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 PROVIDER NO.
(L1) **245367**

2.STATE VENDOR OR MEDICAID NO.
(L2) **346314100**

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

4. TYPE OF ACTION: 7 (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on April 21, 2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 05/1/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/02/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/21/2014
(L33)

DETERMINATION APPROVAL

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 all45 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
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

Kamala Fiske-Downing, Program Specialist
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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245367	A. Building B. Wing	4/21/2014

Name of Facility	Street Address, City, State, Zip Code
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	**04/15/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**04/15/2014**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	**04/15/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**04/15/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	**04/15/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**04/15/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**04/15/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**04/15/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**04/15/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	05/01/2014	10160	4/21/2014
CMS RO				

Followup to Survey Completed on: 3/6/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245367	01 - MAIN BUILDING 01	4/15/2014

Name of Facility	Street Address, City, State, Zip Code
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	03/21/2014	ID Prefix Reg. # NFPA 101 LSC K0147	03/27/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/KFD	05/01/2014	25822	4/15/2014
CMS RO				

Followup to Survey Completed on: 3/5/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: MCDQ

Facility ID: 00390

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245367**

2. STATE VENDOR OR MEDICAID NO. (L2) **346314100**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/06/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michele McFarland, HFE NE II 04/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/21/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/21/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - 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;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
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

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

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
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

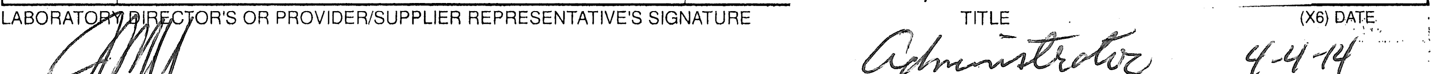
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING ______ B. WING ______	03/06/2014

APR 07 2014
MN Dept of Health
Rochester

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medically-related social services to attain or maintain the highest practicable, physical, mental and psychosocial well-being for 1 of 1 resident (R10) with limited understanding of the English language spoken or written. 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,	F 250	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Interpreter services were offered for R10, family declined services. R10 has been discharged from the nursing facility.	4/10/14 GPN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-4-14



Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245367	A. BUILDING ______ B. WING ______	03/06/2014

APR 07 2014
MN Dept of Health
Rochester

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

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F 250	Continued From page 1 according to physician orders dated 2/27/14. R10's admission Minimum Data Set (MDS) dated 12/18/13 indicated " Yes " to the question R10 needed or wanted an interpreter to communicate with a doctor or health care staff. Identified preferred language as Cambodian, had unclear speech, rarely/never makes self-understood and rarely/never understands others. R10's care plan dated 12/24/14 identified a language barrier as Cambodian was primary language. Care plan interventions read, "Provide translator as available to communicate. Daughter or son will assist when they are present. Use communication 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. communication book, gestures, signs, and pictures." However, the facility did not provide interpreter services and staff were not observed to use picture communication tools to communicate with resident. During an interview on 3/4/14 at 2:46 p.m. registered nurse (RN)-D stated there are times when we have no idea what she needs. We use trial and error, offering toileting, food, drink and watch what she is doing to see if we can determine what she needs. R10 was observed while interviewing RN-D to wheel self over to a rocking chair and started rocking the empty chair. RN-D excused self from the interview and	F 250	2. All residents were reviewed to see if there are language barriers. Completion date: 3/28/14 3. Staff to be educated on revised facility policy. Completion date: 4/8/14 4. Social Service will determine, upon each admission, if there is a language barrier and initiate policy when needed. 5. Upon admission of a resident with a language barrier, Social Service will audit 2x per week for a month and then 1x per month to ensure that residents who have a limited understanding of the English language spoken or written needs are met. 6. The data collected will be presented to the QA committee. The data will be reviewed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies. 7. Social Service is responsible for this area of compliance.	4/15/14 ~~4/8/14~~

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F 250	Continued From page 2 approached R10 and wheeled her back to her room. RN-D kneeled down by R10 and listened as R10 spoke to her in a different language (possibly Cambodian.) RN-D smiled at R10 and informed writer, sometimes it works to just allow resident to talk to staff. R10's tone of voice changed during the interaction with RN-D in her room. R10 started to cry and tone of her voice sounded sad said RN-D. RN-D then stated, " I'm sorry" to R10 and R10 continued to speak using no English words. During the dialog between R10 and RN-D no picture communication sheets or other communication tools were. When surveyor asked RN-D where the picture communication tools were kept, RN-D stated in R10's room but was unable to locate them at this time. During an observation on 3/4/14 at 3:44 p.m. nursing assistant (NA)-D was observed to be kneeling down by R10's wheelchair in a common area of the facility. R10 was speaking a different language and not using English. NA-D wheeled R10 to her room and continued to listen to R10 as she was speaking possible Cambodian. NA-D attempted to communicate with R10, by stating " Sleep " and putting her hands up to the side of her face and closing her eyes. NA-D also stated the word " Bed " and pointed at the bed. R10 continued to speak to NA-D in possible Cambodian. NA-D wheeled R10 back into the hallway close to the nurses ' station and gave R10 yogurt to eat. NA-D stated she wasn't really sure that was what R10 wanted. NA-D stated R10 was having a snack and thought she would offer her some water. R10 ate her yogurt and took a drink of her water. R10 became tearful, then took another drink of the water and then poured the water on her hands. NA-D asked R10 if she wanted to wash her hands. NA-D verified	F 250		

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F 250	Continued From page 3 R10 was tearful during their interaction. Again while communication with R10 NA-D did not use picture communication sheets or tools to assist with identifying what R10 was attempting to verbalize or want. During an interview on 3/5/14 at 11:12 a.m. NA-F stated R10 knows some words in English such as toileting, food, thirty, tired/sleep and stated R10 was able to say " Yes or No " and understand the meaning for the most part. NA-F stated the facility used to have picture flashcards, and paper sheets to use to communicate with R10. However, NA-F stated R10's family (F)-A took them home to write words in her language on them and didn't think they ever got back to the facility. This was some time ago F-A took them home. NA-F verified when R10 became agitated staff were unable to tell why R10 was upset. NA-F stated staff provided one to one supervision quite frequently for R10. NA-F was unaware of any interpreter services available to use with R10. NA-F stated, "I wish we did have one [reference to interpreter] because we can't understand what she is saying. I wish we could have an interpreter to be unable to understand how much pain she is really in. She might be in more pain than we realize. An interpreter would help us to know what she needs and to be able to provide for her. " During an interview on 3/5/14 at 2:36 p.m. NA-G stated staff used hand singles for, drink, eat, sleepy. We have flashcards, to use with R10 that are kept in top drawer of her nightstand and at the nurses' station. NA-G stated she had not used those since R10 had a room on the west wing about a month ago. NA-G stated she thought the flashcards " frightened her when she was first here. She was in a new place and you	F 250		

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F 250	Continued From page 4 could tell she was scared and anxious when she first got here. I would hold up a flashcard and she would shake her head. I totally understand why she gets agitated. It must be so frustrating to be her, in a place that she is not used to and where nobody understands her." NA-G was unaware of any interpreter services that could be utilized to communicate with R10 and stated it would be nice if they did have interpreter service to use. During an interview on 3/6/14 at 8:25 a.m. the director of nursing (DON) stated she expected staff to use the communication sheets when working with R10. The DON verified facility staff was unable to have conversations with R10 because R10 spoke Cambodian only. The DON stated when R10 became upset and agitated facility staff would call the family and have them speak to her in their language and family would relay to staff what she was upset about and what she needed. The DON verified the facility had not made arrangements for interpreter services to communicate with resident. The Communication with Limited English Proficient Persons undated policy and procedure 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	F 250		

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F 250	Continued From page 5 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, FRIENDS OR INFORMAL INTERPRETERS..... " During an interview on 3/6/14 at 9:22 a.m. social services (SS)-A verified she did not offer or ask family if they would like arrangements to be made for interpreter services to be used for R10 during her nursing home stay. SS-A stated she had discussions with F-A about the language barrier and family indicated they would help interpret as needed. SS-A stated she looked for flashcards on the internet to utilize with resident for communication and speech therapy also developed a communication board for staff use.	F 250		

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F 250	Continued From page 6 SS-A stated during the second care conference she also involved family by asking F-A to develop flash cards for pain. SS stated F-A stated they make the flash cards for pain, however never followed through with providing a flashcards to the facility. SS-A verified the facility did not follow the policy and procedure for Communication with Limited English Proficient Persons undated policy services for R10.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to care plan use of lateral	F 280	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Care plan and care sheets were updated for resident R5 to include positioning device per OT recommendation. Completion date: 3/28/14. 2. A comprehensive assessment for	

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F 280	Continued From page 7 support device in wheelchair for 1 of 1 resident (R5) reviewed for positioning needs. Findings include: R5's care plan print date 1/29/14, identified impaired physical mobility, dependence on staff for position changes, requires wheelchair for locomotion, dependent on staff to propel to and from desired destination. The care plan did not address the use of the blue Styrofoam pad to be used for positioning device when in wheel chair. During observation on 3/3/14, at 6:47 p.m., R5 had been in lobby sitting in wheelchair leaning to right side up against a blue Styrofoam pad. Also observed to be leaning to the right and use of blue Styrofoam pad on 3/4/14, at 8:31 a.m., 3/4/14, at 12:58 p.m., 3/5/14, at 9:28 a.m., 3/5/14, at 12:13 p.m., and on 3/5/14, at 1:30 p.m. Occupational Therapy (OT) note dated 11/13/13, identified reason for referral, presents with poor posture as result of positioning deficit, slid out of chair on 11/2/13 and nursing staff also noted positioning difficulties 11/7/13. OT Therapy at this time for wheelchair assessment and modification as needed in order to improve posture so R5 can improve safety and comfort while seated in wheelchair. R5 ' s OT progress and discharge summary dated 11/22/13, identified long term goals positioning, R5 will require total assistance to achieve effective positioning while seated in wheelchair utilizing wheelchair modifications as needed to affect leaning to side, reduce the risk	F 280	positioning devices has been completed for all residents. Care plans and care sheets updated to reflect current positioning devices. Completion date: 4/4/2014. 3. All residents will be screened quarterly by a licensed therapist. 4. The DNS and/or designees will audit two residents a week for one month then one resident a week for one month to ensure that the services provided follow the needs on the resident care plans. 5. The data collected will be presented to the QA committee. The data will be reviewed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies. 6. The DNS is responsible for this area of compliance.	4/15/14 JPN

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

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F 280	Continued From page 8 of skin breakdown and achieve optimum position to reduce the risk of falls. During interview on 3/6/14, at 8:30 a.m., registered nurse (RN)-A had stated had not known why blue Styrofoam pad was being used or when pad had been put in place. RN-A verified blue Styrofoam pad was not on R5's care plan and was not on nursing assistant pocket care plan. During interview on 3/6/14, at 11:15 a.m., director of nursing stated she would expect the blue Styrofoam pad positioning device to be care planned. Document review of the facility Guidelines for Care Plan Completion undated, read, " All Care Plans should include individual and/or Combined Focus Problems that address the following areas: ... assistive or adaptive equipment..."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop initial care plan interventions for 1 of 1 resident (R54) reviewed admitted with multiple purple discolorations. Findings include:	F 281	The preparation of the following plan correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:	

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F 281	Continued From page 9 R54 was observed on 3/3/14, at 4:26 p.m., with multiple large purple discolorations on right and left arms and hands. R54 was admitted to the facility on 2/26/14, with diagnosis that included Alzheimer's disease, chronic airway obstruction, and kidney disease stage 3, according to facility progress notes dated 3/6/14. Facility admission body audit dated 2/26/14 identified multiple bruising to left and right forearms, upper arms, and abdominal area. R54 ' s initial care plan dated 3/4/14, revealed no identification of multiple bruised areas and no interventions for care related to bruised areas. Document review of facility nursing assistant care plan undated, revealed no identification of multiple bruised areas and no interventions for care related to bruised areas. During interview on 3/5/14, 3:37 p.m., with medical records (MR)-A identified R54's initial care plan was in the chart, dated 3/4/14, and verified the lack of identification of multiple bruises. During interview at that time, registered nurse (RN)-consultant stated the nursing assistant (NA) care plan included initial care instructions for staff. During interview at that time, RN-consultant verified NA care plan lacked identification of multiple bruises. During interview on 3/6/14, at 12:30 p.m., director of nursing stated she expected the initial care plan to be started right way at the time of admission. Director of nursing verified the lack of initial care plan from admission of 2/26/14 to	F 281	1. A comprehensive care plan was completed for resident number R54. Care data sheets have been updated. 2. An initial care plan will be completed upon admission. Care plan and care sheets will be revised with changes to initial plan of care. 3. Conditions/follow-up charting tool was implemented with nursing notes for documentation. Completion date: 3/5/14. 4. Licensed staff will be re-educated on the completion of an initial care plan on: 4/8/20104. 5. The DNS and/or designees will audit each new resident one time per week for one month then one resident a week for one month to ensure that the services provided follow the needs on the resident care plans. 6. The data collected will be presented to the QA committee. The data will be reviewed at the quarterly Quality Assurance meeting. At this time the QA committee will make a	

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F 281	Continued From page 10 3/6/14 that included identification of multiple bruises and lacked staff interventions related to multiple bruises.	F 281	decision/recommendation regarding any necessary follow-up studies. 7. The DNS is responsible for this area of compliance.	4/15/14
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement care plan interventions for communication for 1 of 1 resident (R10) reviewed with limited understanding of the English language spoken or written. 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. R10's care plan dated 12/24/14 identified a language barrier as Cambodian was primary language. Care plan interventions read, "Provide translator as available to communicate. Daughter or son will assist when they are present. Use communication techniques which enhance interaction: Allow adequate time to respond, Repeat as necessary, Do not rush, Request feedback, clarification from the resident to ensure	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Interpreter services were offered R10, family declined services. R10 has been discharged from the nursing facility. 2. All residents were reviewed to see if there are language barriers. Completion date: 3/28/14. 3. Staff to be educated on revised facility policy. Completion date 4/8/14. 4. Social Service will determine, upon each admission, if there is a language	

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F 282	Continued From page 11 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. communication book, gestures, signs, and pictures." However, the facility did not provide interpreter services and staff were not observed to use picture communication tools to communicate with resident. During an interview on 3/4/14 at 2:46 p.m. registered nurse (RN)-D stated there are times when we have no idea what she needs. We use trial and error, offering toileting, food, drink and watch what she is doing to see if we can determine what she needs. R10 was observed while interviewing RN-D to wheel self over to a rocking chair and started rocking the empty chair. RN-D excused self from the interview and approached R10 and wheeled her back to her room. RN-D kneeled down by R10 and listened as R10 spoke to her in a different language (possibly Cambodian.) RN-D smiled at R10 and informed writer, sometimes it works to just allow resident to talk to staff. R10's tone of voice changed during the interaction with RN-D in her room. R10 started to cry and tone of her voice sounded sad said RN-D. RN-D then stated, " I'm sorry" to R10 and R10 continued to speak using no English words. During the dialog between R10 and RN-D no picture communication sheets or other communication tools were. When surveyor asked RN-D where the picture communication tools were kept, RN-D stated in R10's room but was unable to locate them at this time. During an observation on 3/4/14 at 3:44 p.m. nursing assistant (NA)-D was observed to be	F 282	barrier and initiate policy when needed. 5. Upon admission of a resident with a language barrier, Social Service will audit 2x per week for a month and then 1x per month to ensure that residents who have a limited understanding of the English language spoken or written needs are met. 6. The data collected will be presented to the QA committee. The data will be reviewed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies. 7. Social Service is responsible for this area of compliance.	4-15-14

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	245367	A. BUILDING ______ B. WING ______	03/06/2014

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

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F 282	Continued From page 12 kneeling down by R10's wheelchair in a common area of the facility. R10 was speaking a different language and not using English. NA-D wheeled R10 to her room and continued to listen to R10 as she was speaking possible Cambodian. NA-D attempted to communicate with R10, by stating " Sleep " and putting her hands up to the side of her face and closing her eyes. NA-D also stated the word " Bed " and pointed at the bed. R10 continued to speak to NA-D in possible Cambodian. NA-D wheeled R10 back into the hallway close to the nurses ' station and gave R10 yogurt to eat. NA-D stated she wasn't really sure that was what R10 wanted. NA-D stated R10 was having a snack and thought she would offer her some water. R10 ate her yogurt and took a drink of her water. R10 became tearful, then took another drink of the water and then poured the water on her hands. NA-D asked R10 if she wanted to wash her hands. NA-D verified R10 was tearful during their interaction. Again while communication with R10 NA-D did not use picture communication sheets or tools to assist with identifying what R10 was attempting to verbalize or want. During an interview on 3/6/14 at 8:25 a.m. the director of nursing (DON) stated she expected staff to use the communication sheets when working with R10. The DON verified the facility had not followed the care plan to provide translator services as available.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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F 309

Continued From page 13
or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide interpreter services to determine resident care needs and complete assessments for 1 of 1 resident (R10) reviewed for communication with limited understanding of the English language spoken or written.

Findings Include:

R10 was admitted on to the facility on 12/12/13 with diagnosis that included intracerebral hemorrhage, cerebrovascular disease and dysphasia, according to physician orders dated 2/27/14.

R10's admission Minimum Data Set (MDS) dated 12/18/13 indicated yes R10 needed or wanted an interpreter to communicate with a doctor or health care staff. Identified preferred language as Cambodian, had unclear speech, rarely/never makes self-understood and rarely/never understands others.

R10's hospital dismissal summary dated 12/12/14 indicated formal interpreter services were needed as primary language was Cambodian.

R10's care plan dated 12/24/14 identified a language barrier as Cambodian was primary

F 309

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

1. Interpreter services were offered R10, family declined services. R10 has been discharged from the nursing facility.
2. All residents were reviewed to see if there are language barriers. Completion date: 3/28/14.
3. Staff to be educated on revised facility policy. Completion date 4/8/14.
4. Social Service will determine, upon each admission, if there is a language barrier and initiate policy when needed.

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F 309	Continued From page 14	F 309		

language. Care plan interventions directed staff to, "Provide translator as available to communicate. [Family (F)-B] or [F-A] will assist when they are present. Use communication 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. communication book, gestures, signs, and pictures. " However, the facility did not provide interpreter services and staff were not observed to use picture communication tools to communicate with resident.

R10's FALL INVESTIGATION revealed on 12/18/13 at 10:30 p.m., "Fall Summary: found on floor (unwitnessed). Fall Location: Resident Room. Resident Description of what they were trying to do just prior to the fall: Resident unable to communicate with staff. Resident's mental status just prior to fall: Communication barrier- does not speak English and understands little. Resident's psychosocial status just prior to fall: Communication barrier- does not speak English and understands little. Describe cause of the fall: Staff observed resident to be incontinent of bowel and bladder at time of unwitnessed fall as she sat on the floor on her buttock at edge of bed. Intervention to prevent future falls: 3 day Bowel and Bladder assessment started."

R10's FALL INVESTIGATION revealed on 12/24/13 at 12:30 p.m., "Fall Summary: found on floor (unwitnessed). Fall Location: Resident

Provider's Plan of Correction (F 309):

5. Upon admission of a resident with a language barrier, Social Service will audit 2x per week for a month and then 1x per month to ensure that residents who have a limited understanding of the English language spoken or written needs are met.
6. The data collected will be presented to the QA committee. The data will be reviewed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.
7. Social Service is responsible for this area of compliance.

Completion date: 4/15/14 SPN

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F 309	Continued From page 15 Room. Description of what they were trying to do just prior to the fall: Resident unable to answer. Describe cause of fall: Attempting to self transfer. Intervention to prevent future falls: staff to lay resident down @ [at] 12:00 daily when in room." R10's FALL INVESTIGATION revealed on 1/20/14 at 12:30 p.m., "Fall Summary: found on floor (unwitnessed). Fall Location: Resident Room. Resident description of what they were trying to do just prior to the fall: Resident unable to communicate. Resident's psychological status just prior to fall: alert, unable to communicate. Resident's usual psychological status: alert, unable to communicate. Root cause of the fall other: Unable to communicate with staff. Describe Cause of fall: Resident lying in bed-since unable to communicate with staff she tried to get up sat on edge of bed with soaker pad under her and both soaker pad and resident slid off side of the bed on to the floor. Soaker pad was under her when found sitting on buttock on floor with back against the mattress and legs straight out in front of her. Interventions to prevent future falls: Continue to build better communication skills to better understand her needs ..." R10's FALL INVESTIGATION revealed on 2/22/14 at 6:10 a.m., "Fall Summary: found on floor (unwitnessed). Fall Location: Day room. Resident description of what they were trying to do just prior to the fall: Wheeling in w/c [wheelchair] in lobby- resident unable to tell staff what she was doing. Describe cause of the fall: Resident attempting to self transfer into chair. Interventions to prevent future falls: ...ordered to D/C [discontinue] nicotine patch. Offer resident recliner."	F 309		

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F 309	Continued From page 16 During an observation on 3/4/14 at 9:45 a.m. R10 was observed to be sitting in front room of the nurses station with nursing assistant (NA)-B and NA-C. R10 appeared agitated, was speaking to the nursing assistants in Cambodian (were told by staff it was Cambodian words) with fast speech and a raised voice. NA-B and NA-C were attempting to assist R10 to listen to music through a headphone set and an IPOD. There were no picture communication sheets or tools being utilized during the observation of the NA-B, NA-C and R10 to help determine what R10 was communicating to the staff or what R10's needs were. During an interview on 3/4/14 at 2:46 p.m. registered nurse (RN)-D stated there are times when we have no idea what she needs. We use trial and error offering toileting, food, drink and watch what she is doing to see if we can determine what she needs. R10 was observed while interviewing RN-D to wheel self over to a rocking chair and started rocking the empty chair. RN-D excused self from the interview and approached R10 and wheeled her back to her room. RN-D kneeled down by R10 and listened as R10 communicated to her in Cambodian. RN-D nurse smiled at R10 and informed writer, sometimes it works to just allow resident to talk to staff. R10's tone of voice changed during the interaction with RN-D in her room. R10 started to cry and tone of her voice sounded sad. RN-D stated, "I'm sorry" to R10 and R10 continued to speak to nurse in Cambodian. There were no picture communication sheets or tools being utilized during the observation of the RN-D and R10 to help determine what R10 was communicating or what R10's needs were. When surveyor asked RN-D where the picture	F 309		

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F 309	Continued From page 17 communication tools were kept, RN-D stated in R10 ' s room but was unable to locate them in to show writer. During an observation on 3/4/14 at 3:44 p.m. NA-D was observed to be kneeling down by R10's wheelchair in a common area of the facility. R10 was speaking in Cambodian. NA-D wheeled R10 to her room continued to listen to R10 as she was speaking Cambodian. NA-D attempted to communicate with R10, by stating sleep and putting her hands up to the side of her face and closing her eyes. NA-D also stated the word bed and pointed at the bed. R10 continued to speak to NA-D in Cambodian. NA-D wheeled R10 back into the hallway close to the nurses' station and gave R10 yogurt. NA-D stated she wasn't really sure that was what R10 wanted. NA-D stated R10 was having a snack and thought she would offer her some water. R10 ate her yogurt and took a drink of her water. R10 became tearful. R10 took another drink of the water and then poured the water on her hands. NA-D asked R10 if she wanted to wash her hands. NA-D verified R10 was tearful during their interaction. There were no picture communication sheets or tools being utilized during the observation of the NA-D and R10 to help determine what R10 was communicating to the staff or what R10's needs were. During an observation on 3/5/14 at 4:15 p.m. medical records (MR)-A was providing a one to one staff intervention. R10 was sitting in a wheelchair in a common area of the facility, appeared agitated, was speaking in Cambodian with fast speech, raised voice and was holding on to an arm rest of a chair, shaking the chair. MR-A was attempting to get R10 to let go of the chair	F 309		

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F 309	Continued From page 18 she was holding on to. There were no picture communication sheets or tools being utilized during the observation of the MR-A and R10 to help determine what R10 was communicating or what R10's needs were. During an interview on 3/5/14 at 11:02 a.m. NA-E stated communication was a little difficult with R10. NA-E stated R10 was able to say toilet and can tell us with looking at the pictures. NA-E stated when R10 was agitated staff will take for a walk and would play music. NA-E stated to an extent staff were are able to meet R10's needs. NA-E stated when R10 was more agitated; staff called the son or daughter to interpret. NA-E stated when R10 talked to family, the family would inform staff of what R10 needed and staff was usually able to get what R10 needed and she would usually calm down. NA-E was not aware of any interpreter services to use with R10. During an interview on 3/5/14 at 11:12 a.m. NA-F stated R10 knows some words in English, toileting, food, thirty, tired/sleep and stated R10 was able to say yes or no and understand for the most part. NA-F stated the facility used to have picture flashcards, and paper sheets to use to communicate with R10. NA-F stated R10's son took them home to write words in her language on them and didn't think they ever got back to the facility. NA-F verified when R10 became agitated staff were unable to tell why R10 was upset. NA-F stated staff provided one to one supervision quite frequently for R10. NA-F was unaware of any interpreter services available to use with R10. NA-F stated, "I wish we did have one because we can't understand what she is saying. I wish we could have an interpreter to be unable to understand how much pain she is really in. She	F 309		

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F 309	Continued From page 19 might be in more pain than we realize. An interpreter would help us to know what she needs and to be able to provide for her." During an interview on 3/5/14 at 2:36 p.m. NA-G stated staff used hand singles for, drink, eat, sleepy. We have flashcards, to use with R10 that are kept in top drawer of her nightstand and at the nurses' station. NA-G stated she had not used those since R10 had a room on the west wing about a month ago. NA-G stated she thought the flashcards "frightened her when she was first here. She was in a new place and you could tell she was scared and anxious when she first got here. I would hold up a flashcard and she would shake her head. I totally understand why she gets agitated. It must be so frustrating to be her, in a place that she is not used to and where nobody understands her." NA-G was unaware of any interpreter services that could be utilized to communicate with R10 and stated it would be nice if they did have interpreter service to use. During an interview on 3/6/14 at 8:25 a.m. the director of nursing (DON) stated she expected staff to use the communication sheets when working with R10. The DON verified facility staff was unable to have conversations with R10. The DON stated when R10 became upset and agitated facility staff would call the family have them speak to her and family would relay to staff what she was upset about and what she needed. The DON verified the facility had not made arrangements for interpreter services to communicate with resident to determine care needs and to complete assessments. The DON verified it was difficult to complete analysis and assessments of R10's falls due to the language barrier and R10 being able to communicate what	F 309		

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F 309	Continued From page 20 she was trying to do prior to her falls. The DON verified the facility had not followed the care plan to provide translator services as available. During an interview on 3/6/14 at 9:22 a.m. social services (SS)-A verified she did not offer or ask family if they would like arrangements to be made for interpreter services to be used for R10 during her nursing home stay. SS-A stated she had discussions with F-A about the language barrier and family indicated they would help interpret as needed. SS-A stated she looked for flashcards on the internet to utilize with resident for communication and speech therapy also developed a communication board for staff use. SS-A stated during the second care conference she also involved family by asking F-A to develop flash cards for pain. SS stated F-A stated they make the flash cards for pain, however never followed through with providing a flashcards to the facility. SS-A verified the facility did not follow the policy and procedure for Communication with Limited English Proficient Persons undated policy services for R10. SS-A verified the facility had not followed the care plan to provide translator services as available. During an interview on 3/6/14/ at 10:20 a.m., SS-A stated assessments for R10 were completed by staff observations, staff interviews and by talking to the family. SS-A verified interpreter services were not utilized to complete assessments. During an interview on 3/6/14 at 10:27 a.m., RN-A stated a lot of the assessments were completed based on observation, using gestures and non-verbal. RN-A stated if the family in the building at the time as assessment needed to be	F 309		

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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 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on 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:	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 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	

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

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F 315	Continued From page 22 R39's medical record was reviewed and indicated that on 2/17/14, R39's physician ordered Cipro (antibiotic) 250 mg (milligrams) po (orally) bid (twice a day) for seven days for a UTI. The physician order note dated 2/17/14, at 2:30 p.m. indicated a new order had been received for diagnosis of UTI however; no symptoms had been identified on the note. Review of progress notes 1/1/14, to 2/17/14, revealed no documentation of symptoms related to a UTI. R42's medical record was reviewed and it was noted that R42's physician ordered a urinalysis to be held for culture, and Cipro 250 mg bid for seven days on 2/23/14 for UTI. Review of progress notes 1/7/14, to 2/23/14, revealed no documentation of symptoms related to a UTI including the presence of foul smelling urine, or discomfort. During interview on 3/6/14, at 1:03 p.m. the director of nursing (DON) confirmed no documentation had been identified to indicate R39 or R42 had a minimum of three symptoms of a UTI to justify the use of antibiotic use. DON stated the expectation was three symptoms were required to treat with an antibiotic. Request was made to review the facilities policy on antibiotic use, none provided.	F 315	that antibiotics were justified. Completion date: 3/5/2014. 3. Licensed staff re-educated on sign and symptoms of urinary tract infection that a minimum of 3 signs/symptoms occur before the use of antibiotic and appropriate documentation is met. Completion date: 4/8/14. 4. The DNS and /or designee will audit each resident who is receiving antibiotics for a UTI two times per week for one month then one resident a week for one month to ensure that the residents have a minimum of 3 signs/symptoms of a UTI. 5. The data collected will be presented to the QA committee. The data will be reviewed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies. 6. DNS is responsible for this area of compliance.	4-15-14 JSPN
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		

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	245367	A. BUILDING ______ B. WING ______	03/06/2014

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F 329	Continued From page 23 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on 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	F 329	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Pain assessments were completed for residents R5 and resident R7. Completion date: 3/31/2014. 2. Licensed staff re-educated on sign and symptoms of pain and appropriate documentation is met. Completion date: 4/8/14. 3. DNS or designee will monitor two resident records per week for one month then weekly for two months for appropriate use, effectiveness, diagnosis and non-pharmaceutical intervention for pain medications. 4. The data collected will be presented to the QA committee. The data will	

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F 329	Continued From page 24 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. R5's physician orders dated 2/4/14, identified an order for Roxicet (a combination of acetaminophen and an opioid pain medication, used for moderate pain) 5-325mg (milligrams) every four hours PRN for pain. During review of R5's medication administration sheets and medication documentation sheets the following had been identified from the dates of 2/1/14 through 3/5/14: R5 had received a total of 37 doses of Roxicet PRN and there was no information if the pain medication was effective to relieve moderate pain for 32 out of the 37 doses given. 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	F 329	be reviewed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies. 5. DNS is responsible for this area of compliance.	4/15/14 [illegible]

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F 329	Continued From page 25 documented on the back of MAR (medication administration record). R7 had been admitted on 4/21/2009. R7's admission record dated 2/22/13, identified diagnoses that included but not limited to pain in joint, shoulder region, generalized osteoarthrosis involving multiple sites, lower limb amputation below knee. R7's quarterly MDS dated 12/5/13, identified brief interview of mental status (BIMS) had been one 10 out of 15 and indicated moderate cognitive impairment, pain management: received scheduled pain medication, received PRN pain medication, received non-medication interventions, pain presence yes, pain frequency frequently, pain has made it hard to sleep at night, had limited day to day activity because of pain, pain intensity rated from 0 to 10 scale with 10 being the worst possible, and R7 was a " 7." R7's care plan print date 3/6/14, identified acute on chronic pain related to osteoarthrosis, obesity, atrophic vaginitis, perineal pain, diabetes mellitus, depression, history of urinary tract infection and interventions of but not limited to provide analgesia as ordered, observe and document for side effects and effectiveness. R7's physician orders dated 1/23/14, identified an order for Belladonna-Opium (a narcotic pain medication) 16.2-30mg suppository PRN every six hours for perineal pain, Oxycodone HCl (a narcotic pain medication) 5 mg every four hours as needed for pain, Tramadol HCl (a synthetic pain medication) 50 mg PRN: one tablet pain rate one to five and two tablets pain rate six to 10 every six hours as needed for pain, should not receive more than 300 mg daily, Tylenol 1000 mg	F 329		

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F 329	Continued From page 26 PRN four times a day as needed, do not exceed 4000 mg per 24 hours. During review of R7 ' s medication administration sheets and medication documentation sheets the following had been identified from the dates of 2/1/14 through 3/5/14: R7 had received a total of one dose of Belladonna-Opium PRN and there was no information if it was effective to relieve pain; A total of 46 doses of Oxycodone HCl PRN and there was no information that identified why this pain medication was given for 25 out of the 46 doses and no information the pain medication was effective to relieve pain for 36 out of 46 doses; had received 25 doses of Tramadol HCl PRN and no information to why this pain medication was given for two of 25 doses and no information as to if the medication was effective to relieve pain for 18 out of 25 doses; had received 26 doses of Tylenol PRN and no information as to why it was indicated to treat pain for three of 26 doses and no information of effectiveness of pain medication for 19 out of 26 doses. During interview on 3/6/14, at 8:09 a.m., RN-A verified the reason given and effectiveness of Belladonna-Opium PRN, Oxycodone HCl PRN, Tramadol HCl 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). Document review of the facility policy MEDICATION ADMINISTRATION-GENERAL	F 329		

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F 329	Continued From page 27 GUIDELINES dated 2006, read, "C. Documentation 5) When PRN medications are administered, the following documentation is provided: b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the consultant pharmacist identified lack of reasons for administering and 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	F 428	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Pharmacy consultant reviewed resident R5 and resident R7 for unecessary medications. Completion date: 3/13/14. 2. Staff educated on the use of conditions/follow-up charting tool and documentation of PRN pain medications and their effectiveness. Completion date: 4/8/14.	

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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. R5's physician orders dated 2/4/14, identified an order for Roxicet (a combination of acetaminophen and an opioid pain medication, used for moderate pain) 5-325 mg (milligrams) every four hours PRN for pain. During review of R5's medication administration sheets and medication documentation sheets the following had been identified from the dates of 2/1/14 through 3/5/14: R5 had received a total of 37 doses of Roxicet PRN and there was no information if the pain medication was effective to relieve moderate pain for 32 out of the 37 doses given. 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.	F 428	3. DNS or designee will monitor two resident records per week for one month then weekly for two months for appropriate use, effectiveness, diagnosis and non-pharmaceutical intervention for pain medications. 4. The data collected will be presented to the QA committee. The data will be reviewed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies. 5. DNS is responsible for this area of compliance.	4/15/14 APN

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F 428	Continued From page 29	F 428		

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).

R7 had been admitted on 4/21/2009. R7's admission record dated 2/22/13, identified diagnoses that included but not limited to pain in joint, shoulder region, generalized osteoarthrosis involving multiple sites, lower limb amputation below knee. R7's quarterly MDS dated 12/5/13, identified brief interview of mental status (BIMS) had been one 10 out of 15 and indicated moderate cognitive impairment, pain management: received scheduled pain medication, received PRN pain medication, received non-medication interventions, pain presence yes, pain frequency frequently, pain has made it hard to sleep at night, had limited day to day activity because of pain, pain intensity rated from 0 to 10 scale with 10 being the worst possible, and R7 was a " 7."

R7's care plan print date 3/6/14, identified acute on chronic pain related to osteoarthrosis, obesity, atrophic vaginitis, perineal pain, diabetes mellitus, depression, history of urinary tract infection and interventions of but not limited to provide analgesia as ordered, observe and document for side effects and effectiveness.

R7's physician orders dated 1/23/14, identified an order for Belladonna-Opium (a narcotic pain medication) 16.2-30 mg suppository PRN every six hours for perineal pain, Oxycodone HCl (a narcotic pain medication) 5 mg every four hours as needed for pain, Tramadol HCl (a synthetic

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F 428	Continued From page 30 pain medication) 50 mg PRN: one tablet pain rate one to five and two tablets pain rate six to 10 every six hours as needed for pain, should not receive more than 300 mg daily, Tylenol 1000 mg PRN four times a day as needed, do not exceed 4000 mg per 24 hours. During review of R7's medication administration sheets and medication documentation sheets the following had been identified from the dates of 2/1/14 through 3/5/14: R7 had received a total of one dose of Belladonna-Opium PRN and there was no information if it was effective to relieve pain; A total of 46 doses of Oxycodone HCI PRN and there was no information that identified why this pain medication was given for 25 out of the 46 doses and no information the pain medication was effective to relieve pain for 36 out of 46 doses; had received 25 doses of Tramadol HCI PRN and no information to why this pain medication was given for two of 25 doses and no information as to if the medication was effective to relieve pain for 18 out of 25 doses; had received 26 doses of Tylenol PRN and no information as to why it was indicated to treat pain for three of 26 doses and no information of effectiveness of pain medication for 19 out of 26 doses. During interview on 3/6/14, at 8:09 a.m., RN-A verified the reason given and effectiveness of 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	F 428		

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F 428	Continued From page 31 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 to ensure proper documentation of medication orders and administration of medications to residents."	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	

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Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the

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as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

1. The facility infection control surveillance procedure has been reviewed and updated to meet current regulations. Completion date: 3/29/14.
2. LPN –A was re-educated on properly sanitizing glucometers. Completion date: 4/8/14.
3. All nursing staff will be re-educated on properly sanitizing glucometers. Completion date: 4/8/14.
4. The facility will track infections and surveillance infections according to the facility procedure.
5. The DNS and/or designee will audit the use of blood glucometers two times per week for one month then

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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:

The facilities employee infection control logs and program was reviewed with the director of nursing (DON) who was identified as the infection control nurse on 3/4/14, at 2:54 p.m.

The employee infection control logs were reviewed between 10/29/13, through 2/22/14. The logs failed to include consistent documentation of symptoms and date of onset, and did not identify which department the employee had worked. No infection control logs prior to 10/29/13 were provided. The DON verified employee illnesses had not been tracked prior to 10/29/13. The DON stated she had not tracked employee illnesses other than the nursing department. She was unable to report that had monitored infections for employees in other departments and was unable to provide the documentation. The DON verified the facility did not have a system in place to track and trend employee illness.

A policy for tracking employee illnesses was requested but not provided.
GLUCOMETER NOT SANITIZED PER SANITIZERS RECOMMENDATIONS:

R3 had diagnosis that included diabetes mellitus according to the facility Admission Record form.

Document review of physician orders signed

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weekly for two months to ensure proper procedure is followed for sanitizing.

6. The DNS and/or designees will audit the infection surveillance log two times weekly for one month then one time weekly for two months to evaluate tracking and trending.
7. The data collected will be presented to the QA committee. The data will be reviewed at the quarterly Quality Assurance meeting. At this time the QA committee will make a decision/recommendation regarding any necessary follow-up studies.
8. DNS is responsible for this area of compliance.

4/15/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34	F 441		

dated 1/23/14, revealed orders for "accu check qid [four times per day]. "

During observations on 3/3/14, at 4:43 p.m., licensed practical nurse (LPN)-A placed R3's blood sample on a test strip in the Assure Platinum Glucometer (a blood sugar monitoring device). When completed, LPN-A placed the Assure Platinum Glucometer on a paper towel on top of the medication cart, wiped the glucometer with one super Sani-wipe sanitizing cloth, and threw away the cloth. During interview at that time, LPN-A verified she wiped the device with the sanitizing cloth, immediately threw away the cloth, and left the device to air dry.

During observations on 3/3/14, at 4:47 p.m., LPN-A placed the Assure Platinum Glucometer into the medication cart drawer.

During interview on 3/3/14, at 7:00 p.m., director of nursing stated the facility had no facility policy for sanitizing multi-resident blood sugar monitoring devices. Director of nursing stated she expected staff to follow directions on the super Sani-wipe container. She stated she expected staff to wipe the device with a super Sani-wipe cloth and let the device air dry. She verified the directions on the super Sani-wipe container included to wipe the device and to remain wet for two minutes.

During interview on 3/3/14, at 7:55 p.m., LPN-A verified the one Assure Platinum Glucometer was used for three residents on the east wing.

Document review of the Super Sani-Wipe container directed, "To Disinfect and Deodorize: To disinfect nonfood contact surface only: Use a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING ______ APR 07 2014 B. WING ______ MN Dept of Health Rochester	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

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F 441	Continued From page 35 wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minutes wet contact time. Let air dry."	F 441		

F5367022

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok [initials] 4-15-14 RECEIVED APR 11 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 3-6-14 Dc: 4-15-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 4-4-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	245367	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

APR 0 7 2014
MN Dept of Health

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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	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are 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 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-4.1.4. This deficient practice could affect all 12 out of 38 residents. Findings include: On facility tour between 9:45 AM and 12:00 noon on 03/05/2014, observation revealed that the spare sprinkler head box does not contain 2 of each type of sprinkler head in the facility This deficient practice was confirmed by the Facility Maintenance Director (SB) at the time of discovery.	K 062	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Contacted sprinkler system contractor who audited our spare sprinkler heads and sent us the required amount for each sprinkler head. Completed by 3/21/2014. 2. Maintenance Supervisor and/or his designee will visually inspect sprinkler spare head box 2x per year. 3. The Maintenance Supervisor is responsible for this area of compliance.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by:	K 147		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING 01 - **MAIN BUILDING 01** B. WING ______	03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	**210 EAST GRAND AVENUE, PO BOX 365** **GRAND MEADOW, MN 55936**

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K 147	Continued From page 3 Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70, 110-26. The deficient practice could affect 12 out of 38 residents. Findings include: On facility tour between 9:45 AM and 12:00 noon on 03/05/2014, observation revealed, that the following was found: 1. Basement - Boiler Room east circuit breaker panel is blocked 2. Basement - Laundry room - by desk- one power strip plugged into other power strip These deficient practices were confirmed by the Facility Maintenance Director (SB) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Power strip cord was removed on 3/5/2014. Unblocked boiler room panel to ensure 30 inches of clearance. 2. Signs have been posted on the electrical panels ~~to remind~~ staff to not store anything within 30 inches. Completed 3/27/14. 3. The Maintenance Supervisor and/or designee ~~will visually~~ inspect the boiler room panel for 30 inches of clearance. 4. The Maintenance Supervisor is responsible for this area of compliance.	

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.

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
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) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: ____ 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**

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On March 3, 4, 5 and 6, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of

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	00390	A. BUILDING: ____ B. WING ____	03/06/2014

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health 18 Wood Lake Drive SE, Rochester, MN 55904 c/o Gary Nederhoff, Unit Supervisor 507-206-2731 Office	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to care plan use of lateral support device in wheelchair for 1 of 1 resident (R5) reviewed for positioning needs. Findings include: R5's care plan print date 1/29/14, identified impaired physical mobility, dependence on staff for position changes, requires wheelchair for	2 555		

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2 555	Continued From page 2	2 555		

locomotion, dependent on staff to propel to and from desired destination. The care plan did not address the use of the blue Styrofoam pad to be used for positioning device when in wheel chair.

During observation on 3/3/14, at 6:47 p.m., R5 had been in lobby sitting in wheelchair leaning to right side up against a blue Styrofoam pad. Also observed to be leaning to the right and use of blue Styrofoam pad on 3/4/14, at 8:31 a.m., 3/4/14, at 12:58 p.m., 3/5/14, at 9:28 a.m., 3/5/14, at 12:13 p.m., and on 3/5/14, at 1:30 p.m.

Occupational Therapy (OT) note dated 11/13/13, identified reason for referral, presents with poor posture as result of positioning deficit, slid out of chair on 11/2/13 and nursing staff also noted positioning difficulties 11/7/13. OT Therapy at this time for wheelchair assessment and modification as needed in order to improve posture so R5 can improve safety and comfort while seated in wheelchair.

R5 ' s OT progress and discharge summary dated 11/22/13, identified long term goals positioning, R5 will require total assistance to achieve effective positioning while seated in wheelchair utilizing wheelchair modifications as needed to affect leaning to side, reduce the risk of skin breakdown and achieve optimum position to reduce the risk of falls.

During interview on 3/6/14, at 8:30 a.m., registered nurse (RN)-A had stated had not known why blue Styrofoam pad was being used or when pad had been put in place. RN-A verified blue Styrofoam pad was not on R5's care plan and was not on nursing assistant pocket care

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2 555	Continued From page 3 plan. During interview on 3/6/14, at 11:15 a.m., director of nursing stated she would expect the blue Styrofoam pad positioning device to be care planned. Document review of the facility Guidelines for Care Plan Completion undated, read, " All Care Plans should include individual and/or Combined Focus Problems that address the following areas: ... assistive or adaptive 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 CORRECTION: Twenty One (21) Days.	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement care plan	2 565		

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2 565	Continued From page 4	2 565		

interventions for communication for 1 of 1 resident (R10) reviewed with limited understanding of the English language spoken or written.

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.

R10's care plan dated 12/24/14 identified a language barrier as Cambodian was primary language. Care plan interventions read, "Provide translator as available to communicate. Daughter or son will assist when they are present. Use communication 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. communication book, gestures, signs, and pictures." However, the facility did not provide interpreter services and staff were not observed to use picture communication tools to communicate with resident.

During an interview on 3/4/14 at 2:46 p.m. registered nurse (RN)-D stated there are times when we have no idea what she needs. We use trial and error, offering toileting, food, drink and watch what she is doing to see if we can determine what she needs. R10 was observed while interviewing RN-D to wheel self over to a

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2 565	Continued From page 5	2 565		

Continued From page 5

rocking chair and started rocking the empty chair. RN-D excused self from the interview and approached R10 and wheeled her back to her room. RN-D kneeled down by R10 and listened as R10 spoke to her in a different language (possibly Cambodian.) RN-D smiled at R10 and informed writer, sometimes it works to just allow resident to talk to staff. R10's tone of voice changed during the interaction with RN-D in her room. R10 started to cry and tone of her voice sounded sad said RN-D. RN-D then stated, " I'm sorry" to R10 and R10 continued to speak using no English words. During the dialog between R10 and RN-D no picture communication sheets or other communication tools were. When surveyor asked RN-D where the picture communication tools were kept, RN-D stated in R10's room but was unable to locate them at this time.

During an observation on 3/4/14 at 3:44 p.m. nursing assistant (NA)-D was observed to be kneeling down by R10's wheelchair in a common area of the facility. R10 was speaking a different language and not using English. NA-D wheeled R10 to her room and continued to listen to R10 as she was speaking possible Cambodian. NA-D attempted to communicate with R10, by stating " Sleep " and putting her hands up to the side of her face and closing her eyes. NA-D also stated the word " Bed " and pointed at the bed. R10 continued to speak to NA-D in possible Cambodian. NA-D wheeled R10 back into the hallway close to the nurses ' station and gave R10 yogurt to eat. NA-D stated she wasn't really sure that was what R10 wanted. NA-D stated R10 was having a snack and thought she would offer her some water. R10 ate her yogurt and took a drink of her water. R10 became tearful, then took another drink of the water and then poured the water on her hands. NA-D asked R10

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

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2 565	Continued From page 6	2 565		

if she wanted to wash her hands. NA-D verified R10 was tearful during their interaction. Again while communication with R10 NA-D did not use picture communication sheets or tools to assist with identifying what R10 was attempting to verbalize or want.

During an interview on 3/6/14 at 8:25 a.m. the director of nursing (DON) stated she expected staff to use the communication sheets when working with R10. The DON verified the facility had not followed the care plan to provide translator services as available.

SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff to follow care plans in regards to specific resident cares and services. Also to monitor for compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General | 2 830

Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.

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2 830	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide interpreter services to determine resident care needs and complete assessments for 1 of 1 resident (R10) reviewed for communication with limited understanding of the English language spoken or written. Findings Include: R10 was admitted on to the facility on 12/12/13 with diagnosis that included intracerebral hemorrhage, cerebrovascular disease and dysphasia, according to physician orders dated 2/27/14. R10's admission Minimum Data Set (MDS) dated 12/18/13 indicated yes R10 needed or wanted an interpreter to communicate with a doctor or health care staff. Identified preferred language as Cambodian, had unclear speech, rarely/never makes self-understood and rarely/never understands others. R10's hospital dismissal summary dated 12/12/14 indicated formal interpreter services were needed as primary language was Cambodian. R10's care plan dated 12/24/14 identified a language barrier as Cambodian was primary language. Care plan interventions directed staff to, "Provide translator as available to communicate. [Family (F)-B] or [F-A] will assist when they are present. Use communication techniques which enhance interaction: Allow adequate time to respond, Repeat as necessary,	2 830		

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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. communication book, gestures, signs, and pictures. " However, the facility did not provide interpreter services and staff were not observed to use picture communication tools to communicate with resident.

R10's FALL INVESTIGATION revealed on 12/18/13 at 10:30 p.m., "Fall Summary: found on floor (unwitnessed). Fall Location: Resident Room. Resident Description of what they were trying to do just prior to the fall: Resident unable to communicate with staff. Resident's mental status just prior to fall: Communication barrier- does not speak English and understands little. Resident's psychosocial status just prior to fall: Communication barrier- does not speak English and understands little. Describe cause of the fall: Staff observed resident to be incontinent of bowel and bladder at time of unwitnessed fall as she sat on the floor on her buttock at edge of bed. Intervention to prevent future falls: 3 day Bowel and Bladder assessment started."

R10's FALL INVESTIGATION revealed on 12/24/13 at 12:30 p.m., "Fall Summary: found on floor (unwitnessed). Fall Location: Resident Room. Description of what they were trying to do just prior to the fall: Resident unable to answer. Describe cause of fall: Attempting to self transfer. Intervention to prevent future falls: staff to lay resident down @ [at] 12:00 daily when in room."

R10's FALL INVESTIGATION revealed on

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2 830	Continued From page 9	2 830		

1/20/14 at 12:30 p.m., "Fall Summary: found on floor (unwitnessed). Fall Location: Resident Room. Resident description of what they were trying to do just prior to the fall: Resident unable to communicate. Resident's psychological status just prior to fall: alert, unable to communicate. Resident's usual psychological status: alert, unable to communicate. Root cause of the fall other: Unable to communicate with staff. Describe Cause of fall: Resident lying in bed-since unable to communicate with staff she tried to get up sat on edge of bed with soaker pad under her and both soaker pad and resident slid off side of the bed on to the floor. Soaker pad was under her when found sitting on buttock on floor with back against the mattress and legs straight out in front of her. Interventions to prevent future falls: Continue to build better communication skills to better understand her needs ..."

R10's FALL INVESTIGATION revealed on 2/22/14 at 6:10 a.m., "Fall Summary: found on floor (unwitnessed). Fall Location: Day room. Resident description of what they were trying to do just prior to the fall: Wheeling in w/c [wheelchair] in lobby- resident unable to tell staff what she was doing. Describe cause of the fall: Resident attempting to self transfer into chair. Interventions to prevent future falls: ...ordered to D/C [discontinue] nicotine patch. Offer resident recliner."

During an observation on 3/4/14 at 9:45 a.m. R10 was observed to be sitting in front room of the nurses station with nursing assistant (NA)-B and NA-C. R10 appeared agitated, was speaking to the nursing assistants in Cambodian (were told by staff it was Cambodian words) with fast speech and a raised voice. NA-B and NA-C were attempting to assist R10 to listen to music

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through a headphone set and an IPOD. There were no picture communication sheets or tools being utilized during the observation of the NA-B, NA-C and R10 to help determine what R10 was communicating to the staff or what R10's needs were.

During an interview on 3/4/14 at 2:46 p.m. registered nurse (RN)-D stated there are times when we have no idea what she needs. We use trial and error offering toileting, food, drink and watch what she is doing to see if we can determine what she needs. R10 was observed while interviewing RN-D to wheel self over to a rocking chair and started rocking the empty chair. RN-D excused self from the interview and approached R10 and wheeled her back to her room. RN-D kneeled down by R10 and listened as R10 communicated to her in Cambodian. RN-D nurse smiled at R10 and informed writer, sometimes it works to just allow resident to talk to staff. R10's tone of voice changed during the interaction with RN-D in her room. R10 started to cry and tone of her voice sounded sad. RN-D stated, "I'm sorry" to R10 and R10 continued to speak to nurse in Cambodian. There were no picture communication sheets or tools being utilized during the observation of the RN-D and R10 to help determine what R10 was communicating or what R10's needs were. When surveyor asked RN-D where the picture communication tools were kept, RN-D stated in R10 ' s room but was unable to locate them in to show writer.

During an observation on 3/4/14 at 3:44 p.m. NA-D was observed to be kneeling down by R10's wheelchair in a common area of the facility. R10 was speaking in Cambodian. NA-D wheeled R10 to her room continued to listen to R10 as she

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was speaking Cambodian. NA-D attempted to communicate with R10, by stating sleep and putting her hands up to the side of her face and closing her eyes. NA-D also stated the word bed and pointed at the bed. R10 continued to speak to NA-D in Cambodian. NA-D wheeled R10 back into the hallway close to the nurses' station and gave R10 yogurt. NA-D stated she wasn't really sure that was what R10 wanted. NA-D stated R10 was having a snack and thought she would offer her some water. R10 ate her yogurt and took a drink of her water. R10 became tearful. R10 took another drink of the water and then poured the water on her hands. NA-D asked R10 if she wanted to wash her hands. NA-D verified R10 was tearful during their interaction. There were no picture communication sheets or tools being utilized during the observation of the NA-D and R10 to help determine what R10 was communicating to the staff or what R10's needs were.

During an observation on 3/5/14 at 4:15 p.m. medical records (MR)-A was providing a one to one staff intervention. R10 was sitting in a wheelchair in a common area of the facility, appeared agitated, was speaking in Cambodian with fast speech, raised voice and was holding on to an arm rest of a chair, shaking the chair. MR-A was attempting to get R10 to let go of the chair she was holding on to. There were no picture communication sheets or tools being utilized during the observation of the MR-A and R10 to help determine what R10 was communicating or what R10's needs were.

During an interview on 3/5/14 at 11:02 a.m. NA-E stated communication was a little difficult with R10. NA-E stated R10 was able to say toilet and can tell us with looking at the pictures. NA-E

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stated when R10 was agitated staff will take for a walk and would play music. NA-E stated to an extent staff were are able to meet R10's needs. NA-E stated when R10 was more agitated; staff called the son or daughter to interpret. NA-E stated when R10 talked to family, the family would inform staff of what R10 needed and staff was usually able to get what R10 needed and she would usually calm down. NA-E was not aware of any interpreter services to use with R10.

During an interview on 3/5/14 at 11:12 a.m. NA-F stated R10 knows some words in English, toileting, food, thirty, tired/sleep and stated R10 was able to say yes or no and understand for the most part. NA-F stated the facility used to have picture flashcards, and paper sheets to use to communicate with R10. NA-F stated R10's son took them home to write words in her language on them and didn't think they ever got back to the facility. NA-F verified when R10 became agitated staff were unable to tell why R10 was upset. NA-F stated staff provided one to one supervision quite frequently for R10. NA-F was unaware of any interpreter services available to use with R10. NA-F stated, "I wish we did have one because we can't understand what she is saying. I wish we could have an interpreter to be unable to understand how much pain she is really in. She might be in more pain than we realize. An interpreter would help us to know what she needs and to be able to provide for her."

During an interview on 3/5/14 at 2:36 p.m. NA-G stated staff used hand singles for, drink, eat, sleepy. We have flashcards, to use with R10 that are kept in top drawer of her nightstand and at the nurses' station. NA-G stated she had not used those since R10 had a room on the west wing about a month ago. NA-G stated she

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thought the flashcards "frightened her when she was first here. She was in a new place and you could tell she was scared and anxious when she first got here. I would hold up a flashcard and she would shake her head. I totally understand why she gets agitated. It must be so frustrating to be her, in a place that she is not used to and where nobody understands her." NA-G was unaware of any interpreter services that could be utilized to communicate with R10 and stated it would be nice if they did have interpreter service to use.

During an interview on 3/6/14 at 8:25 a.m. the director of nursing (DON) stated she expected staff to use the communication sheets when working with R10. The DON verified facility staff was unable to have conversations with R10. The DON stated when R10 became upset and agitated facility staff would call the family have them speak to her and family would relay to staff what she was upset about and what she needed. The DON verified the facility had not made arrangements for interpreter services to communicate with resident to determine care needs and to complete assessments. The DON verified it was difficult to complete analysis and assessments of R10's falls due to the language barrier and R10 being able to communicate what she was trying to do prior to her falls. The DON verified the facility had not followed the care plan to provide translator services as available.

During an interview on 3/6/14 at 9:22 a.m. social services (SS)-A verified she did not offer or ask family if they would like arrangements to be made for interpreter services to be used for R10 during her nursing home stay. SS-A stated she had discussions with F-A about the language barrier and family indicated they would help interpret as needed. SS-A stated she looked for flashcards on

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the internet to utilize with resident for communication and speech therapy also developed a communication board for staff use. SS-A stated during the second care conference she also involved family by asking F-A to develop flash cards for pain. SS stated F-A stated they make the flash cards for pain, however never followed through with providing a flashcards to the facility. SS-A verified the facility did not follow the policy and procedure for Communication with Limited English Proficient Persons undated policy services for R10. SS-A verified the facility had not followed the care plan to provide translator services as available.

During an interview on 3/6/14/ at 10:20 a.m., SS-A stated assessments for R10 were completed by staff observations, staff interviews and by talking to the family. SS-A verified interpreter services were not utilized to complete assessments.

During an interview on 3/6/14 at 10:27 a.m., RN-A stated a lot of the assessments were completed based on observation, using gestures and non-verbal. RN-A stated if the family in the building at the time as assessment needed to be 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.

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2 830	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff to ensure each resident with limited understanding of the English language spoken or written is assessed with the use of an interpreter to determine individual needs and supervision . The DON or designee could then perform audits to ensure each resident receives the care and supervision the individual requires. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify three symptoms for an active urinary tract infection	2 910		

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(UTI) before starting antibiotic therapy for 2 of 4 resident (R39 and R42) reviewed for urinary incontinence.

Findings include:

R39's medical record was reviewed and indicated that on 2/17/14, R39's physician ordered Cipro (antibiotic) 250 mg (milligrams) po (orally) bid (twice a day) for seven days for a UTI. The physician order note dated 2/17/14, at 2:30 p.m. indicated a new order had been received for diagnosis of UTI however; no symptoms had been identified on the note. Review of progress notes 1/1/14, to 2/17/14, revealed no documentation of symptoms related to a UTI.

R42's medical record was reviewed and it was noted that R42's physician ordered a urinalysis to be held for culture, and Cipro 250 mg bid for seven days on 2/23/14 for UTI. Review of progress notes 1/7/14, to 2/23/14, revealed no documentation of symptoms related to a UTI including the presence of foul smelling urine, or discomfort.

During interview on 3/6/14, at 1:03 p.m. the director of nursing (DON) confirmed no documentation had been identified to indicate R39 or R42 had a minimum of three symptoms of a UTI to justify the use of antibiotic use. DON stated the expectation was three symptoms were required to treat with an antibiotic.

Request was made to review the facilities policy on antibiotic use, none provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing could in-service licensed staff on the need to identify three symptoms are

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needed to treat with an antibiotic therapy.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

21375 MN Rule 4658.0800 Subp. 1 Infection Control; Program — 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:

The facilities employee infection control logs and program was reviewed with the director of nursing (DON) who was identified as the infection control nurse on 3/4/14, at 2:54 p.m.

The employee infection control logs were reviewed between 10/29/13, through 2/22/14. The logs failed to include consistent documentation of symptoms and date of onset, and did not identify which department the employee had worked. No infection control logs prior to 10/29/13 were provided. The DON verified employee illnesses had not been tracked prior to 10/29/13. The DON

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stated she had not tracked employee illnesses other than the nursing department. She was unable to report that had monitored infections for employees in other departments and was unable to provide the documentation. The DON verified the facility did not have a system in place to track and trend employee illness.

A policy for tracking employee illnesses was requested but not provided.

GLUCOMETER NOT SANITIZED PER SANITIZERS RECOMMENDATIONS:

R3 had diagnosis that included diabetes mellitus according to the facility Admission Record form.

Document review of physician orders signed dated 1/23/14, revealed orders for "accu check qid [four times per day]. "

During observations on 3/3/14, at 4:43 p.m., licensed practical nurse (LPN)-A placed R3's blood sample on a test strip in the Assure Platinum Glucometer (a blood sugar monitoring device). When completed, LPN-A placed the Assure Platinum Glucometer on a paper towel on top of the medication cart, wiped the glucometer with one super Sani-wipe sanitizing cloth, and threw away the cloth. During interview at that time, LPN-A verified she wiped the device with the sanitizing cloth, immediately threw away the cloth, and left the device to air dry.

During observations on 3/3/14, at 4:47 p.m., LPN-A placed the Assure Platinum Glucometer into the medication cart drawer.

During interview on 3/3/14, at 7:00 p.m., director of nursing stated the facility had no facility policy

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for sanitizing multi-resident blood sugar monitoring devices. Director of nursing stated she expected staff to follow directions on the super Sani-wipe container. She stated she expected staff to wipe the device with a super Sani-wipe cloth and let the device air dry. She verified the directions on the super Sani-wipe container included to wipe the device and to remain wet for two minutes.

During interview on 3/3/14, at 7:55 p.m., LPN-A verified the one Assure Platinum Glucometer was used for three residents on the east wing.

Document review of the Super Sani-Wipe container directed, "To Disinfect and Deodorize: To disinfect nonfood contact surface only: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full two (2) minutes. Use additional wipe(s) if needed to assure continuous two (2) minutes wet contact time. Let air dry."
SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures on infection control measures for tracking and trending employee health, could educate staff on the appropriate cleaning of multiple patient use equipment to prevent cross contamination, and cou;ld ensure equipment used for residents have a sanitary,cleanable surface and then monitor for compliance.

The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures.

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

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21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure screening of active tuberculin symptoms and tuberculosis testing was completed upon admission for 1 of 5 newly admitted residents (R10) reviewed for baseline tuberculosis screening. Findings include: R10's Admission Nursing Data Collection form dated 12/12/13, was reviewed and identified R10 had been admitted on 12/12/13. The form specified "unknown" in all areas of the	21426		

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21426	Continued From page 21 tuberculosis (TB) screening section, Ka. R10's TB screening tool, undated indicated R10 had history of an adverse reaction to a TB skin test, was born outside of the USA, and was age 64 or more. All other areas of the form specified "unknown." During further review, a TB screening was not found in the medical record and there was no evidence documented that a chest X-Ray had been performed. On 3/5/14, at 2:50 p.m., the director of nursing (DON) was interviewed and verified baseline TB screening documentation was not found in R10's record nor located. The facilities Tuberculosis Infection Control Plan policy dated 9/11/13 was reviewed and directed resident baseline screening to be completed within three months prior to or 72 hours after admission. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff responsible for education and documentation of resident TB status. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405.	21495		

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This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to provide medically-related social services to attain or maintain the highest practicable, physical, mental and psychosocial well-being for 1 of 1 resident (R10) with limited understanding of the English language spoken or written.

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.

R10's admission Minimum Data Set (MDS) dated 12/18/13 indicated " Yes " to the question R10 needed or wanted an interpreter to communicate with a doctor or health care staff. Identified preferred language as Cambodian, had unclear speech, rarely/never makes self-understood and rarely/never understands others.

R10's care plan dated 12/24/14 identified a language barrier as Cambodian was primary language. Care plan interventions read, "Provide translator as available to communicate. Daughter or son will assist when they are present. Use communication 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

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words/cues, Use alternative communication tools as needed, i.e. communication book, gestures, signs, and pictures." However, the facility did not provide interpreter services and staff were not observed to use picture communication tools to communicate with resident.

During an interview on 3/4/14 at 2:46 p.m. registered nurse (RN)-D stated there are times when we have no idea what she needs. We use trial and error, offering toileting, food, drink and watch what she is doing to see if we can determine what she needs. R10 was observed while interviewing RN-D to wheel self over to a rocking chair and started rocking the empty chair. RN-D excused self from the interview and approached R10 and wheeled her back to her room. RN-D kneeled down by R10 and listened as R10 spoke to her in a different language (possibly Cambodian.) RN-D smiled at R10 and informed writer, sometimes it works to just allow resident to talk to staff. R10's tone of voice changed during the interaction with RN-D in her room. R10 started to cry and tone of her voice sounded sad said RN-D. RN-D then stated, " I'm sorry" to R10 and R10 continued to speak using no English words. During the dialog between R10 and RN-D no picture communication sheets or other communication tools were. When surveyor asked RN-D where the picture communication tools were kept, RN-D stated in R10's room but was unable to locate them at this time.

During an observation on 3/4/14 at 3:44 p.m. nursing assistant (NA)-D was observed to be kneeling down by R10's wheelchair in a common area of the facility. R10 was speaking a different language and not using English. NA-D wheeled R10 to her room and continued to listen to R10 as she was speaking possible Cambodian. NA-D

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attempted to communicate with R10, by stating " Sleep " and putting her hands up to the side of her face and closing her eyes. NA-D also stated the word " Bed " and pointed at the bed. R10 continued to speak to NA-D in possible Cambodian. NA-D wheeled R10 back into the hallway close to the nurses ' station and gave R10 yogurt to eat. NA-D stated she wasn't really sure that was what R10 wanted. NA-D stated R10 was having a snack and thought she would offer her some water. R10 ate her yogurt and took a drink of her water. R10 became tearful, then took another drink of the water and then poured the water on her hands. NA-D asked R10 if she wanted to wash her hands. NA-D verified R10 was tearful during their interaction. Again while communication with R10 NA-D did not use picture communication sheets or tools to assist with identifying what R10 was attempting to verbalize or want.

During an interview on 3/5/14 at 11:12 a.m. NA-F stated R10 knows some words in English such as toileting, food, thirty, tired/sleep and stated R10 was able to say " Yes or No " and understand the meaning for the most part. NA-F stated the facility used to have picture flashcards, and paper sheets to use to communicate with R10. However, NA-F stated R10's family (F)-A took them home to write words in her language on them and didn't think they ever got back to the facility. This was some time ago F-A took them home. NA-F verified when R10 became agitated staff were unable to tell why R10 was upset. NA-F stated staff provided one to one supervision quite frequently for R10. NA-F was unaware of any interpreter services available to use with R10. NA-F stated, "I wish we did have one [reference to interpreter] because we can't understand what she is saying. I wish we could have an interpreter

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to be unable to understand how much pain she is really in. She might be in more pain than we realize. An interpreter would help us to know what she needs and to be able to provide for her. "

During an interview on 3/5/14 at 2:36 p.m. NA-G stated staff used hand singles for, drink, eat, sleepy. We have flashcards, to use with R10 that are kept in top drawer of her nightstand and at the nurses' station. NA-G stated she had not used those since R10 had a room on the west wing about a month ago. NA-G stated she thought the flashcards " frightened her when she was first here. She was in a new place and you could tell she was scared and anxious when she first got here. I would hold up a flashcard and she would shake her head. I totally understand why she gets agitated. It must be so frustrating to be her, in a place that she is not used to and where nobody understands her." NA-G was unaware of any interpreter services that could be utilized to communicate with R10 and stated it would be nice if they did have interpreter service to use.

During an interview on 3/6/14 at 8:25 a.m. the director of nursing (DON) stated she expected staff to use the communication sheets when working with R10. The DON verified facility staff was unable to have conversations with R10 because R10 spoke Cambodian only. The DON stated when R10 became upset and agitated facility staff would call the family and have them speak to her in their language and family would relay to staff what she was upset about and what she needed. The DON verified the facility had not made arrangements for interpreter services to communicate with resident.

The Communication with Limited English Proficient Persons undated policy and procedure

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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, FRIENDS OR INFORMAL INTERPRETERS..... "

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21495	Continued From page 27 During an interview on 3/6/14 at 9:22 a.m. social services (SS)-A verified she did not offer or ask family if they would like arrangements to be made for interpreter services to be used for R10 during her nursing home stay. SS-A stated she had discussions with F-A about the language barrier and family indicated they would help interpret as needed. SS-A stated she looked for flashcards on the internet to utilize with resident for communication and speech therapy also developed a communication board for staff use. SS-A stated during the second care conference she also involved family by asking F-A to develop flash cards for pain. SS stated F-A stated they make the flash cards for pain, however never followed through with providing a flashcards to the facility. SS-A verified the facility did not follow the policy and procedure for Communication with Limited English Proficient Persons undated policy services for R10. SUGGESTED METHOD OF CORRECTION: The administrator could ensure arrangements were made for residents with limited understanding of the English language spoken or written were provided interpreter services while residening in the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21495		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual,	21530		

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21530	Continued From page 28 Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure the consultant pharmacist identified lack of reasons for administering and	21530		

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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 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.

R5's physician orders dated 2/4/14, identified an order for Roxicet (a combination of acetaminophen and an opioid pain medication, used for moderate pain) 5-325 mg (milligrams) every four hours PRN for pain.

During review of R5's medication administration sheets and medication documentation sheets the following had been identified from the dates of

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2/1/14 through 3/5/14: R5 had received a total of 37 doses of Roxicet PRN and there was no information if the pain medication was effective to relieve moderate pain for 32 out of the 37 doses given.

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).

R7 had been admitted on 4/21/2009. R7's admission record dated 2/22/13, identified diagnoses that included but not limited to pain in joint, shoulder region, generalized osteoarthrosis involving multiple sites, lower limb amputation below knee. R7's quarterly MDS dated 12/5/13, identified brief interview of mental status (BIMS) had been one 10 out of 15 and indicated moderate cognitive impairment, pain management: received scheduled pain medication, received PRN pain medication, received non-medication interventions, pain presence yes, pain frequency frequently, pain has made it hard to sleep at night, had limited day to day activity because of pain, pain intensity rated from 0 to 10 scale with 10 being the worst possible, and R7 was a " 7."

R7's care plan print date 3/6/14, identified acute on chronic pain related to osteoarthrosis, obesity, atrophic vaginitis, perineal pain, diabetes mellitus, depression, history of urinary tract infection and interventions of but not limited to provide

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analgesia as ordered, observe and document for side effects and effectiveness.

R7's physician orders dated 1/23/14, identified an order for Belladonna-Opium (a narcotic pain medication) 16.2-30 mg suppository PRN every six hours for perineal pain, Oxycodone HCl (a narcotic pain medication) 5 mg every four hours as needed for pain, Tramadol HCl (a synthetic pain medication) 50 mg PRN: one tablet pain rate one to five and two tablets pain rate six to 10 every six hours as needed for pain, should not receive more than 300 mg daily, Tylenol 1000 mg PRN four times a day as needed, do not exceed 4000 mg per 24 hours.

During review of R7's medication administration sheets and medication documentation sheets the following had been identified from the dates of 2/1/14 through 3/5/14: R7 had received a total of one dose of Belladonna-Opium PRN and there was no information if it was effective to relieve pain; A total of 46 doses of Oxycodone HCl PRN and there was no information that identified why this pain medication was given for 25 out of the 46 doses and no information the pain medication was effective to relieve pain for 36 out of 46 doses; had received 25 doses of Tramadol HCl PRN and no information to why this pain medication was given for two of 25 doses and no information as to if the medication was effective to relieve pain for 18 out of 25 doses; had received 26 doses of Tylenol PRN and no information as to why it was indicated to treat pain for three of 26 doses and no information of effectiveness of pain medication for 19 out of 26 doses.

During interview on 3/6/14, at 8:09 a.m., RN-A verified the reason given and effectiveness of

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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 to ensure proper documentation of medication

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21530	Continued From page 33 orders and administration of medications to residents." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 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	21535		

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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 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.

R5's physician orders dated 2/4/14, identified an

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order for Roxicet (a combination of acetaminophen and an opioid pain medication, used for moderate pain) 5-325 mg (milligrams) every four hours PRN for pain.

During review of R5's medication administration sheets and medication documentation sheets the following had been identified from the dates of 2/1/14 through 3/5/14: R5 had received a total of 37 doses of Roxicet PRN and there was no information if the pain medication was effective to relieve moderate pain for 32 out of the 37 doses given.

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).

R7 had been admitted on 4/21/2009. R7's admission record dated 2/22/13, identified diagnoses that included but not limited to pain in joint, shoulder region, generalized osteoarthrosis involving multiple sites, lower limb amputation below knee. R7's quarterly MDS dated 12/5/13, identified brief interview of mental status (BIMS) had been one 10 out of 15 and indicated moderate cognitive impairment, pain management: received scheduled pain medication, received PRN pain medication, received non-medication interventions, pain presence yes, pain frequency frequently, pain has made it hard to sleep at night, had limited day to day activity because of pain, pain intensity rated

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from 0 to 10 scale with 10 being the worst possible, and R7 was a " 7."

R7's care plan print date 3/6/14, identified acute on chronic pain related to osteoarthrosis, obesity, atrophic vaginitis, perineal pain, diabetes mellitus, depression, history of urinary tract infection and interventions of but not limited to provide analgesia as ordered, observe and document for side effects and effectiveness.

R7's physician orders dated 1/23/14, identified an order for Belladonna-Opium (a narcotic pain medication) 16.2-30 mg suppository PRN every six hours for perineal pain, Oxycodone HCI (a narcotic pain medication) 5 mg every four hours as needed for pain, Tramadol HCI (a synthetic pain medication) 50 mg PRN: one tablet pain rate one to five and two tablets pain rate six to 10 every six hours as needed for pain, should not receive more than 300 mg daily, Tylenol 1000 mg PRN four times a day as needed, do not exceed 4000 mg per 24 hours.

During review of R7 ' s medication administration sheets and medication documentation sheets the following had been identified from the dates of 2/1/14 through 3/5/14: R7 had received a total of one dose of Belladonna-Opium PRN and there was no information if it was effective to relieve pain; A total of 46 doses of Oxycodone HCI PRN and there was no information that identified why this pain medication was given for 25 out of the 46 doses and no information the pain medication was effective to relieve pain for 36 out of 46 doses; had received 25 doses of Tramadol HCI PRN and no information to why this pain medication was given for two of 25 doses and no information as to if the medication was effective to relieve pain for 18 out of 25 doses; had

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received 26 doses of Tylenol PRN and no information as to why it was indicated to treat pain for three of 26 doses and no information of effectiveness of pain medication for 19 out of 26 doses.

During interview on 3/6/14, at 8:09 a.m., RN-A verified the reason given and effectiveness of 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).

Document review of the facility policy MEDICATION ADMINISTRATION-GENERAL GUIDELINES dated 2006, read, "C. Documentation 5) When PRN medications are administered, the following documentation is provided: b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted."

SUGGESTED METHOD OF CORRECTION: The director of nursing or pharmacist could in-service all staff responsible for medication use on the need to meet the requirements as written under this licensing order.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.