It must be so frustrating to be she is not used to and where ds her." NA-G was unaware of vices that could be utilized to R10 and stated it would be e interpreter service to use. If on 3/6/14 at 8:25 a.m. the (DON) stated she expected numerication sheets when The DON verified facility staff e conversations with R10 e Cambodian only. The DON ecame upset and agitated call the family and have them if language and family would she was upset about and what lon verified the facility had not as for interpreter services to | F2 | | | | |
| | Proficient Persons read, "Policy: Gran Center shall make communication with persons (LEP), incl residents, family, in ensure an equal op services as non-LE procedure will ensumet at no cost to th Procedure: 1. A qualified inter LEP resident, prosp | n with Limited English undated policy and procedure and Meadow Health Care provisions for effective a Limited English Proficient uding current and prospective terested persons, etc., to portunity to benefit from our P persons. The following re that language needs are a LEP resident. | | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | 2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--------------------|-----------------------------------|---|-----|---|--|
| | | 245367 | B. WING | | | 03, | /06/2014 | |
| | PROVIDER OR SUPPLIER W MANOR | , | | 210 | EET ADDRESS, CITY, STATE, ZIP CODE EAST GRAND AVENUE, PO BOX 365 AND MEADOW, MN 55936 | | | |
| (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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 250 | as need is identified 2. Need is identified 2. Need is identified assistance may include bank listing, profession and/or use of a tele Language assistant the Language Resolution. 3. Should a professistaff shall make arragencies in the Language nointerpreter. 4. The offer of an in the resident 's reoffer was accepted phone number, name and summary of pure 5. The use of familiand volunteers and prohibited unless it after a qualified interpret | well as during other services | F2 | 50 | | | 0.00004 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 | |
| | During an interview services (SS)-A verifamily if they would for interpreter service her nursing home standiscussions with F-A and family indicated needed. SS-A stated the internet to utilize | on 3/6/14 at 9:22 a.m. social fied she did not offer or ask like arrangements to be made ses to be used for R10 during say. SS-A stated she had about the language barrier they would help interpret as d she looked for flashcards on | | | | | - netatra) - netatra) - netaron (1 - netaron (1 - netaron (1 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING | PLE CONSTRUCTION G APR 0.7 2014 | (X3) DATE COMPI | SURVEY LETED | |
|--|---|---|-----------------------------------|---|--|----------------------------|
| | | 245367 | B. WING | | 03/0 | 6/2014 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CHOCKES AT E. ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | O BE | (X5) COMPLETION DATE |
| F 280 SS=D | SS-A stated during she also involved fa flash cards for pain make the flash card followed through wi the facility. SS-A ve the policy and proced Limited English Proservices for R10. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under participate in plannic changes in care and A comprehensive asset interdisciplinary tea | the second care conference amily by asking F-A to develop an SS stated F-A stated they do for pain, however never ith providing a flashcards to erified the facility did not follow redure for Communication with officient Persons undated policy IO(k)(2) RIGHT TO INNING CARE-REVISE CP In eright, unless adjudged erwise found to be are the laws of the State, to ining care and treatment or and treatment. The care plan must be developed the completion of the sessment; prepared by an am, that includes the attending | F 250 | 0 | not rpreted t by the eged on nent of | |
| | for the resident, and disciplines as deter and, to the extent p the resident, the resident, the resident representative and revised by a teach assessment. This REQUIREMENT by: Based on observat | ered nurse with responsibility d other appropriate staff in rmined by the resident's needs, oracticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after NT is not met as evidenced tion, interview and document ailed to care plan use of lateral | | solely because it is required by proof State and Federal law. Without the foregoing statement, the facili states that with respect to: 1. Care plan and care sheets were updated for resident R5 to include positioning device per OT recommendation. Completion 3/28/14. 2. A comprehensive assissment for | ovisions waiving ity re lude n date: | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---|-----|--|--|----------------------------|
| | | 245367 | B. WING | | APR 07 2014 | 03/0 | 06/2014 |
| | PROVIDER OR SUPPLIER | | | 21 | REET ADDRESS ^{MO} IPPPS中衛村連邦的P CODE Rochester IO EAST GRAND AVENUE, PO BOX 365 RAND MEADOW, MN 55936 | 2 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | ıx | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE . | (X5) COMPLETION DATE |
| F 280 | Findings include: R5's care plan prin impaired physical r for position change locomotion, dependent from desired destinaddress the use of used for positioning. During observation had been in lobby sight side up agains observed to be leablue Styrofoam part 3/4/14, at 12:58 p.r at 12:13 p.m., and Occupational Theridentified reason for posture as result or chair on 11/2/13 ar positioning difficult time for wheelchair as needed in order improve safety and wheelchair. R5's OT progress | heelchair for 1 of 1 resident | F 2 | 280 | positioning devices has been completed for all residents. plans and care sheets update reflect current positioning de Completion date: 4/4/2014. 3. All residents will be screened quarterly by a licensed thera 4. The DNS and/or designees we two residents a week for one then one resident a week for month to ensure that the serprovided follow the needs or resident care plans. 5. The data collected will be provided to the QA committee. The designees were reviewed at the quarterly Assurance meeting. At this to QA committee will make a decision/recommendation reany necessary follow-up stude. 6. The DNS is responsible for the compliance. | Care ed to evices. I pist. fill audit e month r one rvices n the esented ata will v Quality time the egarding dies. | g . |
| | positioning, R5 will achieve effective p wheelchair utilizing | require total assistance to ositioning while seated in wheelchair modifications as aning to side, reduce the risk | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|--|---|--|
| | | 245367 | B. WING | | 03/06/2014 | |
| | PROVIDER OR SUPPLIER V MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | 1 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION | |
| F 280 | of skin breakdown to reduce the risk of During interview on registered nurse (Richard Known why blue Styrofoam padand was not on nurplan. During interview on of nursing stated styrofoam pad posplanned. Document review of Document review of Document review of the reduced styrofoam padans of the reduced styrofoam pad | and achieve optimum position f falls. 3/6/14, at 8:30 a.m., N)-A had stated had not profoam pad was being used een put in place. RN-A verified was not on R5's care plantsing assistant pocket care 3/6/14, at 11:15 a.m., director ne would expect the blue itioning device to be care | F 280 | | 15-20-1 | |
| F 281 SS=D | Plans should include Focus Problems the services provided must meet professional street by: Based on observative review, the facility focus of the services provided must meet professional street profession | RVICES PROVIDED MEET STANDARDS ded or arranged by the facility onal standards of quality. NT is not met as evidenced tion, interview, and document ailed to develop initial care or 1 of 1 resident (R54) | F 28 | The preparation of the following correction for this deficiency doe constitute and should not be into as an admission nor an agreeme facility of the truth of the facts a conclusions set forth in the state deficiencies. The plan of correcti prepared for this deficiency was solely because it is required by p of State and Federal law. Withouthe foregoing statement, the facts attacts that with respect to: | es not erpreted nt by the Illeged on ement of on executed provisions ut waiving | |

| | | CA WEBTOTHE CETTVICE | | | | | 1410 140. | 0000 0001 |
|--------------------------|--|---|----------------------|-----|-------|---|-----------|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | | APR 0 7 2014 | | E SURVEY PLETED |
| | | 245367 | B. WING | | | | | |
| NAME OF | DDOVIDED OD OUDDI IED | 245367 | B. WING | - | | MN Dept of Health Rocheste ET ADDRESS, CITY, STATE, ZIP CODE | 03/ | 06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | | | | | |
| MEADO | W MANOR | | | | | AST GRAND AVENUE, PO BOX 365 ND MEADOW, MN 55936 | | |
| (//) ID | . SLIMMADV STA | TEMENT OF DEFICIENCIES | | | 11101 | PROVIDER'S PLAN OF CORRECTIO | NI . | 0.00 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 281 | Continued From pa | ae 9 | F 2 | | | | | · |
| 1 201 | R54 was observed on 3/3/14, at 4:26 p.m., with | | Г | 201 | | | | |
| | | e discolorations on right and | | | 1. | A comprehensive care plan v | was | |
| • . | left arms and hands | | | | | completed for resident numb | er R54. | 14 × 1 |
| | | | | | | Care data sheets have been u | | |
| | | o the facility on 2/26/14, with ded Alzheimer's disease, | | | 2. | | • | |
| | | ruction, and kidney disease | | | ۷. | | • | |
| | | to facility progress notes dated | | | | upon admission. Care plan a | | |
| | 3/6/14. | | | | | sheets will be revised with ch | ianges t | O (1, 1) |
| + 111 1 - | Englishy admission b | eady audit dated 2/26/14 | | | | initial plan of care. | | |
| | Facility admission body audit dated 2/26/14 identified multiple bruising to left and right forearms, upper arms, and abdominal area. | | | | 3. | Conditions/follow-up chartin | g tool | 1374 1 2 |
| | | | | | | was implemented with nursi | ng note: | s * 1 12 |
| | DEAL SILL | 1 - 1 - 1 - 1 - 0 / 4 / 4 4 1 - 1 | | | | for documentation. Complet | - | |
| | | lan dated 3/4/14, revealed no tiple bruised areas and no | | | | 3/5/14. | ion date | |
| WO. | | re related to bruised areas. | | | 1 | | | |
| ř. : | | | | | 4. | zidensed stan win be re edde | | |
| | | f facility nursing assistant care aled no identification of | | | | the completion of an initial ca | are plan | Martine (M. 1. 1. 1.) |
| | | eas and no interventions for | | | | on: 4/8/20104. | | |
| | care related to bruis | | | | 5. | The DNS and/or designees w | ll audit | |
| | Desire a factor of | 0/5/4/4 0:07 | | | | each new resident one time p | er wee | k |
| | | 3/5/14, 3:37 p.m., with R)-A identified R54's initial | | | | for one month then one resid | lent a | |
| | | e chart, dated 3/4/14, and | | | | week for one month to ensur | e that | |
| | verified the lack of i | dentification of multiple | | | | the services provided follow | | |
| | | rview at that time, registered ant stated the nursing | | | | · | | · |
| | | plan included initial care | | | _ | needs on the resident care pl | | |
| | instructions for staff | . During interview at that | | | 6. | The data collected will be pre | | |
| | | verified NA care plan lacked | | | | to the QA committee. The da | | |
| • | identification of mul- | upie oruises. | | | | be reviewed at the quarterly | Quality | |
| i.d | During interview on | 3/6/14, at 12:30 p.m., director | | | | Assurance meeting. At this ti | me the | |
| , v., | | e expected the initial care | | | | QA committee will make a | | A GARAGE |
| | | ght way at the time of of of nursing verified the lack of | | }. | | | | |
| | | admission of 2/26/14 to | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|------------------------------------|--|---|
| | · | 245367 | B. WING _ | | 03/06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | , |
| MEADO | W MANOR | | | 210 EAST GRAND AVENUE, PO BOX 365 | |
| | 0/4445/074 | TELEVIS OF DEFICIENCES | , <u> </u> | GRAND MEADOW, MN 55936 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLÉTION DATE |
| * | | 9 | | decision/recommendation re | egarding |
| F 281 | Continued From pa | _ | F 28 | any necessary follow-up stud | lies. |
| | 3/6/14 that included identification of multiple | | | 7. The DNS is responsible for th | is area of |
| F 000 | multiple bruises. | staff interventions related to | F 00 | compliance. | 4/15/14 |
| F 282 SS=D | 1 // // | | F 28 | The preparation of the following | plan of |
| 00-2 | | | | correction for this deficiency doe | es not |
| | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. | | | constitute and should not be inte | erpreted |
| | | | | as an admission nor an agreeme | · . |
| | | | | facility of the truth of the facts a | 4.7.754 (4.7.3) |
| | | | conclusions set forth in the state | | |
| | This REQUIREMEN | IT is not met as evidenced | | | , |
| | by: | | | deficiencies. The plan of correction | i |
| | | ion, interview, and record ailed to implement care plan | | prepared for this deficiency was | |
| A-761 | | nmunication for 1 of 1 | | solely because it is required by p | l |
| v41 | resident (R10) revie | wed with limited | | of State and Federal law. Withou | t waiving |
| | understanding of the written. | e English language spoken or | | the foregoing statement, the fac | ility |
| | willen. | | | states that with respect to: | |
| | Finding Include: | | | | |
| ***** | R10 was admitted o | n to the facility on 12/12/13 | | 1. Interpreter services were off | |
| | | ncluded intracerebral | | family declined services. R10 |) has |
| | hemorrhage, cerebr | ovascular disease and | | been discharged from the nu | rsing |
| | | rebrovascular disease, an orders dated 2/27/14. | | facility. | |
| | according to physicis | an orders dated 2/27/14. | | 2. All residents were reviewed t | co see if |
| | | ed 12/24/14 identified a | | there are language barriers. | |
| | | Cambodian was primary interventions read, "Provide | | Completion date: 3/28/14. | |
| | | le to communicate. Daughter | | 3. Staff to be educated on revis | ed |
| | or son will assist when they are present. Use | | | facility policy. Completion da | A Same I |
| | | niques which enhance equate time to respond, | | 4/8/14. | [] [SVI] [] [SVI] [] |
| | Repeat as necessar | y, Do not rush, Request | | 4. Social Service will determine, | unon |
| | feedback, clarification | on from the resident to ensure | | each admission, if there is a l | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | LE CONSTRUCTION | (X3) DAT | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--------------------|---|---|---|-------------------------------|--|
| | | 245367 | B. WING | | | 03/06/2014 | | |
| NAME OF | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00. | 100/2014 | |
| MEADO\ | W MANOR | | | | 210 EAST GRAND AVENUE, PO BOX 369 GRAND MEADOW, MN 55936 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| · . | understanding, Face eye contact, Turn of reduce noise, Ask y appropriate, Use sir words/cues, Use alt as needed, i.e. com signs, and pictures. provide interpreter sobserved to use piccommunicate with reduced interpreter sobserved nurse (RI when we have no id trial and error, offeri watch what she is determine what she while interviewing R rocking chair and str. RN-D excused self tapproached R10 and room. RN-D kneeled as R10 spoke to her (possibly Cambodia informed writer, som resident to talk to stachanged during the room. R10 started to sounded sad said R sorry" to R10 and R10 and R10 and R10 and RN-D no picture other communication asked RN-D where to tools were kept, RN-was unable to locate. | e when speaking and make ff TV/radio as needed to res/no questions if mple, brief, consistent ternative communication tools munication book, gestures, "However, the facility did not services and staff were not ture communication tools to esident. on 3/4/14 at 2:46 p.m. N)-D stated there are times lea what she needs. We use ng toileting, food, drink and oing to see if we can needs. R10 was observed N-D to wheel self over to a arted rocking the empty chair. from the interview and d wheeled her back to her d down by R10 and listened in a different language n.) RN-D smiled at R10 and netimes it works to just allow aff. R10's tone of voice interaction with RN-D in her or cry and tone of her voice N-D. RN-D then stated, "I'm 10 continued to speak using uring the dialog between R10 e communication sheets or n tools were. When surveyor the picture communication but them at this time. | F 2 | | barrier and initiate policy needed. 5. Upon admission of a reside language barrier, Social Seaudit 2x per week for a month to ensure residents who have a limite understanding of the Englisspoken or written needs are for the QA committee. The be reviewed at the quarter Assurance meeting. At this QA committee will make a decision/recommendation any necessary follow-up social Service is responsible area of compliance. | ent with a rvice will nth and re that ed h language e met. resented data will y Quality time the n regardir tudies. | ge | |
| | | A)-D was observed to be | | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | E SURVEY PLETED |
|--------------------------|---|---|--|--|------------------------------|----------------------------|
| | | 245367 | B. WING | | 03/0 | 06/2014 |
| | PROVIDER OR SUPPLIER V MANOR | à · | | STREET ADDRESS, CITY, STATE, ZIP 210 EAST GRAND AVENUE, PO BC GRAND MEADOW, MN 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 282 | area of the facility. language and not upon to her room and the was speaking attempted to commodified attempted to commodified and closing the word "Bed" as continued to speak Cambodian. NA-District hallway close to the R10 yogurt to eat. Sure that was what R10 was having a offer her some wat took a drink of her then took another of the poured the water of the waste of the waste of the waste afful during while communicating picture communicating sure was speaked. | age 12 R10's wheelchair in a common R10 was speaking a different using English. NA-D wheeled and continued to listen to R10 as possible Cambodian. NA-D municate with R10, by stating "g her hands up to the side of g her eyes. NA-D also stated and pointed at the bed. R10 to NA-D in possible wheeled R10 back into the enurses' station and gave NA-D stated she wasn't really R10 wanted. NA-D stated snack and thought she would er. R10 ate her yogurt and water. R10 became tearful, drink of the water and then in her hands. NA-D asked R10 ash her hands. NA-D verified ring their interaction. Again on with R10 NA-D did not use at R10 was attempting to | F2 | 282 | | |
| F 309 SS=D | director of nursing staff to use the cor working with R10. had not followed th translator services 483.25 PROVIDE HIGHEST WELL E | CARE/SERVICES FOR BEING | F3 | 309 | | |
| 1904) 1904) 1 | | t receive and the facility must sary care and services to attain | | | | |

| | | WINDOWN DELIVIOUS | ()(0) 1411 | TIDI | (X3) DATE S | LIBVEY | |
|--------------------------|---|---|--|--------|---|--|---|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | COMPLETED | |
| | | 245367 | B. WING | · } | | 03/06 | 6/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | s | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/00 | 72011 |
| | | | | 2 | 10 EAST GRAND AVENUE, PO BOX 365 | | |
| MEADO\ | W MANOR | | | G | RAND MEADOW, MN 55936 | | i wi |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | O BE | (X5) COMPLETION DATE |
| F 309 | mental, and psycho | nge 13 nest practicable physical, osocial well-being, in e comprehensive assessment | F: | 309 | The preparation of the following correction for this deficiency does constitute and should not be into as an admission nor an agreeme facility of the truth of the facts a | es not erpreted nt by the lleged on | All |
| | by: Based on observa review, the facility f services to determi complete assessm reviewed for comm | NT is not met as evidenced tion, interview and document ailed to provide interpreter ne resident care needs and ents for 1 of 1 resident (R10) unication with limited ne English language spoken or | | | conclusions set forth in the state deficiencies. The plan of correcti prepared for this deficiency was solely because it is required by pof State and Federal law. Without the foregoing statement, the fact states that with respect to: | on executed provisions ut waiving | 3. ¹¹ .2 |
| | with diagnosis that hemorrhage, cereb dysphasia, accordi 2/27/14. | on to the facility on 12/12/13 included intracerebral rovascular disease and ng to physician orders dated | | | Interpreter services were of family declined services. R1 been discharged from the na facility. All residents were reviewed | 0 has ursing to see if | |
| | 12/18/13 indicated interpreter to commo care staff. Identified Cambodian, had us makes self-unders understands others. R10's hospital dism | nissal summary dated 12/12/14 erpreter services were needed | | | there are language barriers. Completion date: 3/28/14. 3. Staff to be educated on revifacility policy. Completion of 4/8/14. 4. Social Service will determine each admission, if there is a barrier and initiate policy w | sed late e, upon language | 22001 22001 22001 22002 |
| | R10's care plan da language barrier as | ted 12/24/14 identified a s Cambodian was primary | | | needed. | | |

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|---------------|---|--|---------------------------------------|-----|--|----------|--|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | | TE SURVEY MPLETED |
| | | 245367 | B. WING | ì | | l na | /06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/ | 00/2014 |
| MEADO | W MANOR | | | | 10 EAST GRAND AVENUE, PO BOX 365 | | |
| MEADO | WIMANOR | | | | GRAND MEADOW, MN 55936 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID. | | T | | · |
| PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 309 | Continued From pa | no 14 | | 200 | | | |
| 1 000 | | | F3 | 309 | | | i , |
| | language. Care plan interventions directed staff to, "Provide translator as available to | | | | 5. Upon admission of a residen | : with a | and the residence |
| | communicate. [Fam | nily (F)-B] or [F-A] will assist | | | language barrier, Social Servi | ce will | |
| | when they are presented techniques which or | ent. Use communication | | | audit 2x per week for a mont | h and | |
| | techniques which enhance interaction: Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from the resident to ensure understanding, Face when speaking and make eye contact, Turn off TV/radio as needed to reduce noise, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues, Use alternative communication tools as needed, i.e. | | | | then 1x per month to ensure | that | |
| | | | | | residents who have a limited | | |
| | | | | | understanding of the English | languag | e |
| | | | | | spoken or written needs are | met. | |
| | | | | (| 5. The data collected will be pre | sented | |
| # | | | | | to the QA committee. The da | ata will | |
| | communication bool | k, gestures, signs, and | | | be reviewed at the quarterly | Quality | |
| | | the facility did not provide and staff were not observed | | | Assurance meeting. At this t | me the | |
| | to use picture comm | unication tools to | | | QA committee will make a | | |
| | communicate with re | esident. | | | decision/recommendation re | garding | *. * . |
| 4/2 | | IGATION revealed on | | | any necessary follow-up stud | - | |
| | 12/18/13 at 10:30 p. | m., "Fall Summary: found on Fall Location: Resident | | 7 | 7. Social Service is responsible f | 1 | 1 , 1 s. |
| | Room. Resident Des | scription of what they were | | | area of compliance. | | 4/15/14 |
| | trying to do just prior | to the fall: Resident unable | | | • | | 1000 |
| | | staff. Resident's mental | | | • | - | JONE ! |
| | does not speak Engl | ish and understands little. | | | | | * * ** * * * * * * * * * * * * * * * * * |
| | Resident's psychoso | cial status just prior to fall: | | - | | | |
| | Communication barr | ier- does not speak English | | | | | |
| | and understands little | e. Describe cause of the fall: | | 1 | | | |
| | Statt observed reside | ent to be incontinent of bowel | | | | | |
| | on the floor on her hi | of unwitnessed fall as she sat uttock at edge of bed. | | | | - | |
| | Intervention to preven | nt future falls: 3 day Bowel | | | | | |
| | and Bladder assessn | nent started." | | | | | |
| - | Diological LINIVECT | CATION | | | | | |
| | | GATION revealed on n., "Fall Summary: found on | • | - | | | |
| | | Fall Location: Resident | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDINGAPR 07 2014 | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|-----|--|--|-------------|--|
| | | 245367 | B. WING | | MN Dept of Health | 0.3 | 3/06/2014 | |
| | MEADOW MANOR | | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | | 70072014 | |
| (X4) ID PREFIX TAG | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI TAG | | (EACH CORRECTIVE ACTION SHOULD | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| F 309 | Room. Description just prior to the fall: Describe cause of Intervention to prev | age 15 of what they were trying to do Resident unable to answer. fall: Attempting to self transfer. rent future falls: staff to lay at] 12:00 daily when in room." | F3 | 309 | | | 11 (24) (4) | |
| A STATE OF THE STA | 1/20/14 at 12:30 p.r floor (unwitnessed) Room. Resident de trying to do just pric to communicate. Re just prior to fall: aler Resident's usual psunable to communicate to communicate. Unable to con Describe Cause of bed-since unable to tried to get up sat of under her and both off side of the bed of under her when four with back against thout in front of her. Ir | TIGATION revealed on m., "Fall Summary: found on Fall Location: Resident scription of what they were to the fall: Resident unable esident's psychological status t, unable to communicate. ychological status: alert, cate. Root cause of the fall municate with staff. fall: Resident lying in communicate with staff she nedge of bed with soaker pad soaker pad and resident slid in to the floor. Soaker pad was not sitting on buttock on floor e mattress and legs straight atterventions to prevent future ild better communication estand her needs" | | | | | | |
| | 2/22/14 at 6:10 a.m. floor (unwitnessed). Resident description do just prior to the fa [wheelchair] in lobby what she was doing. Resident attempting Interventions to prev | IGATION revealed on , "Fall Summary: found on Fall Location: Day room. of what they were trying to all: Wheeling in w/c - resident unable to tell staff Describe cause of the fall: to self transfer into chair. ent future falls:ordered to cotine patch. Offer resident | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | TIPLE CONSTRUCTION DING | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|----------------------------|--|--|-------------------------|
| | | 245367 | B. WING | | _ 0 | 03/06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | STREET ADDRESS, CITY, ST. 210 EAST GRAND AVENUE GRAND MEADOW, MN | ATE, ZIP CODE E, PO BOX 365 | 9: 1 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | X (EACH CORRECTIV CROSS-REFERENCEI | IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY) | (X5) COMPLETION DATE |
| F 309 | was observed to be nurses station with NA-C. R10 appear the nursing assista by staff it was Cam speech and a raise attempting to assis through a headpho were no picture corbeing utilized durin NA-C and R10 to he | age 16 tion on 3/4/14 at 9:45 a.m. R10 e sitting in front room of the nursing assistant (NA)-B and ed agitated, was speaking to nts in Cambodian (were told bodian words) with fast ed voice. NA-B and NA-C were t R10 to listen to music ne set and an IPOD. There mmunication sheets or tools g the observation of the NA-B, elp determine what R10 was he staff or what R10's needs | F3 | 309 | | |
| | registered nurse (F when we have no ic trial and error offeri watch what she is condetermine what she while interviewing F rocking chair and so RN-D excused self approached R10 ar room. RN-D kneele as R10 communicat RN-D nurse smiled sometimes it works staff. R10's tone of interaction with RN-cry and tone of her stated, "I'm sorry" to speak to nurse in C picture communication or with the R10 to help determine communicating or when the stated of t | on 3/4/14 at 2:46 p.m. (N)-D stated there are times dea what she needs. We use ng toileting, food, drink and doing to see if we can eneeds. R10 was observed RN-D to wheel self over to a tarted rocking the empty chair. from the interview and nd wheeled her back to her d down by R10 and listened ted to her in Cambodian. at R10 and informed writer, to just allow resident to talk to voice changed during the D in her room. R10 started to voice sounded sad. RN-D or R10 and R10 continued to ambodian. There were no ion sheets or tools being bservation of the RN-D and ne what R10 was what R10's needs were. When D where the picture | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|-------------------|-----|---|-------------------------------|----------------------------|
| | | 245367 | B. WING | | | 03 | /06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GRAND AVENUE, PO BOX 365 FRAND MEADOW, MN 55936 | 1 00 | |
| (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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 309 | communication too | age 17 Is were kept, RN-D stated in as unable to locate them in to | FS | 309 | | | 1. 八字 1. 第 |
| | NA-D was observed R10's wheelchair in R10 was speaking R10 to her room co was speaking Cam communicate with I putting her hands u closing her eyes. Nand pointed at the to NA-D in Cambod into the hallway closing ave R10 yogurt. Naure that was what R10 was having a soffer her some wate took a drink of her vR10 took another dipoured the water or if she wanted to was R10 was tearful durwere no picture combeing utilized during and R10 to help det | ion on 3/4/14 at 3:44 p.m. d to be kneeling down by a common area of the facility. in Cambodian. NA-D wheeled intinued to listen to R10 as she bodian. NA-D attempted to R10, by stating sleep and p to the side of her face and A-D also stated the word bed bed. R10 continued to speak lian. NA-D wheeled R10 back are to the nurses' station and A-D stated she wasn't really R10 wanted. NA-D stated inack and thought she would ext. R10 ate her yogurt and water. R10 became tearful. Fink of the water and then in her hands. NA-D asked R10 is her hands. NA-D verified ing their interaction. There inmunication sheets or tools in the observation of the NA-D ermine what R10 was ne staff or what R10's needs | | | | | |
| - | medical records (MF one staff intervention wheelchair in a com- appeared agitated, with fast speech, rai to an arm rest of a co | on on 3/5/14 at 4:15 p.m. R)-A was providing a one to n. R10 was sitting in a mon area of the facility, was speaking in Cambodian sed voice and was holding on thair, shaking the chair. MR-A et R10 to let go of the chair | | | | | |

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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | LE CONSTRUCTION | (X3) DAT | TE SURVEY MPLETED |
|--|--|---|---------------------|--|---|----------|----------------------------|
| | | 245367 | B. WING | ā | | 03 | /06/2014 |
| NAME OF PROVIDER OR SUPPLIER MEADOW MANOR | | | 2 | STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | 1 00 | 00/2014 | |
| (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 309 | she was holding on communication she during the observat | to. There were no picture ets or tools being utilized ion of the MR-A and R10 to to tR10 was communicating or | F: | 309 | | | |
| | stated communicating R10. NA-E stated Figure 10 with look stated when R10 was walk and would play extent staff were are NA-E stated when Figure 10 talled the son or dated when R10 talled inform staff of was usually able to would usually calming stated when R10 was usually able to would usually calming restricted when R10 talled was usually able to would usually calming restricted re | on 3/5/14 at 11:02 a.m. NA-E on was a little difficult with 10 was able to say toilet and ing at the pictures. NA-E as agitated staff will take for a music. NA-E stated to an e able to meet R10's needs. R10 was more agitated; staff ughter to interpret. NA-E liked to family, the family f what R10 needed and staff get what R10 needed and she down. NA-E was not aware of ices to use with R10. | | | | | |
| | stated R10 knows s toileting, food, thirty was able to say yes most part. NA-F star picture flashcards, a communicate with F took them home to not them and didn't t facility. NA-F verified staff were unable to stated staff provided frequently for R10. N interpreter services NA-F stated, "I wish can't understand who could have an interpreter." | on 3/5/14 at 11:12 a.m. NA-F ome words in English, tired/sleep and stated R10 or no and understand for the ted the facility used to have and paper sheets to use to R10. NA-F stated R10's son write words in her language hink they ever got back to the d when R10 became agitated tell why R10 was upset. NA-F d one to one supervision quite NA-F was unaware of any available to use with R10. we did have one because we at she is saying. I wish we wreter to be unable to ch pain she is really in. She | | | | | |

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | | E SURVEY MPLETED |
|--|--|--|----------------------------|---|------|----------------------------|
| | | 245367 | B. WING | | 03/ | /06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | : | STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 309 | | ain than we realize. An elp us to know what she needs | F 309 | | | |
| The state of the s | During an interview stated staff used has sleepy. We have flate are kept in top draw the nurses' station. used those since R wing about a month thought the flashca was first here. She could tell she was sirst got here. I wou would shake her he she gets agitated. It her, in a place that nobody understand any interpreter serv communicate with first sleepy. | on 3/5/14 at 2:36 p.m. NA-G and singles for, drink, eat, ashcards, to use with R10 that wer of her nightstand and at NA-G stated she had not 10 had a room on the west ago. NA-G stated she rds "frightened her when she was in a new place and you cared and anxious when she d hold up a flashcard and she ad. I totally understand why must be so frustrating to be she is not used to and where is her." NA-G was unaware of ices that could be utilized to R10 and stated it would be interpreter service to use. | | | | |
| | director of nursing (staff to use the comworking with R10. Twas unable to have DON stated when Fagitated facility staff them speak to her awhat she was upset The DON verified tharrangements for in communicate with rneeds and to comply verified it was difficults. | on 3/6/14 at 8:25 a.m. the DON) stated she expected munication sheets when he DON verified facility staff conversations with R10. The R10 became upset and would call the family have and family would relay to staff about and what she needed be facility had not made terpreter services to esident to determine care ete assessments. The DON all to complete analysis and D's falls due to the language and able to communicate what | | | | |

| LAND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
|--|---|---|--------------------|---|---|-------|----------------------------|
| | | 245367 | B. WING | | | 03/ | 06/2014 |
| NAME OF PROVIDER OR SUPPLIER MEADOW MANOR | | | | STREET ADDRESS, C 210 EAST GRAND A GRAND MEADOW | VENUE, PO BOX 365 | 1 03/ | 00/2014 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORI | R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 309 | she was trying to do verified the facility in to provide translato. During an interview services (SS)-A ver family if they would for interpreter service her nursing home sediscussions with Feyand family indicated needed. SS-A stated the internet to utilize communication and developed a communication and | o prior to her falls. The DON had not followed the care plan r services as available. on 3/6/14 at 9:22 a.m. social ified she did not offer or ask like arrangements to be made ces to be used for R10 during tay. SS-A stated she had A about the language barrier If they would help interpret as dishe looked for flashcards on a with resident for speech therapy also unication board for staff use, the second care conference mily by asking F-A to develop SS stated F-A stated they is for pain, however never high providing a flashcards to differ the facility did not follow adure for Communication with dicient Persons undated policy S-A verified the facility had not an to provide translator | F3 | 09 | | | |
| | SS-A stated assess completed by staff o and by talking to the | on 3/6/14/ at 10:20 a.m., ments for R10 were bservations, staff interviews family. SS-A verified were not utilized to complete | | · | | | |
| | stated a lot of the as based on observatio non-verbal. RN-A sta | on 3/6/14 at 10:27 a.m., RN-A sessments were completed n, using gestures and ated if the family in the assessment needed to be | | | | | |

| F 309 Continued From page 21 completed, she would use the family to interpret as they could communicate exactly what the resident was saying. During an interview on 3/6/14 at 10:42 a.m., RN-D stated based on the fact resident was unable to speak when admitted and English was not her primary language, she felt it would be helpful to have an interpreter for her. RN-D stated to her knowledge interpreter services had not been offered to family to be used with resident while in the facility. F 315 SS=D Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. F 309 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility | | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|--------|---|---|--|---|---|--------------------------|
| MEADOW MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 FROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECT | | | 245367 | B. WING _ | | 03/06/2 | 2014 |
| F 309 Continued From page 21 completed, she would use the family to interpret as they could communicate exactly what the resident was saying. During an interview on 3/6/14 at 10:42 a.m., RN-D stated based on the fact resident was unable to speak when admitted and English was not her primary language, she felt it would be helpful to have an interpreter for her. RN-D stated to her knowledge interpreter services had not been offered to family to be used with resident while in the facility. F 315 SS=D Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. F 309 | | í | | 210 EAST GRAND AVENUE, PO BOX 365 | | |
| completed, she would use the family to interpret as they could communicate exactly what the resident was saying. During an interview on 3/6/14 at 10:42 a.m., RN-D stated based on the fact resident was unable to speak when admitted and English was not her primary language, she felt it would be helpful to have an interpreter services had not been offered to family to be used with resident while in the facility. F 315 SS=D Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. F 315 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility | PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | BE CO | (X5) MPLETION DATE |
| RN-D stated based on the fact resident was unable to speak when admitted and English was not her primary language, she felt it would be helpful to have an interpreter for her. RN-D stated to her knowledge interpreter services had not been offered to family to be used with resident while in the facility. F 315 SS=D Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. F 315 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility | F 309 | completed, she would as they could comm | uld use the family to interpret nunicate exactly what the | F 30 | 9 | | |
| Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility | | RN-D stated based unable to speak wh not her primary land helpful to have an ir to her knowledge in been offered to fam while in the facility. 483.25(d) NO CATH | on the fact resident was en admitted and English was guage, she felt it would be nterpreter for her. RN-D stated terpreter services had not ily to be used with resident | F 31 | 5 The preparation of the following | olan of | |
| This REQUIREMENT is not met as evidenced by: | 00=0 | Based on the reside assessment, the factoresident who enters indwelling catheter it resident's clinical concatheterization was who is incontinent of treatment and service infections and to resident of the function as possible | ent's comprehensive cility must ensure that a the facility without an s not catheterized unless the andition demonstrates that necessary; and a resident f bladder receives appropriate ces to prevent urinary tract store as much normal bladder | | correction for this deficiency does constitute and should not be inte as an admission nor an agreemen facility of the truth of the facts all conclusions set forth in the staten deficiencies. The plan of correctio prepared for this deficiency was e solely because it is required by pro | s not rpreted t by the eged on nent of n xecuted ovisions | |
| Based on observation, interview and document review, the facility failed to identify three symptoms for an active urinary tract infection (UTI) before starting antibiotic therapy for 2 of 4 resident (R39 and R42) reviewed for urinary incontinence. Findings include: states that with respect to: 1. Resident R39 and resident R42 completed antibiotic therapy prior to time of survey. 2. All residents were reviewed who were using an antibiotic, to ensure | | by: Based on observati review, the facility fa symptoms for an act (UTI) before starting resident (R39 and R incontinence. | on, interview and document illed to identify three tive urinary tract infection antibiotic therapy for 2 of 4 | | the foregoing statement, the facilistates that with respect to: 1. Resident R39 and resident R42 completed antibiotic therapy putime of survey. 2. All residents were reviewed with the facilistates that with respect to: | ty 2 prior to | |

| OLIVIE | TIOT OF WEDIOATE | . A WEDIOAID SERVICES | | | | OMR MO | . 0938-0391 |
|--------------------------|---|---|---------------------|-----|--|-----------|---|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | E CONSTRUCTION | (X3) DAT | E SURVEY MPLETED |
| | | 245367 | B. WING | i | All the control of the second control of the contro | 03 | /06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | Sī | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 00 | 00/2011 |
| MEADOW MANOR | | | | 21 | 10 EAST GRAND AVENUE, PO BOX 365 | | 5 · · · · · · · · · · · · · · · · · · · |
| WEADO | W WIANON | | | G | RAND MEADOW, MN 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | . ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO | LD BE | (X5) COMPLETION DATE |
| | | | ļ | | that antibiotics were justifie | ed. | |
| F 315 | Continued From pa | ge 22 | F: | 315 | Completion date: 3/5/2014 | | |
| | R39's medical reco | rd was reviewed and indicated | | | Licensed staff re-educated of | on sign | |
| | | 9's physician ordered Cipro (milligrams) po (orally) bid (| | | and symptoms of urinary tr | act | * * |
| | twice a day) for sev | en days for a UTI. The | | | infection that a minimum o | f 3 | |
| | physician order note | e dated 2/17/14, at 2:30 p.m. | | | signs/symptoms occur befo | re the us | e |
| | | er had been received for wever; no symptoms had | | | of antibiotic and appropriat | e | |
| | been identified on th | ne note. Review of progress | | | documentation is met. Con | pletion | |
| | notes 1/1/14, to 2/17 | | | | date: 4/8/14. | | 1 8 2 |
| * | documentation of sy | mptoms related to a UTI. | | 4 | 4. The DNS and /or designee w | ill audit | |
| | | d was reviewed and it was | | | each resident who is receivi | ng | |
| | be held for culture | ysician ordered a urinalysis to and Cipro 250 mg bid for | | | antibiotics for a UTI two tim | es per | |
| | seven days on 2/23/ | 14 for UTI. Review of | | | week for one month then o | • | |
| 1,75 | | 14, to 2/23/14, revealed no mptoms related to a UTI | | | resident a week for one mo | | |
| ž | | ce of foul smelling urine, or | | | ensure that the residents ha | ıve a | |
| | discomfort. | , | | | minimum of 3 signs/sympto | ms of a | |
| | During interview on | 3/6/14, at 1:03 p.m. the | | | UTI. | | |
| | director of nursing (I | | | Ę | 5. The data collected will be pr | esented | |
| | | been identified to indicate inimum of three symptoms of | | | to the QA committee. The o | lata will | |
| | a UTI to justify the use of | e of antibiotic use. DON | | | be reviewed at the quarterly | / Quality | |
| | required to treat with | on was three symptoms were an antibiotic. | | | Assurance meeting. At this QA committee will make a | time the | |
| | | to review the facilities policy | | t | decision/recommendation re | garding | |
| F 329 | on antibiotic use, not 483,25(I) DRUG REC | ne provided. GIMEN IS FREE FROM | F 3 | 21 | any necessary follow-up stud | lies. | |
| SS=E | UNNECESSARY DE | | , 0 | 6 | . DNS is responsible for this ar | ea of | مار سید |
| | Each regident's days | ragimon must be free free | | | compliance. | | 4-15-16 MPN |
| 1 | | regimen must be free from An unnecessary drug is any | | | | | Men |
| | drug when used in e | xcessive dose (including | | | | | |
| | duplicate therapy); o | r for excessive duration; or onitoring; or without adequate | | | | | |

| STATEMEN | T OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MUI | TIPI | LE CONSTRUCTION | | E SLIDVEY |
|---|--|--|-------------------|--|---|---|---|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILD | | (X3) DATE SURVEY COMPLETED | | | |
| | | 245367 | B. WING | i | | 03/06/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | | 1 | S | TREET ADDRESS, CITY, STATE, ZIP CODE |] 03/ | 00/2014 |
| MEADOW MANOR | | | 2. | 10 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 329 | adverse consequent should be reduced combinations of the Based on a compre resident, the facility who have not used given these drugs utherapy is necessar as diagnosed and drecord; and resident drugs receive gradubehavioral intervent | se; or in the presence of aces which indicate the dose or discontinued; or any | FS | | The preparation of the following correction for this deficiency documents of the state of the facts and admission nor an agreeme facility of the truth of the facts a conclusions set forth in the state deficiencies. The plan of correction prepared for this deficiency was solely because it is required by pof State and Federal law. Without the foregoing statement, the facts states that with respect to: | es not erpreted nt by th lleged o ement of on execute rovision it waivir | d e n f d Cowkens d Stovicio |
| | by: Based on interview failed to monitor for (PRN) pain medicat R7) reviewed for un Findings include: R5 had been admitt admission record da diagnoses that inclu rheumatoid arthritis, R5's annual Minimu 1/9/14, identified brid (BIMS) had been on severe cognitive imp | and record review the facility effectiveness of as needed ions for 2 of 5 residents (R5, necessary medications. ed on 3/31/2009. R5's ated 2/22/13, identified ded but not limited to generalized osteoarthrosis. m Data Set (MDS) dated ef interview of mental status to out of fifteen and indicated pairment, pain management: | | | Pain assessments were comfor residents R5 and resident Completion date: 3/31/2014 Licensed staff re-educated of and symptoms of pain and appropriate documentation Completion date: 4/8/14. DNS or designee will monitor resident records per week for month then weekly for two refor appropriate use, effective diagnosis and non-pharmace intervention for pain medicated. The data collected will be president to the QA committee. The data | R7. In sign Is met. It two Ir one Inonths Inness, Intical Itions. It is sented | |

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 245367 | B. WING | | | | 03/ | 06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | 2 | STREET ADDRESS, CITY, STATE, ZIF 210 EAST GRAND AVENUE, PO B GRAND MEADOW, MN 55936 | OX 365 | 1 00/1 | 50/2014 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD HE APPROPF | BE | (X5) COMPLETION DATE |
| F 329 | PRN pain medication interventions, indication non-verbal sounds, facial expressions aresident complains | ge 24 on, received non-medication ators of pain or possible pain: vocal complaints of pain, and frequency with which or shows evidence of pain or ators of pain or possible pain | F.3 | 29 | be reviewed at the q Assurance meeting. QA committee will m decision/recommend any necessary follow 5. DNS is responsible fo | At this ti nake a dation re -up studi | me the | |
| ing Tabung High | chronic pain related disease, back/knee stiffness secondary interventions of but | date 1/29/14, identified I to arthritis, degenerative joint pain, impaired mobility, to parkinsonism and not limited to provide ed, observe and document for ectiveness. | | OR DO TO THE WORLD SHOW THE PERSON NAMED IN COLUMN 1 | compliance. | or this are | ea or | 4/15/14 15/14 |
| | order for Roxicet (a acetaminophen and | I an opioid pain medication, pain) 5-325mg (milligrams) | | | | | | 447.2 |
| | sheets and medicat following had been 2/1/14 through 3/5/1 37 doses of Roxicet information if the pa | I's medication administration ion documentation sheets the identified from the dates of 4: R5 had received a total of PRN and there was no in medication was effective to in for 32 out of the 37 doses | | | | | | |
| | registered nurse (RI | 3/6/14, at 8:09 a.m., N)-A verified reason given and kicet PRN had not always | | | | | | |
| | of nursing stated sh | 3/6/14, at 11:15 a.m., director e would expect reason given PRN pain medication to be | | | | | | . * |

| | NT OF DEFICIENCIES I OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | | E SURVEY IPLETED |
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| | | 245367 | B. WING | | | | 03/ | 06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | | | | | 00/2014 |
| (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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD B | | (X5) COMPLETION DATE |
| F 329 | | e back of MAR (medication | F3 | 29 | | | | |
| | admission record d diagnoses that incligiont, shoulder region involving multiple s below knee. R7's q identified brief inter had been one 10 of moderate cognitive | ted on 4/21/2009. R7's lated 2/22/13, identified uded but not limited to pain in on, generalized osteoarthrosis ites, lower limb amputation uarterly MDS dated 12/5/13, view of mental status (BIMS) ut of 15 and indicated impairment, pain ived scheduled pain | | · | | | | 5000000 935 46 0003 945703 200000 |
| | medication, received received non-medic presence yes, pain made it hard to sleed day activity because | ed PRN pain medication, cation interventions, pain frequency frequently, pain has ep at night, had limited day to e of pain, pain intensity rated with 10 being the worst | | | | | | |
| | on chronic pain rela atrophic vaginitis, p depression, history interventions of but | date 3/6/14, identified acute sted to osteoarthrosis, obesity, erineal pain, diabetes mellitus, of urinary tract infection and not limited to provide ed, observe and document for ectiveness. | | | | | | 5 |
| | order for Belladonna medication) 16.2-30 six hours for perinea narcotic pain medic as needed for pain, pain medication) 50 one to five and two every six hours as r | rs dated 1/23/14, identified an a-Opium (a narcotic pain mg suppository PRN every al pain, Oxycodone HCI (a ation) 5 mg every four hours Tramadol HCI (a synthetic mg PRN: one tablet pain rate tablets pain rate six to 10 needed for pain, should not 1000 mg daily. Tylenol 1000 mg | | | | a. | | U U KANTAS TINKAS TINKAS TINKSSAS |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION ING | | ATE SURVEY OMPLETED |
|--------------------------|---|--|---------------------|---|--|---|
| | 245367 AME OF PROVIDER OR SUPPLIER | | B. WING | | _ 0 | 3/06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | STREET ADDRESS, CITY, ST 210 EAST GRAND AVENUI GRAND MEADOW, MN | ATE, ZIP CODE E, PO BOX 365 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | X (EACH CORRECTIV CROSS-REFERENCE | AN OF CORRECTION VE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY) | (X5) COMPLETION DATE |
| F 329 | PRN four times a c 4000 mg per 24 ho During review of R' sheets and medica following had been 2/1/14 through 3/5/ one dose of Bellad was no information pain; A total of 46 c and there was no in this pain medicatio 46 doses and no in was effective to reli doses; had receive PRN and no inform | lay as needed, do not exceed | F3 | 29 | | 75-12-3 15-12- |
| | to relieve pain for 1 received 26 doses information as to w for three of 26 dose | the medication was effective 8 out of 25 doses; had of Tylenol PRN and no hy it was indicated to treat pain es and no information of in medication for 19 out of 26 | | | | |
| | verified the reason Belladonna-Opium | 3/6/14, at 8:09 a.m., RN-A given and effectiveness of PRN, Oxycodone HCI PRN, and Tylenol PRN had not nented. | | | | |
| | of nursing stated shand effectiveness of | 3/6/14, at 11:15 a.m., director ne would expect reason given f PRN pain medications to be back of MAR (medication rd). | | · | | |
| | Document review o | f the facility policy | | | • | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|-------------------------|--|--|
| | | 245367 | B. WING _ | | 03/06/2014 |
| | PROVIDER OR SUPPLIER W. MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLÉTION |
| F 329 | GUIDELINES dated Documentation 5) Nadministered, the for provided: b. Complethe medication was from giving the dosenoted." | d 2006, read, "C. When PRN medications are bllowing documentation is aints or symptoms for which given. c. Results achieved e and the time results were | F 32 | 29 | |
| F 428 SS=D | 483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least or pharmacist. The pharmacist muthe attending physic | eGIMEN REVIEW, REPORT ON of each resident must be not a month by a licensed st report any irregularities to cian, and the director of reports must be acted upon. | F 42 | The preparation of the following procorrection for this deficiency does constitute and should not be interested as an admission nor an agreement facility of the truth of the facts all conclusions set forth in the statered deficiencies. The plan of correction prepared for this deficiency was especially because it is required by prepared by p | s not rpreted t by the eged on nent of n executed ovisions |
| | by: Based on interview failed to ensure the identified lack of rea effectiveness of as medications for 2 of reviewed for unnecesting include: R5 had been admitt admission record dadiagnoses that inclurheumatoid arthritis | 5 residents (R5, R7) | | of State and Federal law. Without the foregoing statement, the facil states that with respect to: 1. Pharmacy consultant reviewer resident R5 and resident R7 for unecessary medications. Comdate: 3/13/14. 2. Staff educated on the use of conditions/follow-up charting and documentation of PRN paredications and their effective Completion date: 4/8/14 | ity ed or opletion tool |

PRINTED: 03/25/2014 FORM APPROVED

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SL COMPLE (X3) DATE SL COMPLE (X4) ID PREFIX (X4) ID PREFIX (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) DATE SL COMPLE (X7) DATE SL COMPLE (X7) DATE SL COMPLE (X3) DATE SL COMPLE (X4) ID PROVIDER OR SUPPLIER (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) DATE SL COMPLE (X8) DATE SL COMPLE (X9) DATE SL COMPLE (X1) DATE SL COMPLE (X2) MULTIPLE CONSTRUCTION (X3) DATE SL COMPLE (X4) DATE SL COMPLE (X5) DATE SL COMPLE (X6) DATE SL COMPLE (X7) DATE SL COMPLE (X8) DATE SL COMPLE (X9) DATE SL COMPLE (X1) DATE SL COMPLE (X2) MULTIPLE CONSTRUCTION (X3) DATE SL COMPLE (X4) DATE SL COMPLE (X5) DATE SL COMPLE (X6) DATE SL COMPLE (X7) DATE SL COMPLE (X7) DATE SL COMPLE (X7) DATE SL COMPLE (X7) DATE SL COMPLE (X8) DATE SL COMPLE (X9) DATE SL COMPLE (X9) DATE SL COMPLE (X9) DATE SL COMPLE (X9) DATE SL COMPLE (X1) DATE SL COMPLE (X2) DATE SL COMPLE (X2) DATE SL COMPLE (X3) DATE SL COMPLE (X4) DATE SL COMPLE (X5) DATE SL COMPLE (X6) DATE SL COMPLE (X7) DATE SL COMPLE (X8) DATE SL COMPLE | STATEME | ENT OF DEFICIENCIES | (X1) PROVIDED (X1) | | | (| OMB NO | O. 0938-03 | 39 |
|--|-------------------|---|--|----------|-----------|--|--|---|----|
| NAME OF PROVIDER OR SUPPLIER MEADOW MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 (X4) ID PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | AND PLAI | N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILD | TIPLE | CONSTRUCTION | (X3) DA | ATE SURVEY DMPLETED | |
| MEADOW MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | : | | 245367 | B. WING | | | | | |
| DEFICIENCY) | (X4) ID PREFIX | OW MANOR SUMMARY STA (EACH DEFICIENCY | MUST BE PRECEDED BY ELLI | PREFI | 210 GR | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD | ON D RE | 3/06/2014 (X5) COMPLETIC DATE | |
| F 428 Continued From page 28 1/9/14, identified brief interview of mental status (BIMS) had been one out of fifteen and indicated severe cognitive impairment, pain management: received scheduled pain medication, received PRN pain medication, received non-medication interventions, indicators of pain or possible pain: non-verbal sounds, vocal complaints of pain, facial expressions and frequency with which resident complains or shows evidence of pain or possible pain: indicators of pain or possible pain observed daily. R5's care plan print date 1/29/14, identified chronic pain related to arthritis, degenerative joint disease, back/knee pain, impaired mobility, stiffness secondary to Parkinsonism and interventions of but not limited to provide analgesia as ordered, observe and document for side effects and effectiveness. | | 1/9/14, identified brid (BIMS) had been on severe cognitive impreceived scheduled PRN pain medication interventions, indicated non-verbal sounds, of facial expressions are resident complains of possible pain: indicated to be served daily. R5's care plan print of chronic pain related the disease, back/knee patiffness secondary to interventions of but not an an algesia as ordered side effects and effect of the secondary for the secondary to the | ef interview of mental status e out of fifteen and indicated bairment, pain management: pain medication, received non-medication tors of pain or possible pain: vocal complaints of pain, and frequency with which or shows evidence of pain or tors of pain or possible pain of limited to provide of limited from the document for the provide of limited pain medication, in 5-325 mg (milligrams) of limited from the dates of limited from the limite | F 4 | 3. | DNS or designee will monitor resident records per week for month then weekly for two m for appropriate use, effective diagnosis and non-pharmaceu intervention for pain medicat. The data collected will be preto the QA committee. The data be reviewed at the quarterly QA ssurance meeting. At this tir QA committee will make a decision/recommendation regany necessary follow-up studied DNS is responsible for this area. | r one nonths eness, utical ions. sented ta will Quality me the garding es. | Poste Poste Poste Post Post Post Post Post Post Post Post | |

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| OLIVIL | TIOT OF MEDICANE | A MEDICAID SERVICES | | | | OMB NO | D. 0938-0391 |
|--------------------------|--|---|----------------------|--------------------|--|----------|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILD | TIPLE CONSTRUCTING | TION | (X3) DA | ATE SURVEY OMPLETED |
| | | 245367 | B. WING | | | 03 | 3/06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | 210 EAST GRA | ET ADDRESS, CITY, STATE, ZIP CODE AST GRAND AVENUE, PO BOX 365 ND MEADOW, MN 55936 | | 3/00/2014 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH | OVIDER'S PLAN OF CORR I CORRECTIVE ACTION S REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION: DATE |
| F 428 | Continued From pa | ge 29 | F4 | 28 | | | |
| | of nursing stated sh and effectiveness o | 3/6/14, at 11:15 a.m., director e would expect reason given f PRN pain medication to be back of MAR (medication rd). | | | | | |
| | admission record da diagnoses that inclu joint, shoulder regio involving multiple sit below knee. R7's quidentified brief intervhad been one 10 ou moderate cognitive imanagement: received medication, received received non-medication presence yes, pain f made it hard to sleet day activity because | ved scheduled pain d PRN pain medication, ation interventions, pain requency frequently, pain has at night, had limited day to of pain, pain intensity rated ith 10 being the worst | | | | | 1. 17. 17. 17. 17. 17. 17. 17. 17. 17. 1 |
| | on chronic pain relat atrophic vaginitis, pe depression, history c interventions of but r | d, observe and document for | | | | | |
| | order for Belladonna medication) 16.2-30 six hours for perinea narcotic pain medica | s dated 1/23/14, identified an -Opium (a narcotic pain mg suppository PRN every pain, Oxycodone HCI (a tion) 5 mg every four hours | | | | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E CONSTRUCTION | | TE SURVEY MPLETED |
|--------------------------|--|---|--------------------|--|---|------|----------------------------|
| | | 245367 | B. WING | | | 03 | /06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | 2 | TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | 1 00 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 428 | pain medication) 50 one to five and two every six hours as a receive more than 3 | o mg PRN: one tablet pain rate tablets pain rate six to 10 needed for pain, should not 300 mg daily, Tylenol 1000 mg ay as needed, do not exceed | F 4 | -28 | | | |
| | sheets and medicate following had been 2/1/14 through 3/5/2 one dose of Belladowas no information pain; A total of 46 do and there was no inthis pain medication 46 doses and no inf | "s medication administration ion documentation sheets the identified from the dates of 14: R7 had received a total of ionna-Opium PRN and there if it was effective to relieve cases of Oxycodone HCI PRN formation that identified why is was given for 25 out of the ormation the pain medication | | | | | |
| | doses; had received PRN and no information was given information as to if to to relieve pain for 18 received 26 doses of information as to what for three of 26 doses. | eve pain for 36 out of 46 d 25 doses of Tramadol HCl ation to why this pain en for two of 25 doses and no he medication was effective 3 out of 25 doses; had of Tylenol PRN and no by it was indicated to treat pain and no information of a medication for 19 out of 26 | | | | | |
| | verified the reason of Belladonna-Opium F | 3/6/14, at 8:09 a.m., RN-A given and effectiveness of PRN, Oxycodone HCI PRN, and Tylenol PRN had not ented. | | The state of the s | | | |
| | of nursing stated she and effectiveness of | 3/6/14, at 11:15 a.m., director would expect reason given PRN pain medications to be back of MAR (medication | | | | | |

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| | | A MEDICAID SERVICES | | | OMB NO | D. 0938-0391 |
|----------------------|---------------------------------------|--|----------------------|---|----------|----------------------|
| STATEMEI AND PLAN | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 245367 | B. WING | | 03 | 3/06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COL |)F | 700/2014 |
| MEADO | W MANOD | | | 210 EAST GRAND AVENUE, PO BOX | | |
| MEADO | OW MANOR | | | GRAND MEADOW, MN 55936 | ,00 | |
| (X4) ID | SLIMMARY STA | TEMENT OF DEFICIENCIES | | | | |
| PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S | ECTION | (X5) COMPLETION |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE AP | | DATE |
| | | | | DEFICIENCY) | | *** |
| | | • | | | | |
| F 428 | Continued From pa | ge 31 | F 4 | 28 | | |
| | administration recor | rd). | | | | |
| | | | | | | |
| | During interview on | 3/6/14, at 1:28 p.m., facility | | | | |
| | consultant pharmac | ist stated would absolutely | | | | |
| | expect reasons give | en and effectiveness of PRN | | | | |
| | pain medications to | be documented. Facility | - | | | |
| | thou were not doing | ist stated,"I did not realize | | | | |
| | they were not doing | ınaı. | | | | |
| i' | Document review of | the facility policy | | | | |
| | CONSULTANT PHA | RMACIST SERVICES | | | | 2012 3 |
| | PROVIDER REQUII | REMENTS dated 2006, read, | | · | | |
| | "Procedures F. The | consultant pharmacist | | | | |
| | provides consultatio | n on all aspects of the | | | | |
| | provision of pharma | cy services in the facility. In | | | | |
| | collaboration with fa | cility staff, the consultant | | | | |
| | pharmacist helps to | identify, communicate. | | | | |
| K. | address, and resolve | e concerns and issues related | | | | |
| | to the provision of pl | narmaceutical services. This | | | | |
| | includes, but is not in | mited to: 2) Evaluating the | | | | |
| | process of receiving | and interpreting prescribers ' | | | | |
| | reconciling, compour | ceiving, storing, controlling, nding, dispensing, packaging, | | | | |
| | labeling distributing | administering, monitoring | | | | |
| | responses to and us | sing and/or disposing of all | | | | |
| | medications, biologic | cals, and chemicals. F. | | | l | |
| | Specific activities that | at the consultant pharmacist | | | ļ | |
| | performs includes, b | ut is not limited to: 7) | | | | |
| | Reviewing medicatio | n administration records | | | | |
| | (MARs), treatment a | dministration records (TARs) | | | | |
| | and physician orders | at least monthly during MRR | | | | |
| | | umentation of medication | | | | |
| | | ation of medications to | | | | 1 |
| E 444 | residents." | CONTROL PREVENT | | | | |
| F 441 | SPREAD, LINENS | CONTROL, PREVENT | F 44 | | | |
| SS=F | OF NEAD, LINENS | 4 | | The preparation of the follow | | |
| | The facility must esta | blish and maintain an | | correction for this deficiency | does not | |
| | radiity mudi edia | solon and maintain an | | constitute and should not be | | , |
| | | 1 | | - Silver and HOLDE | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|----------------------|----|---|-------------------------------|----------------------------|
| | | 245367 | B. WING | | | 02// | 06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 03/0 | 36/2014 |
| MEADO | W MANOR | | | | 10 EAST GRAND AVENUE, PO BOX 365 | | · 4 |
| | | | | G | RAND MEADOW, MN 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | x | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 441 | Continued From pa | ge 32 | F 4 | 41 | | | |
| • | Infection Control Pr | ogram designed to provide a omfortable environment and | | 1 | as an admission nor an agreemer | t by the | e |
| | to help prevent the of disease and infed | development and transmission | | | facility of the truth of the facts all | eged o | n |
| | of disease and inject | cuon. | | | conclusions set forth in the stater | nent of | |
| | (a) Infection Control | Program | | | deficiencies. The plan of correction | 'n | |
| | Program under which | ablish an Infection Control | | | prepared for this deficiency was ϵ | execute | d |
| | (1) Investigates, cor | ntrols, and prevents infections | | | solely because it is required by pr | ovisions | s |
| | in the facility; (2) Decides what pro- | ocedures, such as isolation, | | | of State and Federal law. Without | waivin | g - 11 07/11) |
| | should be applied to | an individual resident; and | | | the foregoing statement, the facil | ity | 11 No. 42. |
| | (3) Maintains a reco actions related to int | rd of incidents and corrective fections. | - | : | states that with respect to: | | .* |
| | (b) Preventing Sprea | | | | 1. The facility infection control | | |
| | (1) When the Infecti | on Control Program sident needs isolation to | | | surveillance procedure has be | en | |
| Ex. U | | of infection, the facility must | | | reviewed and updated to mee | t | |
| | isolate the resident. | | | | current regulations. Completi | on | |
| | | prohibit employees with a ase or infected skin lesions | | | date: 3/29/14. | | |
| - | from direct contact v | vith residents or their food, if | | 2 | LPN –A was re-educated on pr | operly | and areas was |
| | direct contact will tra | require staff to wash their | | | sanitizing glucometers. Comp | letion | |
| | hands after each dire | ect resident contact for which | | | date: 4/8/14. | | |
| | hand washing is indi professional practice | | | 3 | All nursing staff will be re-educ | cated | |
| | | ·· | | | on properly sanitizing glucome | ters. | |
| | (c) Linens | dle, store, process and | | | Completion date: 4/8/14. | | |
| | | s to prevent the spread of | | 4 | . The facility will track infections | and | |
| | infection. | | | | surveillance infections according | ng to | |
| | | | | | the facility procedure. | | |
| | | | | 5 | . The DNS and/or designee will a | nudit | |
| | This REQUIREMEN by: | T is not met as evidenced | | | the use of blood glucometers t | wo | |
| | | and document review, the | | | times per week for one month | then | • |

| | | & MEDICAID SERVICES | | | (| MR NO | 0. 0938-0391 |
|----------------------|--|--|----------------------|-----------|--|---|----------------------------|
| STATEMEI AND PLAN | ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DA | TE SURVEY MPLETED |
| | | 245367 | B. WING | | | 0.3 | 3/06/2014 |
| | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | 210 GR | REET ADDRESS, CITY, STATE, ZIP CODE PEAST GRAND AVENUE, PO BOX 365 AND MEADOW, MN 55936 PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | N O BÉ | (X5) COMPLETION DATE |
| F 441 | facility failed to ensuprogram included transmulti-resident use granitizer recomment (R3) observed during Findings include: The facilities employ program was review (DON) who was identured on 3/4/14, at 22. The employee infect reviewed between 10 logs failed to include symptoms and date which department the infection control logs provided. The DON whad not been tracked stated she had not transmurable to report that employees in other dot provided the docum the facility did not have and trend employee in GLUCOMETER NOT SANITIZERS RECOMETER | are their infection control acking and trending of and failed to sanitize a lucometer according to the dations for 1 of 1 resident g medication pass. The energy infection control logs and ed with the director of nursing nutified as the infection control 2:54 p.m. The consistent documentation of of onset, and did not identify the employee had worked. No prior to 10/29/13 were verified employee illnesses if prior to 10/29/13. The DON acked employee illnesses g department. She was had monitored infections for epartments and was unable entation. The DON verified we a system in place to track liness. Imployee illnesses was vided. SANITIZED PER | F 4 | 6. | weekly for two months to ensproper procedure is followed sanitizing. The DNS and/or designees will the infection surveillance log to times weekly for one month the time weekly for two months to evaluate tracking and trending. The data collected will be proto the QA committee. The does reviewed at the quarterly Assurance meeting. At this to QA committee will make a decision/recommendation reany necessary follow-up study. DNS is responsible for this arcompliance. | for I audit wo nen one c s. esentee ata will Qualit ime the egardin lies. ea of | 1 |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | | (3) DAT | E SURVEY MPLETED |
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| | | 245367 | B. WING | i | | | 03/ | /06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 36 GRAND MEADOW, MN 55936 | | | - 00/ | 00/2014 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | E TE | (X5) COMPLETION DATE |
| | dated 1/23/14, rever qid [four times per of During observations licensed practical medication of Platinum Glucometed device). When come Assure Platinum Glucometed device). When come Assure Platinum Glucometed device) and the medication with one super Sanithrew away the cloth time, LPN-A verified the sanitizing cloth, cloth, and left the definition of During observations LPN-A placed the Assinto the medication of nursing stated the for sanitizing multi-remonitoring devices. She expected staff to super Sani-wipe con expected staff to wip Sani-wipe cloth and verified the directions container included to remain wet for two medication of the properties of the one Assurated Document review of container directed, "Touring interview of container directed," Touring devices, "Touring interview of container directed," Touring devices, "Touring interview of container directed," "Touring devices," "Touring interview of container directed," "Touring devices," "To | aled orders for "accu check day]." s on 3/3/14, at 4:43 p.m., urse (LPN)-A placed R3's test strip in the Assure er (a blood sugar monitoring apleted, LPN-A placed the ucometer on a paper towel on a cart, wiped the glucometer—wipe sanitizing cloth, and an During interview at that I she wiped the device with immediately threw away the evice to air dry. source Platinum Glucometer cart drawer. 3/3/14, at 7:00 p.m., director e facility had no facility policy esident blood sugar. Director of nursing stated to follow directions on the tainer. She stated she the device with a super let the device with a super let the device air dry. She son the super Sani-wipe to wipe the device and to finutes. 3/3/14, at 7:55 p.m., LPN-A are Platinum Glucometer was ints on the east wing. | F | 141 | | | | |
| ' | Io disinfect nonfood | contact surface only: Use a | | | | | | |

| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUILI | | APR 0 7 2014 | (X3) DA | 7. 0938-0391 TE SURVEY MPLETED |
|--------------------------|--|--|---------------------|--|--|----------|---|
| | | 245367 | B. WING | | MN Dept of Health | 03 | /06/2014 |
| | PROVIDER OR SUPPLIER W MANOR | | | 21 | TREET ADDRESS, CITY, \$1知程, ZIP COI IO EAST GRAND AVENUE, PO BOX : RAND MEADOW, MN 55936 | DE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AR DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 441 | and thoroughly wet must remain visibly Use additional wipe | ge 35 vy soil. Unfold a clean wipe surface. Treated surface wet for a full two (2) minutes. (s) if needed to assure ninutes wet contact time. Let | F | 441 | | | |
| | | | | per established and the second | | | 96.596 - 34 139.65 - 3 81.59 - 15 17.5 |
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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 03/05/2014 B. WING 245367 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 210 EAST GRAND AVENUE, PO BOX 365 **MEADOW MANOR** GRAND MEADOW, MN 55936 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 l POC & 4-15-14 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Meadow Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. APR 1 1 2014 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY N DEPT. OF PUBLIC SAFET **DEFICIENCIES** (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or (X6) DATE.

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

Any deligierical transfer ment ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other saleguards 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: 03/25/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245367 03/05/2014 STREET ADDRAS, RITU, TAZU, ZIP CODE NAME OF PROVIDER OR SUPPLIER 210 EAST GRAND AVENUE PO BOX 365 **MEADOW MANOR** GRAND MEADOW/MNe55936 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Meadow Manor is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction, with a partial basement. In 1990, an addition was added to the South and was determined to be Type II (111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is

| | | A MILDIONID SETTIOLS | - | | | DIVID IVO. | 1 660-0660 | |
|--------------------------|--|--|-------------------|---------|---|--|----------------------------|--|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | | |
| | | 245367 | B. WING | B. WING | | 03/ | 03/05/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE EAST GRAND AVENUE, PO BOX 365 | | 0 | |
| MEADO | W MANOR | | | | AND MEADOW, MN 55936 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE | |
| K 000 K 062 SS=D | NOT MET as evide NFPA 101 LIFE SA | • | | 000 | The preparation of the followin | ng plan c | of | |
| | continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 | | - | | correction for this deficiency d constitute and should not be in as an admission nor an agreem facility of the truth of the facts conclusions set forth in the sta | nterpreto nent by t alleged | he on | |
| de consti | Based on observat facility failed to mair in accordance with 1 NFPA 101, Sections 1998 NFPA 25, sect | s not met as evidenced by: ion and staff interview, the ntain the fire sprinkler system the requirements of 2000 19.3.4.1 and 9.6, as well as ion 2-4.1.4. This deficient t all 12 out of 38 residents. | | i s | deficiencies. The plan of correct prepared for this deficiency was solely because it is required by of State and Federal law. Withouther the foregoing statement, the factors | tion s execut provisio out waiv | ted ins | |
| K 147 SS=D | on 03/05/2014, obsespare sprinkler headeach type of sprinkle. This deficient practic Facility Maintenance discovery. NFPA 101 LIFE SAF | een 9:45 AM and 12:00 noon ervation revealed that the down does not contain 2 of er head in the facility be was confirmed by the Director (SB) at the time of ETY CODE STANDARD equipment is in accordance anal Electrical Code. 9.1.2 | K 1 | 2 47 | contacted sprinkler system contractor who audited our sprinkler heads and sent us required amount for each shead. Completed by 3/21/2. Maintenance Supervisor and designee will visually inspective spare head box 2x per year. The Maintenance Supervisor responsible for this area of | the prinkler 2014. d/or his |) | |
| ž į | This STANDARD is | not met as evidenced by: | | | compliance. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--|--|---|---|---------------------------------|--|
| | | 245367 | B. WING | | | 03/ | 05/2014 | |
| | PROVIDER OR SUPPLIER W MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| K 147 | facility failed to main accordance with the 101 - 19.5.1, 9.1.2, deficient practice or residents. Findings include: On facility tour betwon 03/05/2014, obsfollowing was found 1. Basement - Boile panel is blocked 2. Basement - Laun power strip plugged These deficient practices with the second practices of the second practices are resident to make the second practices are resident practices. | ion and staff interview, the intain electrical supply in erequirements of 2000 NFPA 1999 NFPA 70, 110-26. The build affect 12 out of 38 reen 9:45 AM and 12:00 noon ervation revealed, that the liter Room east circuit breaker dry room - by desk- one into other power strip citices were confirmed by the endirector (SB) at the time of | K. | | The preparation of the following correction for this deficiency doconstitute and should not be int as an admission nor an agreeme facility of the truth of the facts a conclusions set forth in the state deficiencies. The plan of correctiprepared for this deficiency was solely because it is required by pof State and Federal law. Without the foregoing statement, the facts states that with respect to: 1. Power strip cord was remove 3/5/2014. Unblocked boiler in panel to ensure 30 inches of clearance. 2. Signs have been posted on the electrical panels to remind state not store anything within 30 Completed 3/27/14. 3. The Maintenance Supervisor designee will visually inspect boiler room panel for 30 incheclearance. 4. The Maintenance Supervisor responsible for this area of compliance. | es not erprete nt by th lleged cement o on execute rovision at waivin ility d on room e aff to inches. and/or the es of | d ne on of ed ns | |



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8262

April 1, 2014

Mr. Jim Ingersoll, Administrator Meadow Manor 210 East Grand Avenue, PO Box 365 Grand Meadow, Minnesota 55936

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5367024

Dear Mr. Ingersoll:

The above facility was surveyed on March 3, 2014 through March 6, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Meadow Manor April 1, 2014 Page 2

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, attention:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731 Fax: (507) 206-2711

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|-------------------------|---|------------|------------------|
| | | 0000 | B. WING | | 00/00/0044 | |
| | | 00390 | b. Willa | | 03/0 | 6/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| MEADO\ | W MANOR | | GRAND AVI IEADOW, MI | ENUE, PO BOX 365 | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTI | ON | (X5) |
| PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | *****ATTE | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Department of t | | | | | |
| | 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 compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was | | | | |
| | that may result from orders provided tha the Department witl | hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance. | | | | |
| | Department's staff of the following licensic corrections are come on the bottom of the with "Laboratory Dir | rS: and 6, 2014, surveyors of this visited the above provider and ang orders were issued. When appleted, please sign and date be first page in the line marked rector's or Provider/Supplier gnature." Make a copy of | | | | |

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|----------------------------|---|-------------------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| MEADO\ | W MANOR | | GRAND AVI IEADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Continued From pa | ge 1 | 2 000 | | | |
| | these orders for you original to the addre | ur records and return the ess below: | | | | |
| | Minnesota Departm 18 Wood Lake Driv c/o Gary Nederhoff 507-206-2731 Office | e SE, Rochester, MN 55904 , Unit Supervisor | | | | |
| 2 555 | MN Rule 4658.0409 Plan of Care; Deve | 5 Subp. 1 Comprehensive lopment | 2 555 | | | |
| | must develop a coreach resident withir completion of the cassessment as deficomprehensive platon by an interdisciplinate attending physician responsibility for the appropriate staff in the resident's need practicable, with the the resident's legal representative. | elopment. A nursing home inprehensive plan of care for in seven days after the comprehensive resident ined in part 4658.0400. The in of care must be developed ary team that includes the interest in a registered nurse with the resident, and other disciplines as determined by its interest in and its includes the interest in and its includes the interest in and its includes the interest in a registered nurse with the resident, and other indisciplines as determined by its interest in a registered nurse in a registered nurse with the interest in a registered nurse in a r | | | | |
| | by: Based on observati review, the facility f | on, interview and document ailed to care plan use of lateral heelchair for 1 of 1 resident | | | | |
| | Findings include: | | | | | |
| | impaired physical n | date 1/29/14, identified nobility, dependence on staff s, requires wheelchair for | | | | |

Minnesota Department of Health

STATE FORM 6899 MCDQ11 If continuation sheet 2 of 38

| - | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|-------------------------------|--|------------------------------|-------------------------------|--|
| | | 00390 | B. WING | | 03/ | 06/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| MEADO | W MANOR | | T GRAND AVE MEADOW, MN | ENUE, PO BOX 365 I 55936 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | |
| 2 555 | locomotion, dependence from desired destine address the use of used for positioning. During observation had been in lobby sight side up agains observed to be lear blue Styrofoam pad 3/4/14, at 12:58 p.m. | ge 2 dent on staff to propel to and ation. The care plan did not the blue Styrofoam pad to be device when in wheel chair. on 3/3/14, at 6:47 p.m., R5 ditting in wheelchair leaning to set a blue Styrofoam pad. Also hing to the right and use of 1 on 3/4/14, at 8:31 a.m., n., 3/5/14, at 9:28 a.m., 3/5/14, on 3/5/14, at 1:30 p.m. | 2 555 | | | | |
| | identified reason for posture as result of chair on 11/2/13 and positioning difficultie time for wheelchair as needed in order | apy (OT) note dated 11/13/13, referral, presents with poor positioning deficit, slid out of d nursing staff also noted es 11/7/13. OT Therapy at this assessment and modification to improve posture so R5 can comfort while seated in | | | | | |
| | dated 11/22/13, idel positioning, R5 will achieve effective po wheelchair utilizing needed to affect lea | and discharge summary ntified long term goals require total assistance to ositioning while seated in wheelchair modifications as aning to side, reduce the risk and achieve optimum position f falls. | | | | | |
| | registered nurse (R known why blue Sty or when pad had be blue Styrofoam pad | 3/6/14, at 8:30 a.m., N)-A had stated had not vrofoam pad was being used een put in place. RN-A verified I was not on R5's care plan sing assistant pocket care | | | | | |

Minnesota Department of Health

STATE FORM 6899 MCDQ11 If continuation sheet 3 of 38

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|-----------------------|--|-------|-------------------------------|--|
| | | | | | | | |
| <u> </u> | | 00390 | B. WING | | 03/0 | 6/2014 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| MEADOV | V MANOR | | GRAND AV EADOW, MI | ENUE, PO BOX 365 N 55936 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE | |
| 2 555 | Continued From page 3 | | 2 555 | | | | |
| | plan. | | | | | | |
| | of nursing stated sh | 3/6/14, at 11:15 a.m., director ne would expect the blue itioning device to be care | | | | | |
| | Care Plan Complet Plans should includ | f the facility Guidelines for ion undated, read, " All Care le individual and/or Combined at address the following areas: tive equipment" | | | | | |
| | SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure a care plan is developed to reflect each residents' current care needs. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance. | | | | | | |
| | TIME PERIOD FOR (21) Days. | R CORRECTION: Twenty One | | | | | |
| 2 565 | MN Rule 4658.0409 Plan of Care; Use | 5 Subp. 3 Comprehensive | 2 565 | | | | |
| | | omprehensive plan of care personnel involved in the | | | | | |
| | by: Based on observati | ent is not met as evidenced on, interview, and record ailed to implement care plan | | | | | |

Minnesota Department of Health

STATE FORM 6899 MCDQ11 If continuation sheet 4 of 38

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|---------------------|--|-------------------|--------------------------|
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MEADO\ | W MANOR | | GRAND AVI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 565 | 5 Continued From page 4 | | 2 565 | | | |
| | resident (R10) revie | mmunication for 1 of 1 ewed with limited e English language spoken or | | | | |
| | Finding Include: | | | | | |
| | R10 was admitted on to the facility on 12/12/13 with diagnosis that included intracerebral hemorrhage, cerebrovascular disease and dysphasia due to cerebrovascular disease, according to physician orders dated 2/27/14. | | | | | |
| | language barrier as language. Care pla translator as availal or son will assist who communication techniteraction: Allow an Repeat as necessafeedback, clarificati understanding, Faceye contact, Turn or reduce noise, Asky appropriate, Use si words/cues, Use all as needed, i.e. comsigns, and pictures provide interpreters observed to use piccommunicate with a During an interview | mple, brief, consistent ternative communication tools immunication book, gestures, "However, the facility did not services and staff were not sture communication tools to resident. on 3/4/14 at 2:46 p.m. | | | | |
| | registered nurse (R when we have no ic trial and error, offer watch what she is of determine what she | on 3/4/14 at 2:46 p.m. N)-D stated there are times dea what she needs. We use ing toileting, food, drink and loing to see if we can e needs. R10 was observed RN-D to wheel self over to a | | | | |

Minnesota Department of Health

STATE FORM 6899 MCDQ11 If continuation sheet 5 of 38

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|----------------------------|--|-------------------------------|--------------------------|
| | | | A. BUILDING: | | | |
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| MEADO | W MANOR | | GRAND AVI IEADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 2 565 | rocking chair and s RN-D excused self approached R10 ar room. RN-D kneele as R10 spoke to he (possibly Cambodia informed writer, sor resident to talk to s changed during the room. R10 started is sounded sad said if sorry" to R10 and if no English words. I and RN-D no pictur other communicatio asked RN-D where tools were kept, RN was unable to locat During an observat nursing assistant (N kneeling down by it area of the facility. language and not u R10 to her room ar she was speaking in attempted to comm Sleep " and putting her face and closin the word " Bed " a continued to speak Cambodian. NA-D hallway close to the R10 yogurt to eat. It sure that was what R10 was having a s offer her some wat took a drink of her it then took another of | tarted rocking the empty chair. from the interview and and wheeled her back to her ad down by R10 and listened er in a different language an.) RN-D smiled at R10 and metimes it works to just allow taff. R10's tone of voice interaction with RN-D in her to cry and tone of her voice RN-D. RN-D then stated, "I'm R10 continued to speak using During the dialog between R10 re communication sheets or on tools were. When surveyor the picture communication I-D stated in R10's room but | 2 565 | | | |

Minnesota Department of Health

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--|--|------|-------------------------------|--|
| | | 00390 | B. WING | | 03/0 | 6/2014 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | | |
| MEADOV | V MANOR | | GRAND AVI | ENUE, PO BOX 365 N 55936 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| 2 565 | if she wanted to wa R10 was tearful dur while communication picture communication with identifying what verbalize or want. During an interview director of nursing (staff to use the communication working with R10. Thad not followed the translator services at SUGGESTED MET The director of nursifollow care plans in cares and services. Compliance. TIME PERIOD FOR (21) days. MN Rule 4658.0520 Proper Nursing Care Subpart 1. Care in receive nursing care | sh her hands. NA-D verified ing their interaction. Again on with R10 NA-D did not use tion sheets or tools to assist t R10 was attempting to on 3/6/14 at 8:25 a.m. the DON) stated she expected imunication sheets when the DON verified the facility e care plan to provide as available. CHOD OF CORRECTION: sing could in-service all staff to regards to specific resident Also to monitor for R CORRECTION: Twenty One O Subp. 1 Adequate and e; General general. A resident must e and treatment, personal and | 2 565 | | | | |
| | individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the | supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed. | | | | | |

Minnesota Department of Health

STATE FORM 6899 MCDQ11 If continuation sheet 7 of 38

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | | OATE SURVEY COMPLETED | |
|--|--|-------------------------|--|------|--------------------------|--|
| | | A. BOILDING. | | | | |
| | 00390 | B. WING | | 03/0 | 6/2014 | |
| NAME OF PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| MEADOW MANOR | | GRAND AVI MEADOW, MN | ENUE, PO BOX 365 N 55936 | | | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| 2 830 Continued From pa | age 7 | 2 830 | | | | |
| This MN Requiremby: Based on observative review, the facility services to determ complete assessmere viewed for communderstanding of the written. Findings Include: R10 was admitted with diagnosis that hemorrhage, cerebedysphasia, according 2/27/14. R10's admission Magnesis according 2/27/14. R10's admission Magnesis according 2/27/14. R10's admission Magnesis according 2/27/14. R10's hospital distributed interpreter to communderstands others. R10's hospital distributed formal interpreter according accordi | tion, interview and document failed to provide interpreter ine resident care needs and tents for 1 of 1 resident (R10) nunication with limited ne English language spoken or on to the facility on 12/12/13 included intracerebral provascular disease and ng to physician orders dated with a doctor or health d preferred language as nclear speech, rarely/never tood and rarely/never so. Inissal summary dated 12/12/14 terpreter services were needed ge was Cambodian. Intel 12/24/14 identified a so Cambodian was primary an interventions directed staff | | | | | |

Minnesota Department of Health

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|---------------------|---|-------------------|--------------------------|
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | , , , , , | |
| MEADO | W MANOR | | GRAND AVI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | Do not rush, Requestive resident to ensus speaking and make TV/radio as needed questions if appropionsistent words/communication too communication boo pictures. "However interpreter services to use picture commonicate with the R10's FALL INVES 12/18/13 at 10:30 pfloor (unwitnessed) Room. Resident Detrying to do just prior to communicate with status just prior to for does not speak Eng Resident's psychos Communication bate and understands lit Staff observed resident down derivation to prevand Bladder assess R10's FALL INVES 12/24/13 at 12:30 pfloor (unwitnessed) Room. Description just prior to the fall: Describe cause of the Intervention to prevand Bladder down @ [at the Inte | est feedback, clarification from are understanding, Face when a eye contact, Turn off at to reduce noise, Ask yes/no riate, Use simple, brief, ares, Use alternative as needed, i.e. ok, gestures, signs, and ar, the facility did not provide and staff were not observed munication tools to resident. TIGATION revealed on a.m., "Fall Summary: found on a.m., "Fall Summary: found on a.m., "Fall Summary: found on a fall Location: Resident a fall Location: Resident and understands little. Toocial status just prior to fall: and understands little. The scribe cause of the fall: dent to be incontinent of bowels of unwitnessed fall as she sat buttock at edge of bed. The series and solve the fall: 3 day Bowels. | 2 830 | | | |

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Minnesota Department of Health STATE FORM

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|-------------------------------|--------------------------|
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 03/0 | 0/2014 |
| | W MANOR | 210 EAST | | ENUE, PO BOX 365 | | |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 830 | 1/20/14 at 12:30 p.i floor (unwitnessed) Room. Resident de trying to do just prict to communicate. Rijust prior to fall: ale Resident's usual psunable to communiother: Unable to co Describe Cause of bed-since unable to tried to get up sat ounder her and both off side of the bed ounder her when fou with back against thout in front of her. I falls: Continue to be skills to better under R10's FALL INVES 2/22/14 at 6:10 a.m floor (unwitnessed) Resident description do just prior to the fell [wheelchair] in lobb what she was doing Resident attempting Interventions to pre D/C [discontinue] in recliner." During an observativas observed to be nurses station with NA-C. R10 appeare the nursing assistat by staff it was Cam speech and a raise | m., "Fall Summary: found on . Fall Location: Resident escription of what they were or to the fall: Resident unable esident's psychological status rt, unable to communicate. sychological status: alert, cate. Root cause of the fall mmunicate with staff. fall: Resident lying in communicate with staff she on edge of bed with soaker pad soaker pad and resident slid on to the floor. Soaker pad was and sitting on buttock on floor the mattress and legs straight enterventions to prevent future wild better communication erstand her needs" TIGATION revealed on a., "Fall Summary: found on . Fall Location: Day room. In of what they were trying to fall: Wheeling in w/c by resident unable to tell staff g. Describe cause of the fall: g to self transfer into chair. Event future falls:ordered to icotine patch. Offer resident ion on 3/4/14 at 9:45 a.m. R10 as sitting in front room of the nursing assistant (NA)-B and ad agitated, was speaking to this in Cambodian (were told bodian words) with fast d voice. NA-B and NA-C were at R10 to listen to music | 2 830 | | | |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--|--|-------------------------------|--------------------------|
| | | 00390 | B. WING | | 03/0 | 06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| MEADO | MEADOW MANOR | | | NUE, PO BOX 365 | | |
| | | | MEADOW, MN | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 10 | 2 830 | | | |
| 2 830 | through a headphorwere no picture corbeing utilized during NA-C and R10 to home communicating to twere. During an interview registered nurse (Rwhen we have no intrial and error offeriwatch what she is determine what she while interviewing Frocking chair and sir RN-D excused self approached R10 arroom. RN-D kneele as R10 communication RN-D nurse smiled sometimes it works staff. R10's tone of interaction with RN-cry and tone of her stated, "I'm sorry" to speak to nurse in Cpicture communication. | ne set and an IPOD. There numinication sheets or tools of the observation of the NA-B, elp determine what R10 was the staff or what R10's needs on 3/4/14 at 2:46 p.m. N)-D stated there are times dea what she needs. We use not to the total death of the total d | | | | |
| | communicating or v surveyor asked RN communication too | what R10's needs were. When -D where the picture is were kept, RN-D stated in as unable to locate them in to | | | | |
| | NA-D was observed R10's wheelchair in R10 was speaking | ion on 3/4/14 at 3:44 p.m. If to be kneeling down by If a common area of the facility. If Cambodian. NA-D wheeled Intinued to listen to R10 as she | | | | |

Minnesota Department of Health

STATE FORM 6899 MCDQ11 If continuation sheet 11 of 38

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | | X3) DATE SURVEY COMPLETED | |
|--|---|---|-----------------------------------|--|------------------------------|--------------------------|
| | 00390 B. WING | | | 03/0 | 6/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | • | |
| MEADO\ | W MANOR | | | ENUE, PO BOX 365 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | IEADOW, MI ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | was speaking Cam communicate with I putting her hands u closing her eyes. N and pointed at the k to NA-D in Camboo into the hallway clos gave R10 yogurt. N sure that was what R10 was having a soffer her some wate took a drink of her vR10 took another d poured the water or if she wanted to wa R10 was tearful dur were no picture corbeing utilized during and R10 to help decommunicating to twere. During an observati medical records (M one staff intervention wheelchair in a comappeared agitated, with fast speech, rate oan arm rest of a was attempting to go she was holding on communication she during the observation help determine what what R10's needs we buring an interview. | bodian. NA-D attempted to R10, by stating sleep and p to the side of her face and A-D also stated the word bed bed. R10 continued to speak lian. NA-D wheeled R10 back se to the nurses' station and A-D stated she wasn't really R10 wanted. NA-D stated snack and thought she would er. R10 ate her yogurt and water. R10 became tearful. rink of the water and then her hands. NA-D asked R10 sh her hands. NA-D verified ring their interaction. There munication sheets or tools of the observation of the NA-D termine what R10 was he staff or what R10's needs fon on 3/5/14 at 4:15 p.m. R)-A was providing a one to be staff or what R10's needs fon on R10 was sitting in a mon area of the facility, was speaking in Cambodian ised voice and was holding on chair, shaking the chair. MR-A let R10 to let go of the chair to. There were no picture test or tools being utilized ion of the MR-A and R10 to let R10 was communicating or were. | 2 830 | | | |
| | stated communicat R10. NA-E stated F | on was a little difficult with R10 was able to say toilet and ling at the pictures. NA-E | | | | |

Minnesota Department of Health

STATE FORM 6899 MCDQ11 If continuation sheet 12 of 38

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--|---|---|---------------------|---|-------------------|--------------------------|
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, S | STATE, ZIP CODE | | |
| MEADO\ | W MANOR | | | ENUE, PO BOX 365 | | |
| (VA) ID | CHMMADV CTA | TEMENT OF DEFICIENCIES | EADOW, MI | | | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T | D BE | (X5) COMPLETE DATE |
| | walk and would play extent staff were an NA-E stated when I called the son or dastated when R10 ta would inform staff owas usually able to would usually calmany interpreter service. | as agitated staff will take for a y music. NA-E stated to an e able to meet R10's needs. R10 was more agitated; staff tughter to interpret. NA-E lked to family, the family of what R10 needed and staff get what R10 needed and she down. NA-E was not aware of ices to use with R10. on 3/5/14 at 11:12 a.m. NA-F some words in English, | | | | |
| | toileting, food, thirty was able to say yes most part. NA-F state picture flashcards, a communicate with I took them home to on them and didn't facility. NA-F verifies taff were unable to stated staff provide frequently for R10. interpreter services NA-F stated, "I wish can't understand who could have an interpunderstand how munight be in more painterpreter would he and to be able to present the state of | r, tired/sleep and stated R10 for no and understand for the sted the facility used to have and paper sheets to use to R10. NA-F stated R10's son write words in her language think they ever got back to the d when R10 became agitated tell why R10 was upset. NA-F d one to one supervision quite NA-F was unaware of any available to use with R10. In we did have one because we nat she is saying. I wish we preter to be unable to uch pain she is really in. She ain than we realize. An elp us to know what she needs ovide for her." | | | | |
| | stated staff used has sleepy. We have flat are kept in top draw the nurses' station. used those since R | on 3/5/14 at 2:36 p.m. NA-G and singles for, drink, eat, ashcards, to use with R10 that ver of her nightstand and at NA-G stated she had not 10 had a room on the west ago. NA-G stated she | | | | |

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Minnesota Department of Health STATE FORM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|---|---|--|-------------------------|--|-------------------|--------------------------|
| | | | 7.1. 20.23 | | | |
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| MEADO | W MANOR | | GRAND AVI IEADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | thought the flashca was first here. She could tell she was sirst got here. I wou would shake her he she gets agitated. I her, in a place that nobody understand any interpreter serv communicate with nice if they did have director of nursing staff to use the comworking with R10. I was unable to have DON stated when agitated facility staft them speak to her awhat she was upse The DON verified the arrangements for incommunicate with needs and to compverified it was diffic assessments of R1 barrier and R10 be she was trying to do verified the facility it to provide translato. During an interview services (SS)-A ver family if they would for interpreter serviher nursing home so discussions with Fand family indicated. | ge 13 rds "frightened her when she was in a new place and you cared and anxious when she ld hold up a flashcard and she ead. I totally understand why the must be so frustrating to be she is not used to and where sher." NA-G was unaware of rices that could be utilized to R10 and stated it would be enterpreter service to use. on 3/6/14 at 8:25 a.m. the RDON) stated she expected from the DON verified facility staff a conversations with R10. The R10 became upset and for would call the family have and family would relay to staff the about and what she needed. The properties services to resident to determine care lete assessments. The DON will to complete analysis and O's falls due to the language ing able to communicate what to prior to her falls. The DON and not followed the care plan in services as available. Ton 3/6/14 at 9:22 a.m. social ified she did not offer or ask like arrangements to be made cost to be used for R10 during stay. SS-A stated she had A about the language barrier of they would help interpret as and she looked for flashcards on the looked flashcards | 2 830 | | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|--|------------------------|--|-------------------------------|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00390 | B. WING | | 03/06/2014 | |
| NAME OF PROV | VIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MEADOW MA | ANOR | | GRAND AVI EADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| the condex SS she flas ma foll the the Lin ser foll ser Du SS cor and into ass nor buil cor as res Du RN una not hel to l bed | eveloped a commusion of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments. Turing an interview ated a lot of the assessments and the time and the time and the time and the time ated and the time and the time ated and the time and the | e with resident for a speech therapy also unication board for staff use. The second care conference unily by asking F-A to develop. SS stated F-A stated they als for pain, however never the providing a flashcards to rified the facility did not follow edure for Communication with ficient Persons undated policy S-A verified the facility had not an to provide translator e. on 3/6/14/ at 10:20 a.m., ments for R10 were observations, staff interviews a family. SS-A verified were not utilized to complete on 3/6/14 at 10:27 a.m., RN-A seessments were completed on, using gestures and cated if the family in the as assessment needed to be all use the family to interpret nunicate exactly what the | 2 830 | | | |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|---|--|--|------------------------|--|-------------------|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| MEADO | W MANOR | | GRAND AVI EADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | SUGGESTED MET The director of nurs educate staff to ens understanding of th written is assessed to determine individ The DON or design to ensure each resi supervision the indi | HOD OF CORRECTION: sing (DON) or designee could sure each resident with limited e English language spoken or with the use of an interpreter lual needs and supervision. ee could then perform audits dent receives the care and | 2 830 | | | |
| 2 910 | Incontinence Subp. 5. Incontiner have a continuous properties and the summan series and | nce. A nursing home must program of bowel and bladder luce incontinence and the catheters. Based on the ident assessment, a nursing that: ho enters a nursing home g catheter is not catheterized s clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to t infections and to restore as er function as possible. | 2 910 | | | |
| | by: Based on observati review, the facility for | ent is not met as evidenced on, interview and document ailed to identify three ctive urinary tract infection | | | | |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|-------------------------------|--------------------------|
| | | | 7.11.20.25.110.1 | | | |
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| MEADO\ | MEADOW MANOR | | | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 2 910 | Continued From pa | ge 16 | 2 910 | | | |
| | (UTI) before starting antibiotic therapy for 2 of 4 resident (R39 and R42) reviewed for urinary incontinence. | | | | | |
| | Findings include: | | | | | |
| | that on 2/17/14, R3 (antibiotic) 250 mg twice a day) for sev physician order not indicated a new ord diagnosis of UTI hobeen identified on t notes 1/1/14, to 2/1 documentation of s | ymptoms related to a UTI. rd was reviewed and it was | | | | |
| | be held for culture, seven days on 2/23 progress notes 1/7/ documentation of s | aysician ordered a urinalysis to and Cipro 250 mg bid for 14/14 for UTI. Review of 14, to 2/23/14, revealed no ymptoms related to a UTI nce of foul smelling urine, or | | | | |
| | director of nursing (documentation had R39 or R42 had a ra UTI to justify the | 3/6/14, at 1:03 p.m. the (DON) confirmed no been identified to indicate minimum of three symptoms of use of antibiotic use. DON ion was three symptoms were h an antibiotic. | | | | |
| | Request was made on antibiotic use, no | to review the facilities policy one provided. | | | | |
| | The director of nurs | THOD OF CORRECTION: sing could in-service licensed identify three symptoms are | | | | |

Minnesota Department of Health

STATE FORM 6899 MCDQ11 If continuation sheet 17 of 38

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|---|---|------------------------|---|-------------------------------|--------------------------|
| | | | A. BUILDING. | | | |
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MEADO\ | W MANOR | | GRAND AVI EADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 910 | Continued From pa | ge 17 | 2 910 | | | |
| | needed to treat with | n an antibiotic therapy. | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty One | | | | |
| 21375 | MN Rule 4658.0800 Program | Subp. 1 Infection Control; | 21375 | | | |
| | Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. | | | | | |
| | This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure their infection control program included tracking and trending of employee infections and failed to sanitize a multi-resident use glucometer according to the sanitizer recommendations for 1 of 1 resident (R3) observed during medication pass. | | | | | |
| | Findings include: | | | | | |
| | program was review | yee infection control logs and wed with the director of nursing entified as the infection control 2:54 p.m. | | | | |
| | reviewed between logs failed to includ symptoms and date which department t infection control log provided. The DON | etion control logs were 10/29/13, through 2/22/14. The e consistent documentation of e of onset, and did not identify he employee had worked. No s prior to 10/29/13 were verified employee illnesses ed prior to 10/29/13. The DON | | | | |

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|-------------------------|--|-------|--------------------------|
| | | | A. BOILDING. | | | |
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| MEADO\ | W MANOR | | GRAND AVI IEADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 21375 | stated she had not other than the nursi unable to report that employees in other to provide the docu the facility did not hand trend employee. A policy for tracking requested but not possible for tracking requested but not possible for tracking requested but not possible for the factor of the f | tracked employee illnesses ing department. She was at had monitored infections for departments and was unable mentation. The DON verified ave a system in place to track e illness. If employee illnesses was provided. If SANITIZED PER DMMENDATIONS: Inat included diabetes mellitus cility Admission Record form. If physician orders signed caled orders for "accu check day]. " If son 3/3/14, at 4:43 p.m., urse (LPN)-A placed R3's test strip in the Assure er (a blood sugar monitoring appleted, LPN-A placed the ucometer on a paper towel on on cart, wiped the glucometer i-wipe sanitizing cloth, and h. During interview at that d she wiped the device with immediately threw away the evice to air dry. Is on 3/3/14, at 4:47 p.m., assure Platinum Glucometer | 21375 | | | |
| | | e facility had no facility policy | | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|------------------------------|---|--------|-------------------------------|--|
| | | 00390 | B. WING | | 03/0 | 06/2014 | |
| - | PROVIDER OR SUPPLIER W MANOR | 210 EAST | 1.5 | STATE, ZIP CODE ENUE, PO BOX 365 N 55936 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE | |
| 21375 | for sanitizing multi-remonitoring devices. She expected staff to wis Sani-wipe cook expected staff to wis Sani-wipe cloth and verified the direction container included to remain wet for two for the main wet for two for the monitoring interview on verified the one Assused for three resides the one Assused for three resides to container directed, To disinfect nonfood wipe to remove heat and thoroughly wet must remain visibly Use additional wipe continuous two (2) air dry." SUGGESTED MET The director of nursed development and in procedures on infect tracking and trendirect educate staff on the multiple patient use contamination, and used for residents in surface and then monitor the apt to the policies and procedures and procedures and the monitor the apt to the policies and procedures and the monitor the apt to the policies and procedures and the monitor the apt to the policies and procedures and the monitor the apt to the policies and procedures and the monitor the apt to the policies and procedures and the monitor the apt to the policies and procedures and the monitor the apt to the policies and procedures and the monitor the apt to the policies and procedures and the monitor the apt to the policies and procedures and the monitor the apt to the policies and procedures are procedured. | resident blood sugar Director of nursing stated to follow directions on the intainer. She stated she pe the device with a super let the device air dry. She ins on the super Sani-wipe to wipe the device and to minutes. 3/3/14, at 7:55 p.m., LPN-A sure Platinum Glucometer was ents on the east wing. If the Super Sani-Wipe To Disinfect and Deodorize: dicontact surface only: Use a any soil. Unfold a clean wipe surface. Treated surface wet for a full two (2) minutes. (s) if needed to assure minutes wet contact time. Let THOD OF CORRECTION: sing or her designee could inplement policies and cition control measures for a gemployee health, could appropriate cleaning of equipment to prevent cross cou; did ensure equipment nave a sanitary, cleanable onitor for compliance. | 21375 | | | | |

6899

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED | |
|---|--|---|------------------------|--|-----------------|--------------------------|
| | | | 7. BOILDING. | | | |
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| MEADO | W MANOR | | GRAND AV IEADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21426 | (a) A nursing home maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Prever Tuberculosis Elimir Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implements | e provider must establish and hensive tuberculosis ogram according to the most is infection control guidelines distates Centers for Disease action (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines. | 21426 | | | |
| | by: Based on interview facility failed to ens tuberculin symptom completed upon ad | ent is not met as evidenced and document review, the ure screening of active as and tuberculosis testing was mission for 1 of 5 newly (R10) reviewed for baseline ning. | | | | |
| | Findings include: | | | | | |
| | dated 12/12/13, wa | ursing Data Collection form s reviewed and identified R10 on 12/12/13. The form in all areas of the | | | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--|--|------|-------------------------------|--|
| | | 00390 | B. WING | ····· | 03/0 | 6/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| MEADO\ | W MANOR | | GRAND AVI EADOW, MI | ENUE, PO BOX 365 N 55936 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE | |
| 21426 | tuberculosis (TB) so screening tool, undo of an adverse react outside of the USA, other areas of the form of During further revier found in the medical evidence document been performed. On 3/5/14, at 2:50 processory (DON) was interviewded as a comparation of the facilities of the | ge 21 creening section, Ka. R10's TB ated indicated R10 had history ion to a TB skin test, was born and was age 64 or more. All orm specified "unknown." w, a TB screening was not al record and there was noted that a chest X-Ray had o.m., the director of nursing wed and verified baseline TB station was not found in R10's culosis Infection Control Plan as was reviewed and directed creening to be completed a prior to or 72 hours after thou of CORRECTION: sing could in-service all staffication and documentation of R CORRECTION: Twenty One | 21426 | | | | |
| 21495 | Providing Social Se Subp. 5. Providing services must be pr | 5 Subp. 5 Social Services; rvices social services. Social rovided on the basis of vice needs of each resident. | 21495 | | | | |
| | according to the corassessment and co | mprehensive resident mprehensive plan of care 4658.0400 and 4658.0405. | | | | | |

6899

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|--|-------------------------------|--------------------------|
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | - | |
| MEADO | W MANOR | 210 EAST | GRAND AVI | ENUE, PO BOX 365 | | |
| WILADO | WIMMON | GRAND M | IEADOW, MI | N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21495 | Continued From pa | ge 22 | 21495 | | | |
| | by: Based on interview facility failed to proviservices to attain or practicable, physical well-being for 1 of 1 | and document review, the vide medically-related social maintain the highest al, mental and psychosocial resident (R10) with limited e English language spoken or | | | | |
| | Findings Include: | | | | | |
| | R10 was admitted on to the facility on 12/12/13 with diagnosis that included intracerebral hemorrhage due to cerebrovascular disease and dysphasia due to cerebrovascular disease, according to physician orders dated 2/27/14. | | | | | |
| | 12/18/13 indicated needed or wanted a with a doctor or hea preferred language | inimum Data Set (MDS) dated "Yes" to the question R10 an interpreter to communicate alth care staff. Identified as Cambodian, had unclear er makes self-understood and tands others. | | | | |
| | language barrier as language. Care pla translator as availal or son will assist wh communication techniteraction: Allow as Repeat as necessafeedback, clarification understanding, Faceye contact, Turn oreduce noise, Ask y | red 12/24/14 identified a Cambodian was primary in interventions read, "Provide ole to communicate. Daughter nen they are present. Use hiniques which enhance dequate time to respond, ry, Do not rush, Request on from the resident to ensure e when speaking and make ff TV/radio as needed to res/no questions if mple, brief, consistent | | | | |

| - | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|------------------------------|--|-------------------------------|--------------------------|
| | | 00390 | B. WING | | 03/0 | 06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | ORESS, CITY, S | STATE, ZIP CODE | | |
| MEADO | W MANOR | | GRAND AVI EADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21495 | words/cues, Use all as needed, i.e. com signs, and pictures. provide interpreter sobserved to use piccommunicate with rues and an interview registered nurse (Rues when we have no ictrial and error, offer watch what she is determine what she while interviewing Frocking chair and stroom. RN-D excused self approached R10 ar room. RN-D kneele as R10 spoke to he (possibly Cambodia informed writer, sor resident to talk to st changed during the room. R10 started the sounded sad said From Sorry' to R10 and Rno English words. If and RN-D no pictur other communication asked RN-D where tools were kept, RN was unable to located. During an observation nursing assistant (Not kneeling down by Rarea of the facility, language and not unsigned to located.) | ternative communication tools imunication book, gestures, "However, the facility did not services and staff were not sture communication tools to resident. on 3/4/14 at 2:46 p.m. N)-D stated there are times dea what she needs. We use ing toileting, food, drink and loing to see if we can eneeds. R10 was observed RN-D to wheel self over to a tarted rocking the empty chair. from the interview and and wheeled her back to her down by R10 and listened or in a different language an.) RN-D smiled at R10 and metimes it works to just allow taff. R10's tone of voice interaction with RN-D in her o cry and tone of her voice RN-D. RN-D then stated, "I'm at 10 continued to speak using During the dialog between R10 e communication sheets or on tools were. When surveyor the picture communication l-D stated in R10's room but | 21495 | | | |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | | A. BUILDING. | | | |
| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MEADO | W MANOR | | GRAND AVI IEADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE |
| 21495 | attempted to commodise and putting her face and closing the word "Bed" a continued to speak Cambodian. NA-D hallway close to the R10 yogurt to eat. It is sure that was what R10 was having a soffer her some wate took a drink of her of then took another of poured the water of if she wanted to wa R10 was tearful dur while communication picture communication with identifying what werbalize or want. During an interview stated R10 knows stoileting, food, thirty was able to say "Yes the meaning for the facility used to have sheets to use to condition the communication of the staff were unable to staff provide frequently for R10. interpreter services NA-F stated, "I wish to interpreter] became to staff provide frequently for R10. interpreter] became to staff provide frequently for R10. interpreter] became to staff were unable to staff provide frequently for R10. interpreter] became to staff were unable to staff provide frequently for R10. interpreter] | unicate with R10, by stating "her hands up to the side of gher eyes. NA-D also stated and pointed at the bed. R10 to NA-D in possible wheeled R10 back into the enurses' station and gave NA-D stated she wasn't really R10 wanted. NA-D stated snack and thought she would er. R10 ate her yogurt and water. R10 became tearful, lrink of the water and then in her hands. NA-D asked R10 sh her hands. NA-D verified ring their interaction. Again on with R10 NA-D did not use tion sheets or tools to assist it R10 was attempting to on 3/5/14 at 11:12 a.m. NA-F some words in English such as a tired/sleep and stated R10 are or No" and understand a most part. NA-F stated the expicture flashcards, and paper mmunicate with R10. Ited R10's family (F)-A took words in her language on the they ever got back to the me time ago F-A took them d when R10 became agitated of tell why R10 was upset. NA-F d one to one supervision quite NA-F was unaware of any available to use with R10. In we did have one [reference use we can't understand what in we could have an interpreter | 21495 | | | |

| winnesc | <u>ita Department of He</u> | aith | | | | |
|--------------------------|---|---|----------------------------|--|-------------------------------|--------------------------|
| | NT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
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| | | 00390 | B. WING | | 03/0 | 6/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| | | 210 EAST | GRAND AVI | ENUE, PO BOX 365 | | |
| MEADO\ | W MANOR | | EADOW, MI | | | |
| (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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21495 | Continued From pa | ge 25 | 21495 | | | |
| | really in. She might realize. An interpret she needs and to be During an interview stated staff used has sleepy. We have flatare kept in top draw the nurses' station. used those since R wing about a month thought the flashcal was first here. She could tell she was sfirst got here. I wou would shake her he she gets agitated. Her, in a place that nobody understand any interpreter serv communicate with I nice if they did have During an interview director of nursing (staff to use the comworking with R10. The was unable to have because R10 spoke stated when R10 befacility staff would compeak to her in their relay to staff what s | erstand how much pain she is be in more pain than we er would help us to know what e able to provide for her. " on 3/5/14 at 2:36 p.m. NA-G and singles for, drink, eat, ishcards, to use with R10 that wer of her nightstand and at NA-G stated she had not 10 had a room on the west in ago. NA-G stated she was in a new place and you cared and anxious when she was in a new place and you cared and anxious when she wad. I totally understand why lit must be so frustrating to be she is not used to and where is her." NA-G was unaware of ices that could be utilized to R10 and stated it would be interpreter service to use. on 3/6/14 at 8:25 a.m. the DON) stated she expected imunication sheets when the DON verified facility staff conversations with R10 are Cambodian only. The DON ecame upset and agitated all the family and have them are language and family would he was upset about and what ON verified the facility had not | | | | |
| | communicate with r | s for interpreter services to resident. n with Limited English undated policy and procedure | | | | |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: | COMPLETED |
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| 00300 B. WING | |
| 00390 B. WING | 03/06/2014 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| MEADOW MANOR 210 EAST GRAND AVENUE, PO BOX 365 | |
| GRAND MEADOW, MN 55936 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AT AG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENT TAG DEFICIENT TAG TAG TAG TAG TAG TAG TAG TAG TAG TA | CTION SHOULD BE COMPLETE D THE APPROPRIATE DATE |
| read, "Policy; Grand Meadow Health Care Center shall make provisions for effective communication with Limited English Proficient persons (LEP), including current and prospective residents, family, interested persons, etc., to ensure an equal opportunity to benefit from our services as non-LEP persons. The following procedure will ensure that language needs are met at no cost to the LEP resident. Procedure: 1. A qualified interpreter will be offered to the LEP resident, prospective resident or family member upon request of the LEP resident, at first point of contact as well as during other services as need is identified, 2. Need is identified by using the departmental "important/urgent "guideline. Language assistance may include: use of staff language bank listing, professional interpreter services, and/or use of a telephone language line service. Language assistant resources shall be located in the Language Resource Manual at each nurse 's station. 3. Should a professional interpreter be needed, staff shall make arrangements using the list of agencies in the Language Resource Manual. During non-business hours, the facility Nursing Supervisor is responsible to arrange for the interpreter. 4. The offer of an interpreter will be documented in the resident 's record and shall include if the offer was accepted or declined, the agency used, phone number, name of professional interpreter and summary of purpose of discussion 5. The use of family, friends, other residents and volunteers and staff as interpreters will be prohibited unless it is the resident 's preference after a qualified interpreter has been offered. DO NOT RELY ON LEP FAMILY MEMBERS. | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
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| | | 00390 | B. WING | | 03/0 | 6/2014 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| MEADO | W MANOR | | IEADOW, MI | ENUE, PO BOX 365 N 55936 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | |
| 21495 | | ge 27 on 3/6/14 at 9:22 a.m. social | 21495 | | | | |
| | services (SS)-A ver family if they would for interpreter service her nursing home so discussions with Fand family indicated needed. SS-A state the internet to utilize communication and developed a communication and developed a communication and she also involved fallash cards for pain make the flash card followed through with the facility. SS-A ver the policy and process. | ified she did not offer or ask like arrangements to be made ces to be used for R10 during tay. SS-A stated she had A about the language barrier d they would help interpret as d she looked for flashcards on | | | | | |
| | The administrator of were made for residunderstanding of the | e English language spoken or ed interpreter services while | | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty One | | | | | |
| 21530 | MN Rule 4658.1310 | A.B.C Drug Regimen Review | 21530 | | | | |
| | reviewed at least m currently licensed b This review must be | en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, | | | | | |

6899

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|------------------------------|---|-------------------------------|--------------------------|
| | | 00390 | B. WING | | 03/0 | 06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | | |
| MEADO | W MANOR | | GRAND AVI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21530 | Surveyor Procedure Requirements in Lo the Department of I Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the ac report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affe refer the matter to t if the medical direct physician. If the me the attending physic justification for the o physician does not must be referred fo assessment and as by part 4658.0070. the medical direct must refer the matter | ge 28 es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. Corporated by reference. It is the Minitex interlibrary loan bject to frequent change. Coist must report any director of nursing services hysician, and these reports in by the time of the next coner, if indicated by the proses of this part, "acted coceptance or rejection of the ing or initialing by the director and the attending physician. In ing physician does not concur its recommendation, or does the justification, and the ingest that the medical director for review for is not the attending edical director determines that coin does not have adequate order and if the attending change the order, the matter or review to the quality issurance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality issurance committee. | 21530 | | | |
| | by: Based on interview failed to ensure the | ent is not met as evidenced and record review the facility consultant pharmacist | | | | |

6899

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 00390 | B. WING | | 03/0 | 06/2014 |
| NAME OF PF | ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | - | |
| MEADOW | MANOR | | GRAND AVI MEADOW, MI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| | medications for 2 of reviewed for unnecessive seems admitted admission record diagnoses that inclured admission record diagnoses that inclured admission record diagnoses that inclured and arthritis R5's annual Minimuted 1/9/14, identified brickly and been or severe cognitive im received scheduled PRN pain medication interventions, indication and expressions are sident complains possible pain: indicators and expressions are sident complains possible pain: indicators are plan print chronic pain related disease, back/knees tiffness secondary interventions of but analgesia as orderes side effects and ef | needed (PRN) pain f 5 residents (R5, R7) essary medications. ted on 3/31/2009. R5's ated 2/22/13, identified ided but not limited to generalized osteoarthrosis. Im Data Set (MDS) dated ief interview of mental status ne out of fifteen and indicated pairment, pain management: pain medication, received on, received non-medication ators of pain or possible pain: vocal complaints of pain, and frequency with which or shows evidence of pain or ators of pain or possible pain impaired mobility, to Parkinsonism and not limited to provide ed, observe and document for ectiveness. Trs dated 2/4/14, identified an combination of an opioid pain medication, pain) 5-325 mg (milligrams) | 21530 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|---|-------------------------------|--------------------------|
| | 00390 | | B. WING | | 03/06/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | - | |
| MEADO\ | W MANOR | | | ENUE, PO BOX 365 | | |
| (VA) ID | CHMMADV CTA | TEMENT OF DEFICIENCIES | EADOW, MI | PROVIDER'S PLAN OF CORRECTION | ON! | (VE) |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETE DATE |
| 21530 | Continued From pa | ge 30 | 21530 | | | |
| | 37 doses of Roxice information if the parelieve moderate pagiven. | 14: R5 had received a total of t PRN and there was no ain medication was effective to ain for 32 out of the 37 doses | | | | |
| | During interview on 3/6/14, at 8:09 a.m., registered nurse (RN)-A verified reason given and effectiveness of Roxicet PRN had not always been documented. | | | | | |
| | During interview on 3/6/14, at 11:15 a.m., director of nursing stated she would expect reason given and effectiveness of PRN pain medication to be documented on the back of MAR (medication administration record). | | | | | |
| | admission record d diagnoses that inclujoint, shoulder region involving multiple sibelow knee. R7's quidentified brief internad been one 10 or moderate cognitive management: received medication, received received non-medic presence yes, pain made it hard to sleed day activity because | ved scheduled pain and PRN pain medication, cation interventions, pain frequency frequently, pain has ep at night, had limited day to e of pain, pain intensity rated with 10 being the worst | | | | |
| | on chronic pain rela atrophic vaginitis, p depression, history | date 3/6/14, identified acute ated to osteoarthrosis, obesity, erineal pain, diabetes mellitus, of urinary tract infection and not limited to provide | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|--|-------------------------------|--------------------------|
| | | 00200 | B. WING | | 03/06/2014 | |
| NAME OF | | 00390 | | TATE ZID CODE | 03/0 | 10/2014 |
| | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE ENUE, PO BOX 365 | | |
| MEADO | W MANOR | | EADOW, MI | | | |
| (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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21530 | Continued From pa | ge 31 | 21530 | | | |
| | analgesia as ordere side effects and eff | ed, observe and document for ectiveness. | | | | |
| | order for Belladonn medication) 16.2-30 six hours for perine narcotic pain medication some pain medication) 50 one to five and two every six hours as receive more than 3 PRN four times a d 4000 mg per 24 ho During review of R3 sheets and medication following had been 2/1/14 through 3/5/ one dose of Belladowas no information pain; A total of 46 d and there was no in this pain medication 46 doses and no in was effective to reli doses; had received PRN and no inform medication was givinformation as to if to relieve pain for 1 | It's medication administration tion documentation sheets the identified from the dates of 14: R7 had received a total of onna-Opium PRN and there if it was effective to relieve oses of Oxycodone HCI PRN afformation that identified why has given for 25 out of the formation the pain medication eve pain for 36 out of 46 d 25 doses of Tramadol HCI ation to why this pain en for two of 25 doses and no the medication was effective 8 out of 25 doses; had | | | | |
| | information as to w for three of 26 dose effectiveness of pai doses. During interview on | of Tylenol PRN and no hy it was indicated to treat pain as and no information of n medication for 19 out of 26 | | | | |
| | | given and effectiveness of | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | | |
|--|---|--|---------------------|--|-------------------------------|--------------------------|--|--|
| | | 00390 | B. WING | · · · · · · · · · · · · · · · · · · · | 03/06/2014 | | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | • | | | |
| MEADO | 210 FAST GRAND AVENUE PO BOX 365 | | | | | | | |
| MEADO | W MANOR | GRAND I | MEADOW, MN | N 55936 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE | | |
| 21530 | Continued From pa | ge 32 | 21530 | | | | | |
| | Belladonna-Opium PRN, Oxycodone HCI PRN, Tramadol HCI PRN and Tylenol PRN had not always been documented. | | | | | | | |
| | During interview on 3/6/14, at 11:15 a.m., director of nursing stated she would expect reason given and effectiveness of PRN pain medications to be documented on the back of MAR (medication administration record). | | | | | | | |
| | During interview on 3/6/14, at 1:28 p.m., facility consultant pharmacist stated would absolutely expect reasons given and effectiveness of PRN pain medications to be documented. Facility consultant pharmacist stated,"I did not realize they were not doing that." | | | | | | | |
| | Document review of the facility policy CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS dated 2006, read, "Procedures E. The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. In collaboration with facility staff, the consultant pharmacist helps to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical services. This includes, but is not limited to: 2) Evaluating the process of receiving and interpreting prescribers 'orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring responses to, and using and/or disposing of all medications, biologicals, and chemicals. F. Specific activities that the consultant pharmacist performs includes, but is not limited to: 7) Reviewing medication administration records (MARs), treatment administration records (TARs) and physician orders at least monthly during MRR | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | 00390 B. WIN | | | | 03/0 | 6/2014 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | STATE, ZIP CODE | • | |
| MEADO\ | W MANOR | | GRAND AVI | ENUE, PO BOX 365 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM | | (X5) COMPLETE DATE |
| 21530 | Continued From pa | ge 33 | 21530 | | | |
| | orders and adminis residents." | tration of medications to | | | | |
| | The administrator, of consulting pharmacy policies and proced medication usage. In necessary. The direct could monitor mediensure compliance regulations. TIME PERIOD FOR (21) days. | CHOD OF CORRECTION: director of nursing and sist could review and revise lures for proper monitoring of Staff could be educated as ector of nursing or designee cations on a regular basis to with state and federal R CORRECTION: Twenty One | | | | |
| 21535 | MN Rule4658.1315 Drug Usage; Gener | Subp.1 ABCD Unnecessary | 21535 | | | |
| | Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is | | | | | |

| | (X3) DATE SURVEY COMPLETED | |
|--|-------------------------------|--|
| 00390 B. WING | 3/06/2014 | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| MEADOW MANOR 210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936 | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| 21535 Continued From page 34 available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to monitor for effectiveness of as needed (PRN) pain medications for 2 of 5 residents (R5, R7) reviewed for unnecessary medications. Findings include: R5 had been admitted on 3/31/2009. R5's admission record dated 2/22/13, identified diagnoses that included but not limited to rheumatoid arthritis, generalized osteoarthrosis. R5's annual Minimum Data Set (MDS) dated 1/9/14, identified brief interview of mental status (BIMS) had been one out of fifteen and indicated severe cognitive impairment, pain management: received scheduled pain medication, received PRN pain medication, received PRN pain medication, indicators of pain or possible pain: non-verbal sounds, vocal complaints of pain, facial expressions and frequency with which resident complains or shows evidence of pain or possible pain: indicators of pain or possible pain: non-verbal midication, received non-medication interventions, indicators of pain or possible pain: non-verbal sounds, vocal complaints of pain, facial expressions and frequency with which resident complains or shows evidence of pain or possible pain: indicators of pain or possible pain: nobserved daily. R5's care plan print date 1/29/14, identified chronic pain related to arthritis, degenerative joint disease, back/knee pain, impaired mobility, stiffness secondary to Parkinsonism and interventions of but not limited to provide analgesia as ordered, observe and document for side effects and effectiveness. | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|---------------------|--|-------|--------------------------|
| | | 00390 | B. WING | | 03/0 | 06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADI | DRESS, CITY, S | TATE, ZIP CODE | | |
| MEADO | W MANOR | | GRAND AVE | ENUE, PO BOX 365 I 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21535 | order for Roxicet (a acetaminophen and used for moderate every four hours PFD During review of R5 sheets and medicate following had been 2/1/14 through 3/5/37 doses of Roxice information if the parelieve moderate pagiven. During interview on registered nurse (R effectiveness of Robeen documented. During interview on of nursing stated shand effectiveness of documented on the administration record diagnoses that inclujoint, shoulder region involving multiple sibelow knee. R7's quidentified brief internal been one 10 or moderate cognitive management: receimedication, receive received non-medication. | combination of d an opioid pain medication, pain) 5-325 mg (milligrams) RN for pain. S's medication administration tion documentation sheets the identified from the dates of 14: R5 had received a total of t PRN and there was no ain medication was effective to ain for 32 out of the 37 doses 3/6/14, at 8:09 a.m., N)-A verified reason given and xicet PRN had not always 3/6/14, at 11:15 a.m., director ne would expect reason given of PRN pain medication to be back of MAR (medication rd). ted on 4/21/2009. R7's ated 2/22/13, identified add but not limited to pain in on, generalized osteoarthrosis tes, lower limb amputation warterly MDS dated 12/5/13, view of mental status (BIMS) at of 15 and indicated impairment, pain ved scheduled pain ad PRN pain medication, cation interventions, pain | 21535 | | | |
| | received non-medic presence yes, pain made it hard to slee | | | | | |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | 00390 | B. WING | | 03/0 | 06/2014 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| MEADO | W MANOR | | GRAND AVE | ENUE, PO BOX 365 I 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 21535 | from 0 to 10 scale of possible, and R7 with R7's care plan print on chronic pain relator atrophic vaginitis, put depression, history interventions of but analgesia as ordereside effects and medication) 16.2-30 six hours for perine narcotic pain medication) 50 one to five and two every six hours as receive more than 3 PRN four times and 4000 mg per 24 horder and medication following had been 2/1/14 through 3/5/3 one dose of Belladd was no information pain; A total of 46 dand there was no in this pain medication 46 doses and no inform medication was given information as to if | with 10 being the worst as a "7." date 3/6/14, identified acute ated to osteoarthrosis, obesity, erineal pain, diabetes mellitus, of urinary tract infection and not limited to provide ad, observe and document for ectiveness. ars dated 1/23/14, identified an a-Opium (a narcotic pain o mg suppository PRN every al pain, Oxycodone HCI (a action) 5 mg every four hours. Tramadol HCI (a synthetic o mg PRN: one tablet pain rate tablets pain rate six to 10 needed for pain, should not 300 mg daily, Tylenol 1000 mg ay as needed, do not exceed | 21535 | | | |

Minnesota Department of Health

STATE FORM 6899 MCDQ11 If continuation sheet 37 of 38

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | COMPLETED | | |
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| | | 00390 | B. WING | | 03/06/2014 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, S | STATE, ZIP CODE | • | |
| MEADO | W MANOR | | GRAND AVI | ENUE, PO BOX 365 N 55936 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 21535 | received 26 doses of information as to wh for three of 26 dose effectiveness of pai doses. During interview on verified the reason of Belladonna-Opium Tramadol HCI PRN always been documented on the administration recombed. Document review of MEDICATION ADM GUIDELINES dated Documentation 5) vadministered, the form giving the dose noted." SUGGESTED MET The director of nursin-service all staff recombed to mee under this licensing | of Tylenol PRN and no my it was indicated to treat pain as and no information of an medication for 19 out of 26 3/6/14, at 8:09 a.m., RN-A given and effectiveness of PRN, Oxycodone HCI PRN, and Tylenol PRN had not mented. 3/6/14, at 11:15 a.m., director are would expect reason given of PRN pain medications to be back of MAR (medication rd). If the facility policy INISTRATION-GENERAL at 2006, read, "C. When PRN medications are following documentation is a aints or symptoms for which given. c. Results achieved a and the time results were HOD OF CORRECTION: sing or pharmacist could be sponsible for medication use the requirements as written | 21535 | | | |