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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MF85

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00775

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245361**

2.STATE VENDOR OR MEDICAID NO.
(L2) **134543500**

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

4. TYPE OF ACTION: **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 **09/12/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (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
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 09/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/16/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/23/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/09/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245361
September 16, 2016

Mr. Daniel Strittmater, Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

Dear Mr. Strittmater:

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 August 22, 2016 the above facility is certified for or recommended for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 16, 2016

Mr. Daniel Strittmater, Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: Project Number S5361025

Dear Mr. Strittmater:

On August 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 28, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 22, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 28, 2016, effective August 22, 2016 and therefore remedies outlined in our letter to you dated August 12, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245361 Y1	A. Building B. Wing Y2	9/12/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0257	Correction	ID Prefix F0279	Correction	ID Prefix F0309	Correction
Reg. # 483.15(h)(6)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25	Completed
LSC	08/22/2016	LSC	08/22/2016	LSC	08/22/2016
ID Prefix F0334	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(n)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/22/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 09/16/2016	SIGNATURE OF SURVEYOR 10562	DATE 09/12/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245361 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/24/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	08/22/2016	LSC K0018	08/22/2016	LSC K0022	08/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	08/22/2016	LSC K0027	08/22/2016	LSC K0029	08/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0051	08/22/2016	LSC K0052	08/22/2016	LSC K0056	08/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	08/22/2016	LSC K0076	08/22/2016	LSC K0141	08/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0144	08/22/2016	LSC K0147	08/22/2016	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	09/16/2016	10562	08/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/27/2016

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

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245361	MEEKER MANOR REHABILITATION CENTER, LLC

Type of Survey (select all that apply)

I	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 10562			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 3.25

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245361	MEEKER MANOR REHAB CTR LLC

Type of Survey (select all that apply):

D	H				

A Complaint Investigation E Initial Certification I Recertification
B Dumping Investigation F Inspection of Care J Sanction/Hearing
C Federal Monitoring G Validation K State License
D Follow-up Visit H Life safety Code L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader 1. 34764			0.50	0.00	0.00	0.00	0.00	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.00

Total Clerical/Data Entry Hours.....

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MF85

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00775

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245361**

2.STATE VENDOR OR MEDICAID NO.
(L2) **134543500**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Andrea Koshiol, HFE NE II — 08/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/09/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 12, 2016

Mr. Blaine Gamst, Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: Project Number S5361025

Dear Mr. Gamst:

On July 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

Electronic 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

Informal Dispute Resolution - 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:

Maria King, Assistant Program Manager
Licensing and Certification Program
Minnesota Department of Health
Health Regulation Division
12 Civic Center, Plaza Suite #2105
Mankato, Minnesota 56001
Telephone: (507)344-2716 Fax: (507)344-2723

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 September 6, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 6, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 28, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 28, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 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
	245361	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure comfortable room temperatures were maintained for 6 of 35 residents (R141, R127, R17, R46, R84, R77) who complained about their room temperatures. Findings include: During an observation on 7/25/16 at 3:25 p.m., R141 stated his room and the hallways, "get too cold," and when he tells the staff, they give him a blanket.	F 257	F 257 Comfortable & Safe Temperature Levels Plan of correction for residents cited with this survey: 1. Adjusted temperature in resident rooms and common areas to keep between 71-81 degrees Farenheit. Interviewed residents R141, 127, 17, 46, 84 and 77 to see what a comfortable temperature for them is. Plan to address and prevent this	8/22/16

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

Electronically Signed | 08/22/2016

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F 257	Continued From page 1 During an observation on 7/25/16 at 6:22 p.m., R127 stated she kept the door to her room closed because, "Opening the door is like opening a refrigerator door." R127 stated, "The staff kind of ignore it." During an observation on 7/25/16 at 6:44 p.m., R17 was wearing a long sleeved shirt and a thick sweatshirt. R17 stated, "It's too cold. I always have to wear two shirts." During an observation on 7/26/16 at 9:20 a.m., R46 was wearing a long sleeved button up shirt and a zip up grey fleece sweater, and stated he wears the fleece sweater at all times because it's too cool in the facility. R46 stated he had complained to the staff but they told him it was too hot for them. During an interview on 7/26/16 at 9:54 a.m., R84 stated, "The temperature is cold," and stated when she tells the staff, they give her a blanket and a sweater. During observation on 7/26/16, at 10:20 a.m., R77 was being assisted to the bathroom. R77 was wrapped in a blanket, kept her head tucked down in the blanket, did not make eye contact, and kept repeating, "I'm cold...I'm cold." During an observation on 7/27/16, at 7:08 a.m., R77 was sitting on the toilet in the bathroom, and stated, "Leave me alone, I'm cold." The wall air conditioning unit in R77's room was on, blowing cold air. Nursing assistant (NA)-C and NA-D transferred R77 and then shut off the air conditioning unit. R77 was observed to b bundled in blankets.	F 257	deficiency with other residents: 1. Will audit resident rooms and common areas regularly, to make sure temperatures are maintained between 71-81 degrees Farenheit. 2. All staff members to be educated in regards to temperature regulation and the expectations of keeping residents comfortable. Measures put into place to prevent in the future: 1. Education will be provided to all staff members re: making sure that the residents are comfortable, with temperature and that temperatures are maintained between 71-81 degrees Farenheit. Plans to Monitor Performance: 1. Will audit a random sample of 20% of resident rooms and/or common areas daily x 1 week, weekly x4 weeks, and then monthly. 2. Will review audit results with QAPI committee and will follow QAPI committee recommendations for further auditing needs. DON and Administrator will be responsible to ensure that the facility remains compliant in this area. This deficiency will be corrected by August 22, 2016.	

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F 257	Continued From page 2 During an interview on 7/28/16 at 11:00 a.m., the environmental services director (ED) stated the goal was to maintain the building and room temperatures at "about 70 degrees," but he was not aware of a facility policy that addressed this. The ED stated he was not aware if the facility routinely monitored the temperature in resident rooms or common areas, but stated if the residents complained about the temperature, the nursing staff would notify the maintenance staff. ED was not aware of any complaints from residents regarding room or common area temperatures. During an environmental tour with the ED on 7/28/16 at 11:15 a.m., the following temperatures were observed: On the 100 wing, room 102 was 71 degrees Fahrenheit (F), room 114 was 71.5 degrees F, room 116 was 74.5 degrees F (with the door shut), and the 100 wing hallway temperature was 70 degrees F. On the 300 wing, room 315 was 67.5 degrees F and the 300 wing hallway temperature was 67 degrees F. On the 400 wing, room 404 was 69.5 degrees F and the 400 wing hallway temperature was 70 degrees F. During an interview at the time of the environmental tour on the 300 wing hallway, the ED stated, "It is kind of cool." At that time it was observed the wall air conditioning unit at the end of the hallway was on and blowing cold air. The ED stated staff had probably turned the air conditioning unit on because they preferred the	F 257		

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F 257	Continued From page 3 temperature to be cooler, but the residents' comfort was most important. The ED turned off the air conditioning unit and stated he would be monitoring the hallway and resident room temperatures more closely. During an interview on 7/28/16, at 1:07 p.m., the administrator stated the ED needed to develop an ongoing monitoring plan of the temperatures in the building and confirmed the temperatures would be adjusted, "per resident comfort." The facility's policy Quality of Life-Homelike Environment dated 4/14, included: "The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include...Comfortable temperatures."	F 257		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279		8/22/16

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F 279	Continued From page 4 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were developed for 1 of 3 residents (R51) reviewed for positioning. Findings include: R51's admission record dated 12/5/12, indicated R51 had diagnoses of osteoarthritis, Parkinson's Disease, had difficulty in walking, and was dependent on a wheelchair for mobility. R51's quarterly Minimum Data Set (MDS) dated 4/26/16, indicated R51 was cognitively intact, required extensive assistance for activities of daily living, used a wheelchair for mobility, and was totally dependent for locomotion. Review of R51's care plan dated 7/26/16, indicated R51 had limited physical mobility, was unable to wheel herself, and required extensive assistance for all locomotion once she was in her wheelchair. The care plan lacked interventions for proper positioning for R51 while in her wheelchair. During an observation on 7/25/16 at 3:46 p.m., R51 was sitting in her room, in her wheelchair. The wheelchair had a high back that extended above her head, and the back of the wheelchair was at a 90 degree angle to the seat of the	F 279	F279 Develop Comprehensive Care Plans Plan of correction for residents cited with this survey: 1. R51 wheelchair will be evaluated by therapy staff for proper positioning. Education will be provided to staff members and care card and care plan will be updated. Plan to address and prevent this deficiency with other residents: 1. Will audit wheelchair positioning for residents, with wheelchairs, and verify that their care plan and care card interventions match. 2. Will educate nurse managers on care planning and care cards related to wheelchair positioning. 3. Therapy sheets, with changes, will be given to nurse mangers. Nurse managers will place in NAR report binder for them to review. If education needs to be provided, therapy staff will train staff. Measures put into place to prevent in the future: 1. Education will be provided to the nurse managers and floor staff on wheelchair positioning. Making sure that the care	

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F 279	Continued From page 5 wheelchair. R51 was observed to have a cushion behind her back that was approximately three inches thick. The cushion extended from the seat of the wheelchair to just under R51's shoulder blades. This caused R51's shoulders and the crown of her head to press against the back of the wheelchair and her face was pointed toward the ceiling. R51's feet were observed to be supported on the foot pedals with a pad behind her heels and lower legs. During an observation on 7/25/16 at 5:35 p.m., R51 was in the dining room and was being assisted to eat. R51 was observed to continue to have the cushion behind her back, causing her head to press against the back of the wheelchair with her face pointed toward the ceiling. During an observation on 7/26/16 at 3:35 p.m., R51 was observed sitting in her room in her wheelchair. Again, R51 had the cushion in place behind her lower back, causing her buttocks to be 3-4 inches from the back of the wheelchair, and her shoulders and head were pressed into the back of the wheelchair with her face pointed toward the ceiling. During interview with R51 on 7/26/16 at 3:41 p.m., R51 stated she was not very comfortable in her wheelchair and that she had asked the nursing staff several times to have the therapist look at her wheelchair. R51 stated that to her knowledge that had not happened. R51also stated she had asked for a smaller pillow for behind her back because she slides forward and has to ask to be boosted up regularly. During an observation on 7/27/16 at 7:15 a.m., nursing assistant (NA)-A provided personal cares	F 279	plan and care card interventions match. Plans to Monitor Performance: 1. Will audit a random sample of 20% of residents in wheelchairs x4 weeks, monthly x3 months and then quarterly. 2. Will review audit results with QAPI committee and will follow QAPI committee recommendations for further auditing needs. DON and Administrator will be responsible to ensure that the facility remains compliant in this area. This deficiency will be corrected by August 22, 2016.	

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F 279	Continued From page 6	F 279		

for R51 and used a mechanical lift to transfer her into her wheelchair. A thick black cushion with a half moon shaped indent, was attached to the upper back of the wheelchair and supported R51's head and neck, allowing her to sit upright and to look straight ahead, instead of at the ceiling. R51 stated she felt so much more comfortable with the cushion supporting her head and neck.

NA-A was interviewed on 7/27/16 at 7:28 a.m. NA-A stated R51 had received a new wheelchair a couple of months ago and NA-A said she couldn't recall having received any training about the wheelchair or how R51 should be positioned in it. NA-A stated the cushion used to support R51's head was usually attached to her wheelchair but it wasn't this morning and she didn't know why. NA-A stated when she'd seen it on the chair in the corner of the room she'd attached it to the wheelchair.

During an interview on 7/28/16 at 9:21 a.m., NA-B stated she hadn't received any training for how to best use R51's wheelchair when it was new. NA-B stated she wasn't aware of any written information about how R51 should be positioned in the wheelchair either.

During an interview on 7/28/16 at 9:24 a.m., registered nurse (RN)-A stated, "OT [occupational therapy] gets the new wheelchair and tells us how to use it. [R51] usually has the headrest on. The nursing assistant sheet in the room, behind the bathroom door, should have that on there." RN-A verified the nursing assistant care sheet in R51's room lacked information regarding proper positioning for R51. RN-A stated, "OT usually provides written information with directions for

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F 279	Continued From page 7 how to position the resident, but, apparently we didn't get one for [R51]." RN-A also verified R51's care plan lacked interventions for proper positioning while in her wheelchair. During an interview on 7/28/16 at 3:26 p.m., OT-A stated she had ordered the new wheelchair for R51 because she needed a larger chair. OT-A indicated written information is given to the nursing staff when a resident received a new wheelchair, and the therapists educate the staff how to position the resident however, OT-A could not recall whether she had provided written information or instructed the nursing staff on how to position R51 in the the new wheelchair. OT-A further stated the facility had changed therapy providers recently and the records from the previous company were not available to review. Review of the facility's policy Care Planning IDT (interdisciplinary team) dated 5/11, included; "Care is planned to help attain or maintain the resident's/patient's highest practicable physical, mental and psychosocial well being...The comprehensive care plan is holistic and individualized to the specific needs and preferences of the resident."	F 279		
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 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		8/22/16

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F 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper wheelchair positioning for 1 of 3 residents (R51) reviewed for positioning. Findings include: R51's admission record dated 12/5/12, indicated R51 had diagnoses of osteoarthritis, Parkinson's Disease, had difficulty in walking, and was dependent on a wheelchair for mobility. R51's quarterly Minimum Data Set (MDS) dated 4/26/16, indicated R51 was cognitively intact, required extensive assistance for activities of daily living, used a wheelchair for mobility, and was totally dependent for locomotion. Review of R51's care plan dated 7/26/16, indicated R51 had limited physical mobility, was unable to wheel herself, and required extensive assistance for all locomotion once she was in her wheelchair. The care plan lacked interventions for proper positioning for R51 while in her wheelchair. During an observation on 7/25/16 at 3:46 p.m., R51 was sitting in her room, in her wheelchair. The wheelchair had a high back that extended above her head, and the back of the wheelchair was at a 90 degree angle to the seat of the wheelchair. R51 was observed to have a cushion behind her back that was approximately three inches thick. The cushion extended from the seat of the wheelchair to just under R51's shoulder blades. This caused R51's shoulders	F 309	F309 Provide Care/Services for Highest Well Being Plan of correction for residents cited with this survey: 1. R51 wheelchair will be evaluated by therapy staff for proper positioning. Education will be provided to staff members and care card and care plan will be updated. Plan to address and prevent this deficiency with other residents: 1. Will audit wheelchair positioning for residents, with wheelchairs, and verify that their care plan and care card interventions match. 2. Will educate nurse managers on care planning and care cards related to wheelchair positioning. 3. Therapy sheets, with changes, will be given to nurse mangers. Nurse managers will place in NAR report binder for them to review. If education needs to be provided, therapy staff will train staff. Measures put into place to prevent in the future: 1. Education will be provided to the nurse managers and floor staff on wheelchair positioning. Making sure that the care plan and care card interventions match. Plans to Monitor Performance: 1. Will audit a random sample of 20% of	

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F 309	Continued From page 9 and the crown of her head to press against the back of the wheelchair and her face was pointed toward the ceiling. R51's feet were observed to be supported on the foot pedals with a pad behind her heels and lower legs. During an observation on 7/25/16 at 5:35 p.m., R51 was in the dining room and was being assisted to eat. R51 was observed to continue to have the cushion behind her back, causing her head to press against the back of the wheelchair with her face pointed toward the ceiling. During an observation on 7/26/16 at 3:35 p.m., R51 was observed sitting in her room in her wheelchair. Again, R51 had the cushion in place behind her lower back, causing her buttocks to be 3-4 inches from the back of the wheelchair, and her shoulders and head were pressed into the back of the wheelchair with her face pointed toward the ceiling. During interview with R51 on 7/26/16 at 3:41 p.m., R51 stated she was not very comfortable in her wheelchair and that she had asked the nursing staff several times to have the therapist look at her wheelchair. R51 stated that to her knowledge that had not happened. R51also stated she had asked for a smaller pillow for behind her back because she slides forward and has to ask to be boosted up regularly. During an observation on 7/27/16 at 7:15 a.m., nursing assistant (NA)-A provided personal cares for R51 and used a mechanical lift to transfer her into her wheelchair. A thick black cushion with a half moon shaped indent, was attached to the upper back of the wheelchair and supported R51's head and neck, allowing her to sit upright	F 309	residents in wheelchairs x4 weeks, monthly x3 months and then quarterly. 2. Will review audit results with QAPI committee and will follow QAPI committee recommendations for further auditing needs. DON and Administrator will be responsible to ensure that the facility remains compliant in this area. This deficiency will be corrected by August 22, 2016.	

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F 309	Continued From page 10	F 309		

and to look straight ahead, instead of at the ceiling. R51 stated she felt so much more comfortable with the cushion supporting her head and neck.

NA-A was interviewed on 7/27/16 at 7:28 a.m. NA-A stated R51 had received a new wheelchair a couple of months ago and NA-A said she couldn't recall having received any training about the wheelchair or how R51 should be positioned in it. NA-A stated the cushion used to support R51's head was usually attached to her wheelchair but it wasn't this morning and she didn't know why. NA-A stated when she'd seen it on the chair in the corner of the room she'd attached it to the wheelchair.

During an interview on 7/28/16 at 9:21 a.m., NA-B stated she hadn't received any training for how to best use R51's wheelchair when it was new. NA-B stated she wasn't aware of any written information about how R51 should be positioned in the wheelchair either.

During an interview on 7/28/16 at 9:24 a.m., registered nurse (RN)-A stated, "OT [occupational therapy] gets the new wheelchair and tells us how to use it. [R51] usually has the headrest on. The nursing assistant sheet in the room, behind the bathroom door, should have that on there." RN-A verified the nursing assistant care sheet in R51's room lacked information regarding proper positioning for R51. RN-A stated, "OT usually provides written information with directions for how to position the resident, but, apparently we didn't get one for [R51]." RN-A also verified R51's care plan lacked interventions for proper positioning while in her wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 During an interview on 7/28/16 at 3:26 p.m., OT-A stated she had ordered the new wheelchair for R51 because she needed a larger chair. OT-A indicated written information is given to the nursing staff when a resident received a new wheelchair, and the therapists educate the staff how to position the resident however, OT-A could not recall whether she had provided written information or instructed the nursing staff on how to position R51 in the the new wheelchair. OT-A further stated the facility had changed therapy providers recently and the records from the previous company were not available to review. A policy related to wheelchair positioning was requested but not provided.	F 309		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal	F 334		8/22/16

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F 334	Continued From page 12 representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or	F 334		

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F 334	Continued From page 13 the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their facility policy related to pneumococcal conjugate vaccine (PCV13) for 5 of 5 residents (R37, R45, R49, R77 and R118) whose vaccination histories were reviewed. Findings include: The Center for Disease Control and Prevention (CDC) information regarding pneumococcal vaccination included: "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R37's Clinical Immunizations report undated, indicated the 83 year old resident had not received a Pneumovax. Additional review of R37's documented record did not reflect any offer of PCV13 either. R45's Clinical Immunizations report undated, indicated the 84 year old had received a Pneumovax vaccine on 4/12/13 however, there was no indication as to whether a PCV13 had been offered as outlined in the CDC guidelines.	F 334	F334 Influenza & Pneumococcal Immunizations Plan of correction for residents cited with this survey: 1. Will review residents (R37, 45, 49,77 and 118), vaccination record in MIIC and with primary care provider. Will offer PCV13 vaccine to residents if warranted per recommendations of CDC. 2. Will update Point Click Care Immunization tab with vaccine dates and/or declination. Plan to address and prevent this deficiency with other residents: 1. For all current and new residents in facility, their vaccination record will be reviewed and pneumococcal vaccine offered as indicated and recommended by CDC. 4. Will educate nursing staff on CDC recommendations and facility policy for pneumococcal vaccination. Measures put into place to prevent in the future: 1. Education will be provided to nursing staff on the CDC recommendations and facility policy for pneumococcal vaccination.	

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F 334	Continued From page 14 R49's Clinical Immunizations report undated, indicated the 91 year old had received a Pneumovax on 5/8/08 however, there was no indication as to whether a PCV13 had been offered as outlined in the CDC guidelines. R77 ' s Clinical Immunizations report undated, indicated the 98 year old had received a Pneumovax on 2/27/13 however, there was no indication as to whether a PCV13 had been offered as outlined in the CDC guidelines. R118's Clinical Immunizations report undated, indicated the 97 year old had received a Pneumovax on 11/26/05 however, there was no indication as to whether a PCV13 had been offered as outlined in the CDC guidelines. During interview on 7/27/16 at 1:06 p.m., the assistant director of nursing (ADON) stated that at the present time, the facility was not currently offering the PCV13 vaccine. The ADON stated that it was their intent for everyone who would like to receive this vaccination to be given it this by fall. The ADON stated she would be contacting the clinic prior to administration to determine what had previously been given and to assure that there were not contraindications for residents receiving the vaccination however, the ADON verified this had not yet been started. The facility's policies regarding influenza and pneumococcal vaccinations was dated June 2011. They had no updated policies reflecting the recommendations of the CDC for receipt of the PCV 13. The ADON stated that the facility had recently undergone a change of ownership and their policies were currently being transitioned to those of the new organization. The ADON stated,	F 334	2. For nursing staff who did not attend the in-service, information regarding the CDC recommendations and facility policy for pneumococcal vaccination will be mailed to them by August 19, 2016 Plans to Monitor Performance: 1. Will audit a random sample of 20% of residents, pneumococcal vaccination record in PCC weekly x4 weeks, monthly x3 months and then quarterly to make sure that the pneumococcal vaccine is up to date and/or was offered. 3. Will review audit results with QAPI committee and will follow QAPI committee recommendations for further auditing needs. DON and Administrator will be responsible to ensure that the facility remains compliant in this area. This deficiency will be corrected by August 22, 2016.	

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F 334	Continued From page 15 "a review of current policies is currently in process."	F 334		

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	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2016**

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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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT 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, on July 27, 2016. At the time of this survey, Emmanuel Home was found not to be 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/22/2016

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Emmanuel Home is a one-story building with partial basement. The original building was constructed in 1978, with building additions constructed in 1979 and 1988. The original building and both building additions are fully fire sprinkler protected, and were determined to be of Type V(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 71 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls	K 017		8/22/16

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K 017	Continued From page 2 constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed: 1) The smoke barrier wall located on First Street has huge holes in the concrete, along with some holes that are filled with unapproved material	K 017	K017 Life Safety Code Standard Description of what has, or will be done to correct the deficiency. 1. Smoke barrier wall located on first street has holes in the concrete that will be filled by 8/26/16. Materials to fill holes in concrete have been ordered. 2. Date of Completion: 8/26/16 3. Administrator and Environmental Services Director will be responsible for correction and prevention of future occurrence.	

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K 017	Continued From page 3 around pipes and conduit. This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 017		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.6.3.2. This deficient practice could affect 30 of 71 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on	K 018	K018 Life Safety Code Description of what has been, or will be done to correct the deficiency. 1. The corridor doors to resident rooms in 207, 214, 114 have been adjusted and properly latch to the door frame. The Activities Director door to the corridor has been adjusted and latches to the door frame. These have been completed on 7/29/16. A monthly audit has been created to check each door leading to corridor in	8/22/16

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K 018	Continued From page 4 07/27/2016, revealed: 1) The corridor door to resident room 207, 214, 114 did not positively latch into the frame when tested during the facility tour. 2) The corridor door to the activities director off would not shut when tested during the facility tour. This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 018	facility. 2. Completion Date: 7/29/16 3. Administrator and The Environmental Services Director will be responsible to make sure audits are completed monthly.	
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This deficient practice could affect all of the 71 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: Based on observations and staff interview during	K 022	K022 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. The activities and both sun rooms exits now have approved visible exit/no smoking signs. Completed on 7/29/16 2. Date of Completion: 7/29/16 3. Administrator and the Environmental Services Director will be responsible for correction and prevention of future occurrence.	8/22/16

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K 022	Continued From page 5 the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the following required exits did not have the proper signage: 1) Activities room. 2) Both sun rooms. This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 022		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 2 of 4 smoke barrier walls that were checked in accordance with the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19-3.7.3 and 8.3. This deficient practice could affect 30 of 71 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the following deficient conditions:	K 025	K025 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. The smoke barrier wall located by the activity room had penetrations found around pipe and conduit. Fire resistant materials have been ordered. All pipes and conduit leaving room will be sealed with a completion date of 8/26/16. 2. Completion date: 8/26/16. 3. Administrator and Environmental Services Director will be responsible for correction and prevention of future occurrence.	8/22/16

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K 025	Continued From page 6 1) The smoke barrier wall located by the activity room had penetrations found around a pipe and section of conduit that was passing through the smoke barrier above the ceiling tile over the double doors. 2) The smoke barrier wall located by the laundry department had a 3 inch diameter hole found above the ceiling tiles over the double doors. This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 025		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This deficient practice could affect 30 of	K 027	K027 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. Smoke barrier doors in the North Hall will be planed down to properly close with a completion date on 8/26/16. A monthly audit has been developed to check each fire door for proper closing and latching. 2. Date of Completion: 8/26/16	8/22/16

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	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/27/2016**

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

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K 027	Continued From page 7 71 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed:: 1) Smoke barrier doors in the North Hall would not close when tested. This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 027	3. Administrator and Environmental Services Director will be responsible for correction, future auditing and prevention of future occurrence.	
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: The facility has failed to provide proper protection	K 029	K029 Life Safety Code Standard	8/22/16

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K 029	Continued From page 8 for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.2.1. Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the corridor door to the laundry room did no latch when tested during the facility tour. This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 029	Description of what has been, or will be done to correct the deficiency. 1. The corridor door to the laundry room has been adjusted on 7/29/16 and now latches to the door frame properly. A monthly audit has been created to check each door to corridor. 2. Date of Completion:7/29/16 3. Administrator and Environmental Services Director will be responsible for correction, future auditing and prevention of future occurrence.	
K 051 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically	K 051		8/22/16

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K 051	Continued From page 9 activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.3.4.1 and 9.6, as well as the NFPA 72 "National Fire Alarm Code" 1999 edition section 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 20 of 71 residents, as well as an undetermined number of staff, and visitors. Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the following deficient conditions of the manual pull stations. The pull station in the Northwest exit and the Main entrance were obstructed. This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 051	K051 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. The fire pull stations on the Northwest exit and main entrance were obstructed. A sign has been place for the location of our concierge cart. Staff education has been provided on 8/18/16 of policies and procedures of fire pull station. Audits will be completed weekly for one month and monthly from then on. 2. Completion Date: 8/18/16 3. Administrator and Environmental Services Director will be responsible for correction and prevention of future occurrence.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with	K 052		8/22/16

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K 052	Continued From page 10 applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 71 of 71 residents, as well as an undetermined number of staff, and visitors Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the following deficient conditions: Replacement of sealed lead-acid batteries has not occured in the last 5 years. This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 052	K052 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. The sealed lead-acid batteries for the Simplex fire panel has been replaced on 8/16/16. 2. Date of Completion: 8/16/16 3. Administrator and Environmental Services Director will be responsible for prevention of future recurrence.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures	K 056		8/22/16

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K 056	Continued From page 11 shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility faille to ensure that the automatic sprinkler system is installed in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5.1 and the NFPA 13 "The Standard for the Installation of Sprinkler Systems" 1999 edition sections 5-4 and 5-5. Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the following deficient conditions: 1) The area located in above the sump pump is not provided with fire sprinkler protection. The current configuration and coverage of the sprinkler heads located in the area cannot provide coverage to the area of the sump pump. This was also revealed in the sprinkler report and not corrected. Report was dated 11/2/2015. 2) Under the mezzanine by the sprinkler riser is not sprinkler protected. This was also revealed in the sprinkler report and not corrected. Report was dated 11/2/2015. This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 056	K056 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. The location above the sump pump did not have proper fire sprinkler protection. Simplex Grinell is scheduled to install proper sprinkler protection above sump pumps and under mezzanine by 8/26/16 2. Completion Date: 8/26/16 3. Administrator and Environmental Services Director will be responsible for correction and prevention of future occurrence.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		8/22/16

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K 062	Continued From page 12 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 documentation review and interview with staff, the facility has failed to properly maintain the automatic sprinkler system in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5.1, and "The Standard for the Installation of Sprinkler Systems" 1999 edition section 3-2.7.2, 3-2.6.3, 5-5.6, and 6-1.1.5. This deficient practice does not ensure that the fire sprinkler system will function properly and is fully operational in the event of a fire and could negatively affect 71 of 71 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the following deficient conditions: 1) There is a dirty sprinkler head in the cooler. 2) The facility failed to perform the 5 year internal pip inspection. 3) There was storage found to be within 18 inches of the fire sprinkler deflector in the therapy office. 4) There was a sprinkler head in the new employee training room that was obstructed by a light.	K 062	K062 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. The sprinklers in the walk in cooler in the kitchen has been cleaned. 2. Simplex Grinell has been contacted and set up an inspection date to be completed by 8/26/16 to perform the 5 year internal pipe inspection. 3. The therapy office was assessed and items were removed from shelf to ensure there is 18 inches from fire sprinklers. 4. We will audit 100% of resident rooms/office spaces to ensure items are 18 inches from fire sprinklers. 5. Education will be provided on 8/18/16 and ongoing during monthly fire drills. 6. Will audit a random sample of 20% residents rooms 4x a week for 3 months then quarterly to make sure items are placed more than 18 inches away from a sprinkler head. 7. Date of Completion:8/26/16 8. Administrator and Environmental Services Director will be responsible for correction and monitoring to prevent recurrence.	

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K 062	Continued From page 13 This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 062		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the following deficient conditions: 1) On the North and South Lanes, Oxygen tanks were not seperated between empty and full.	K 076	K076 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. The North and South Lane oxygen rooms will be reorganized. The oxygen supplier has been contacted and will pick up extra supplies in oxygen rooms. The supplier will be given a par level for tanks left on hand. The oxygen supplier will leave an empty rack for used tanks. Oxygen tags will be left and stored in the oxygen room completed by 8/26/16. Education regarding proper oxygen storage was provided to staff at a mandatory staff meeting on 8/18/16. 2. Completion Date: 8/26/16. 3. Administrator and the Director of Nursing will be responsible for correction and monitoring to prevent re-occurrence.	8/22/16

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K 076	Continued From page 14 This deficient condition was verified by Enviromental Service director (JB) and Administrator (BG).	K 076	Education will be provided at monthly fire drills. Audits will be conducted. Daily x 1 week, Weekly x 1 month.	
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99) This STANDARD is not met as evidenced by: Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99) Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the following: 1) Improper signage at the main entrance for Oxygen in use. No Smoking. No Open flames. 2) All Entrances need to have signage. This deficient condition was verified by Environmental Service director (JB) and	K 141	K141 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. Proper signs including no smoking and no open flames are in the process of being made for placement on all entrances. Once we obtain signs they will be place on entrances. 2. Date of Completion: 8/26/16 3. Administrator and the Environmental Services Director will be responsible for correction and monitoring to prevent recurrence.	8/22/16

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K 141	Continued From page 15 Administrator (BG).	K 141		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: Based on interview and record review between 8:30 AM to 6:30 PM on 07/27/2016, revealed the following: 1) During the review of all available documentation for the emergency generator, revealed the facility did not document the required cool down for the emergency generator. 2) During the review of all available documentation for the emergency generator, revealed the facility the facility did not meet 30% of the KW of the generator and failed to have the load bank test on the emergency generator. This deficient condition was verified by Environmental Service director (JB) and Administrator (BG).	K 144	K144 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. A generator checklist has been created. After weekly inspections the checklist will be used and kept in a file. 2. A load bank test was completed on 8/2/16 on the emergency generator. Generators will be inspected weekly and exercised and documented in accordance with NFPA guidelines. 3. Completion Date: 4. 8/26/16 4. Administrator and the Environmental Services Director will be responsible for correction and monitoring to prevent recurrence.	8/22/16
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2	K 147		8/22/16

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K 147	Continued From page 16 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Findings include: Based on observations and staff interview during the facility tour between 8:30AM to 6:30 PM on 07/27/2016, revealed the following: 1) The Therapy Room had an extension cord into a power strip. 2) Room 214 had a power strip plugged into a power strip. 3) The Activities Director Office had a power strip plugged into a power strip and a multi-plug adapter. 4) The sump pump was plugged in with an extension cord. This deficient condition was verified by Environmental Service director (JB) and Administrator (BG).	K 147	K147 Life Safety Code Standard Description of what has been, or will be done to correct the deficiency. 1. An electrician installed an outlet in the therapy room on 8/2/16 2. One power strip was removed from room 214. Audits will be done for all resident rooms monthly. 3. Power strip was removed from activities office. An electrician installed a new outlet on 8/2/16. 4. An electrician installed a new outlet near the sump pump on 8/2/16. 5. Staff education on 8/18/16 for policies of use of power strips/extension cords in the nursing home setting at a mandatory staff meeting 6. Completion Date: 8/18/16 7. Administrator and the Environmental Services Director will be responsible for correction and monitoring to prevent recurrence.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
August 12, 2016

Mr. Blaine Gamst, Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5361025

Dear Mr. Gamst:

The above facility was surveyed on July 25, 2016 through July 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Maria King, Assistant Program Manager at (507)344-2716.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 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
	00775	A. BUILDING: _____ B. WING _____	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/25/16-7/28/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were developed for 1 of 3 residents (R51) reviewed for positioning. Findings include:	2 560	Corrected	8/22/16

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2 560	Continued From page 2 R51's admission record dated 12/5/12, indicated R51 had diagnoses of osteoarthritis, Parkinson's Disease, had difficulty in walking, and was dependent on a wheelchair for mobility. R51's quarterly Minimum Data Set (MDS) dated 4/26/16, indicated R51 was cognitively intact, required extensive assistance for activities of daily living, used a wheelchair for mobility, and was totally dependent for locomotion. Review of R51's care plan dated 7/26/16, indicated R51 had limited physical mobility, was unable to wheel herself, and required extensive assistance for all locomotion once she was in her wheelchair. The care plan lacked interventions for proper positioning for R51 while in her wheelchair. During an observation on 7/25/16 at 3:46 p.m., R51 was sitting in her room, in her wheelchair. The wheelchair had a high back that extended above her head, and the back of the wheelchair was at a 90 degree angle to the seat of the wheelchair. R51 was observed to have a cushion behind her back that was approximately three inches thick. The cushion extended from the seat of the wheelchair to just under R51's shoulder blades. This caused R51's shoulders and the crown of her head to press against the back of the wheelchair and her face was pointed toward the ceiling. R51's feet were observed to be supported on the foot pedals with a pad behind her heels and lower legs. During an observation on 7/25/16 at 5:35 p.m., R51 was in the dining room and was being assisted to eat. R51 was observed to continue to have the cushion behind her back, causing her head to press against the back of the wheelchair	2 560		

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2 560	Continued From page 3 with her face pointed toward the ceiling. During an observation on 7/26/16 at 3:35 p.m., R51 was observed sitting in her room in her wheelchair. Again, R51 had the cushion in place behind her lower back, causing her buttocks to be 3-4 inches from the back of the wheelchair, and her shoulders and head were pressed into the back of the wheelchair with her face pointed toward the ceiling. During interview with R51 on 7/26/16 at 3:41 p.m., R51 stated she was not very comfortable in her wheelchair and that she had asked the nursing staff several times to have the therapist look at her wheelchair. R51 stated that to her knowledge that had not happened. R51also stated she had asked for a smaller pillow for behind her back because she slides forward and has to ask to be boosted up regularly. During an observation on 7/27/16 at 7:15 a.m., nursing assistant (NA)-A provided personal cares for R51 and used a mechanical lift to transfer her into her wheelchair. A thick black cushion with a half moon shaped indent, was attached to the upper back of the wheelchair and supported R51's head and neck, allowing her to sit upright and to look straight ahead, instead of at the ceiling. R51 stated she felt so much more comfortable with the cushion supporting her head and neck. NA-A was interviewed on 7/27/16 at 7:28 a.m. NA-A stated R51 had received a new wheelchair a couple of months ago and NA-A said she couldn't recall having received any training about the wheelchair or how R51 should be positioned in it. NA-A stated the cushion used to support R51's head was usually attached to her	2 560		

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2 560	Continued From page 4 wheelchair but it wasn't this morning and she didn't know why. NA-A stated when she'd seen it on the chair in the corner of the room she'd attached it to the wheelchair. During an interview on 7/28/16 at 9:21 a.m., NA-B stated she hadn't received any training for how to best use R51's wheelchair when it was new. NA-B stated she wasn't aware of any written information about how R51 should be positioned in the wheelchair either. During an interview on 7/28/16 at 9:24 a.m., registered nurse (RN)-A stated, "OT [occupational therapy] gets the new wheelchair and tells us how to use it. [R51] usually has the headrest on. The nursing assistant sheet in the room, behind the bathroom door, should have that on there." RN-A verified the nursing assistant care sheet in R51's room lacked information regarding proper positioning for R51. RN-A stated, "OT usually provides written information with directions for how to position the resident, but, apparently we didn't get one for [R51]." RN-A also verified R51's care plan lacked interventions for proper positioning while in her wheelchair. During an interview on 7/28/16 at 3:26 p.m., OT-A stated she had ordered the new wheelchair for R51 because she needed a larger chair. OT-A indicated written information is given to the nursing staff when a resident received a new wheelchair, and the therapists educate the staff how to position the resident however, OT-A could not recall whether she had provided written information or instructed the nursing staff on how to position R51 in the the new wheelchair. OT-A further stated the facility had changed therapy providers recently and the records from the previous company were not available to review.	2 560		

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2 560	Continued From page 5 Review of the facility's policy Care Planning IDT (interdisciplinary team) dated 5/11, included; "Care is planned to help attain or maintain the resident's/patient's highest practicable physical, mental and psychosocial well being...The comprehensive care plan is holistic and individualized to the specific needs and preferences of the resident." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review systems to ensure comprehensive care plans are developed and revised in a timely manner. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the monitoring results to the QA committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		8/22/16

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2 830	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper wheelchair positioning for 1 of 2 residents (R51) reviewed with wheelchair positioning needs. Findings include: R51's admission record dated 12/5/12, indicated R51 had diagnoses of osteoarthritis, Parkinson's Disease, had difficulty in walking, and was dependent on a wheelchair for mobility. R51's quarterly Minimum Data Set (MDS) dated 4/26/16, indicated R51 was cognitively intact, required extensive assistance for activities of daily living, used a wheelchair for mobility, and was totally dependent for locomotion. Review of R51's care plan dated 7/26/16, indicated R51 had limited physical mobility, was unable to wheel herself, and required extensive assistance for all locomotion once she was in her wheelchair. The care plan lacked interventions for proper positioning for R51 while in her wheelchair. During an observation on 7/25/16 at 3:46 p.m., R51 was sitting in her room, in her wheelchair. The wheelchair had a high back that extended above her head, and the back of the wheelchair was at a 90 degree angle to the seat of the wheelchair. R51 was observed to have a cushion behind her back that was approximately three inches thick. The cushion extended from the seat of the wheelchair to just under R51's shoulder blades. This caused R51's shoulders	2 830	Corrected	

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2 830	Continued From page 7	2 830		

and the crown of her head to press against the back of the wheelchair and her face was pointed toward the ceiling. R51's feet were observed to be supported on the foot pedals with a pad behind her heels and lower legs.

During an observation on 7/25/16 at 5:35 p.m., R51 was in the dining room and was being assisted to eat. R51 was observed to continue to have the cushion behind her back, causing her head to press against the back of the wheelchair with her face pointed toward the ceiling.

During an observation on 7/26/16 at 3:35 p.m., R51 was observed sitting in her room in her wheelchair. Again, R51 had the cushion in place behind her lower back, causing her buttocks to be 3-4 inches from the back of the wheelchair, and her shoulders and head were pressed into the back of the wheelchair with her face pointed toward the ceiling.

During interview with R51 on 7/26/16 at 3:41 p.m., R51 stated she was not very comfortable in her wheelchair and that she had asked the nursing staff several times to have the therapist look at her wheelchair. R51 stated that to her knowledge that had not happened. R51also stated she had asked for a smaller pillow for behind her back because she slides forward and has to ask to be boosted up regularly.

During an observation on 7/27/16 at 7:15 a.m., nursing assistant (NA)-A provided personal cares for R51 and used a mechanical lift to transfer her into her wheelchair. A thick black cushion with a half moon shaped indent, was attached to the upper back of the wheelchair and supported R51's head and neck, allowing her to sit upright and to look straight ahead, instead of at the

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2 830	Continued From page 8 ceiling. R51 stated she felt so much more comfortable with the cushion supporting her head and neck. NA-A was interviewed on 7/27/16 at 7:28 a.m. NA-A stated R51 had received a new wheelchair a couple of months ago and NA-A said she couldn't recall having received any training about the wheelchair or how R51 should be positioned in it. NA-A stated the cushion used to support R51's head was usually attached to her wheelchair but it wasn't this morning and she didn't know why. NA-A stated when she'd seen it on the chair in the corner of the room she'd attached it to the wheelchair. During an interview on 7/28/16 at 9:21 a.m., NA-B stated she hadn't received any training for how to best use R51's wheelchair when it was new. NA-B stated she wasn't aware of any written information about how R51 should be positioned in the wheelchair either. During an interview on 7/28/16 at 9:24 a.m., registered nurse (RN)-A stated, "OT [occupational therapy] gets the new wheelchair and tells us how to use it. [R51] usually has the headrest on. The nursing assistant sheet in the room, behind the bathroom door, should have that on there." RN-A verified the nursing assistant care sheet in R51's room lacked information regarding proper positioning for R51. RN-A stated, "OT usually provides written information with directions for how to position the resident, but, apparently we didn't get one for [R51]." RN-A also verified R51's care plan lacked interventions for proper positioning while in her wheelchair. During an interview on 7/28/16 at 3:26 p.m., OT-A stated she had ordered the new wheelchair for	2 830		

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2 830	Continued From page 9 R51 because she needed a larger chair. OT-A indicated written information is given to the nursing staff when a resident received a new wheelchair, and the therapists educate the staff how to position the resident however, OT-A could not recall whether she had provided written information or instructed the nursing staff on how to position R51 in the the new wheelchair. OT-A further stated the facility had changed therapy providers recently and the records from the previous company were not available to review. A policy related to wheelchair positioning was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review systems to ensure residents are properly positioned for optimal body aligment. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the monitoring results to the QA committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR).	21426		8/22/16

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21426	Continued From page 10 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 implement interventions to ensure appropriate screening for tuberculosis (TB) was conducted for 1 of 5 employees (E-1) reviewed for TB. Findings include: E-1's start of employment date was 6/13/16. Review of E-1's personnel record revealed the employee had received a mantoux (TST) on 6/10/13 which was negative witih 0 mm (millimiters) of induration on 6/13/16. A second step TST had been administered on 7/10/16, however results were not read until 7/15/16. During interview on 7/28/16 at 1:30 p.m., the director of nursing (DON) stated the second step TST "should have been read within 72 hours of administration." On 7/28/16 at 3:17 p.m., the assistant director of nursing (ADON) stated, "the second step	21426	Corrected	

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21426	Continued From page 11 mantoux will need to be repeated for this employee [E-1]. " The facility's policy and procedure Tuberculosis (TB) Prevention and Control dated 6/11, indicated all employees of the facility would be tested prior to employment. "Baseline TB screening consists of two components: 1) assessing for current symptoms of active TB disease and 2) testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or a single TB blood test." The current CDC (Centers for Disease Control and Prevention) recommendation include: "The skin test reaction should be read between 48 and 72 hours after administration. A patient who does not return within 72 hours will need to be rescheduled for another skin test." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the assessment process for employees to be sure the documentation of the tuberculin screens and tests are completed, the administrator or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review tuberculosis screening standards to ensure they meet appropriate standards. The DON or designee could educate all licensed nursing staff regarding the importance of tuberculosis screening systems, and could develop ongoing audits and monitoring to ensure compliance.	21426		

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21426	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure comfortable room temperatures were maintained for 6 of 35 residents (R141, R127, R17, R46, R84, R77) who complained about their room temperatures. Findings include: During an observation on 7/25/16 at 3:25 p.m., R141 stated his room and the hallways, "get too cold," and when he tells the staff, they give him a blanket.	21705	Corrected	8/22/16

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	00775	A. BUILDING: _____ B. WING _____	07/28/2016

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21705	Continued From page 13 During an observation on 7/25/16 at 6:22 p.m., R127 stated she kept the door to her room closed because, "Opening the door is like opening a refrigerator door." R127 stated, "The staff kind of ignore it." During an observation on 7/25/16 at 6:44 p.m., R17 was wearing a long sleeved shirt and a thick sweatshirt. R17 stated, "It's too cold. I always have to wear two shirts." During an observation on 7/26/16 at 9:20 a.m., R46 was wearing a long sleeved button up shirt and a zip up grey fleece sweater, and stated he wears the fleece sweater at all times because it's too cool in the facility. R46 stated he had complained to the staff but they told him it was too hot for them. During an interview on 7/26/16 at 9:54 a.m., R84 stated, "The temperature is cold," and stated when she tells the staff, they give her a blanket and a sweater. During observation on 7/26/16, at 10:20 a.m., R77 was being assisted to the bathroom. R77 was wrapped in a blanket, kept her head tucked down in the blanket, did not make eye contact, and kept repeating, "I'm cold...I'm cold." During an observation on 7/27/16, at 7:08 a.m., R77 was sitting on the toilet in the bathroom, and stated, "Leave me alone, I'm cold." The wall air conditioning unit in R77's room was on, blowing cold air. Nursing assistant (NA)-C and NA-D transferred R77 and then shut off the air conditioning unit. R77 was observed to b bundled in blankets. During an interview on 7/28/16 at 11:00 a.m., the	21705		

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21705	Continued From page 14 environmental services director (ED) stated the goal was to maintain the building and room temperatures at "about 70 degrees," but he was not aware of a facility policy that addressed this. The ED stated he was not aware if the facility routinely monitored the temperature in resident rooms or common areas, but stated if the residents complained about the temperature, the nursing staff would notify the maintenance staff. ED was not aware of any complaints from residents regarding room or common area temperatures. During an environmental tour with the ED on 7/28/16 at 11:15 a.m., the following temperatures were observed: On the 100 wing, room 102 was 71 degrees Fahrenheit (F), room 114 was 71.5 degrees F, room 116 was 74.5 degrees F (with the door shut), and the 100 wing hallway temperature was 70 degrees F. On the 300 wing, room 315 was 67.5 degrees F and the 300 wing hallway temperature was 67 degrees F. On the 400 wing, room 404 was 69.5 degrees F and the 400 wing hallway temperature was 70 degrees F. During an interview at the time of the environmental tour on the 300 wing hallway, the ED stated, "It is kind of cool." At that time it was observed the wall air conditioning unit at the end of the hallway was on and blowing cold air. The ED stated staff had probably turned the air conditioning unit on because they preferred the temperature to be cooler, but the residents' comfort was most important. The ED turned off	21705		

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21705	Continued From page 15 the air conditioning unit and stated he would be monitoring the hallway and resident room temperatures more closely. During an interview on 7/28/16, at 1:07 p.m., the administrator stated the ED needed to develop an ongoing monitoring plan of the temperatures in the building and confirmed the temperatures would be adjusted, "per resident comfort." The facility's policy Quality of Life-Homelike Environment dated 4/14, included: "The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include...Comfortable temperatures." SUGGESTED METHOD OF CORRECTION: The environmental services director (ED), could educate staff regarding the importance of maintaining temperatures at or above 71 degrees to meet the needs of residents. The ED, could coordinate with housekeeping and nursing staff to conduct periodic audits of areas residents frequent to ensure temperatures were comfortable for residents. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21705		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/25/16-7/28/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were developed for 1 of 3 residents (R51) reviewed for positioning. Findings include:	2 560		

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2 560	Continued From page 2 R51's admission record dated 12/5/12, indicated R51 had diagnoses of osteoarthritis, Parkinson's Disease, had difficulty in walking, and was dependent on a wheelchair for mobility. R51's quarterly Minimum Data Set (MDS) dated 4/26/16, indicated R51 was cognitively intact, required extensive assistance for activities of daily living, used a wheelchair for mobility, and was totally dependent for locomotion. Review of R51's care plan dated 7/26/16, indicated R51 had limited physical mobility, was unable to wheel herself, and required extensive assistance for all locomotion once she was in her wheelchair. The care plan lacked interventions for proper positioning for R51 while in her wheelchair. During an observation on 7/25/16 at 3:46 p.m., R51 was sitting in her room, in her wheelchair. The wheelchair had a high back that extended above her head, and the back of the wheelchair was at a 90 degree angle to the seat of the wheelchair. R51 was observed to have a cushion behind her back that was approximately three inches thick. The cushion extended from the seat of the wheelchair to just under R51's shoulder blades. This caused R51's shoulders and the crown of her head to press against the back of the wheelchair and her face was pointed toward the ceiling. R51's feet were observed to be supported on the foot pedals with a pad behind her heels and lower legs. During an observation on 7/25/16 at 5:35 p.m., R51 was in the dining room and was being assisted to eat. R51 was observed to continue to have the cushion behind her back, causing her head to press against the back of the wheelchair	2 560		

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2 560	Continued From page 3 with her face pointed toward the ceiling. During an observation on 7/26/16 at 3:35 p.m., R51 was observed sitting in her room in her wheelchair. Again, R51 had the cushion in place behind her lower back, causing her buttocks to be 3-4 inches from the back of the wheelchair, and her shoulders and head were pressed into the back of the wheelchair with her face pointed toward the ceiling. During interview with R51 on 7/26/16 at 3:41 p.m., R51 stated she was not very comfortable in her wheelchair and that she had asked the nursing staff several times to have the therapist look at her wheelchair. R51 stated that to her knowledge that had not happened. R51also stated she had asked for a smaller pillow for behind her back because she slides forward and has to ask to be boosted up regularly. During an observation on 7/27/16 at 7:15 a.m., nursing assistant (NA)-A provided personal cares for R51 and used a mechanical lift to transfer her into her wheelchair. A thick black cushion with a half moon shaped indent, was attached to the upper back of the wheelchair and supported R51's head and neck, allowing her to sit upright and to look straight ahead, instead of at the ceiling. R51 stated she felt so much more comfortable with the cushion supporting her head and neck. NA-A was interviewed on 7/27/16 at 7:28 a.m. NA-A stated R51 had received a new wheelchair a couple of months ago and NA-A said she couldn't recall having received any training about the wheelchair or how R51 should be positioned in it. NA-A stated the cushion used to support R51's head was usually attached to her	2 560		

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2 560	Continued From page 4 wheelchair but it wasn't this morning and she didn't know why. NA-A stated when she'd seen it on the chair in the corner of the room she'd attached it to the wheelchair. During an interview on 7/28/16 at 9:21 a.m., NA-B stated she hadn't received any training for how to best use R51's wheelchair when it was new. NA-B stated she wasn't aware of any written information about how R51 should be positioned in the wheelchair either. During an interview on 7/28/16 at 9:24 a.m., registered nurse (RN)-A stated, "OT [occupational therapy] gets the new wheelchair and tells us how to use it. [R51] usually has the headrest on. The nursing assistant sheet in the room, behind the bathroom door, should have that on there." RN-A verified the nursing assistant care sheet in R51's room lacked information regarding proper positioning for R51. RN-A stated, "OT usually provides written information with directions for how to position the resident, but, apparently we didn't get one for [R51]." RN-A also verified R51's care plan lacked interventions for proper positioning while in her wheelchair. During an interview on 7/28/16 at 3:26 p.m., OT-A stated she had ordered the new wheelchair for R51 because she needed a larger chair. OT-A indicated written information is given to the nursing staff when a resident received a new wheelchair, and the therapists educate the staff how to position the resident however, OT-A could not recall whether she had provided written information or instructed the nursing staff on how to position R51 in the the new wheelchair. OT-A further stated the facility had changed therapy providers recently and the records from the previous company were not available to review.	2 560		

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2 560	Continued From page 5 Review of the facility's policy Care Planning IDT (interdisciplinary team) dated 5/11, included; "Care is planned to help attain or maintain the resident's/patient's highest practicable physical, mental and psychosocial well being...The comprehensive care plan is holistic and individualized to the specific needs and preferences of the resident." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review systems to ensure comprehensive care plans are developed and revised in a timely manner. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the monitoring results to the QA committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		

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2 830	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper wheelchair positioning for 1 of 2 residents (R51) reviewed with wheelchair positioning needs. Findings include: R51's admission record dated 12/5/12, indicated R51 had diagnoses of osteoarthritis, Parkinson's Disease, had difficulty in walking, and was dependent on a wheelchair for mobility. R51's quarterly Minimum Data Set (MDS) dated 4/26/16, indicated R51 was cognitively intact, required extensive assistance for activities of daily living, used a wheelchair for mobility, and was totally dependent for locomotion. Review of R51's care plan dated 7/26/16, indicated R51 had limited physical mobility, was unable to wheel herself, and required extensive assistance for all locomotion once she was in her wheelchair. The care plan lacked interventions for proper positioning for R51 while in her wheelchair. During an observation on 7/25/16 at 3:46 p.m., R51 was sitting in her room, in her wheelchair. The wheelchair had a high back that extended above her head, and the back of the wheelchair was at a 90 degree angle to the seat of the wheelchair. R51 was observed to have a cushion behind her back that was approximately three inches thick. The cushion extended from the seat of the wheelchair to just under R51's shoulder blades. This caused R51's shoulders	2 830		

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2 830	Continued From page 7 and the crown of her head to press against the back of the wheelchair and her face was pointed toward the ceiling. R51's feet were observed to be supported on the foot pedals with a pad behind her heels and lower legs. During an observation on 7/25/16 at 5:35 p.m., R51 was in the dining room and was being assisted to eat. R51 was observed to continue to have the cushion behind her back, causing her head to press against the back of the wheelchair with her face pointed toward the ceiling. During an observation on 7/26/16 at 3:35 p.m., R51 was observed sitting in her room in her wheelchair. Again, R51 had the cushion in place behind her lower back, causing her buttocks to be 3-4 inches from the back of the wheelchair, and her shoulders and head were pressed into the back of the wheelchair with her face pointed toward the ceiling. During interview with R51 on 7/26/16 at 3:41 p.m., R51 stated she was not very comfortable in her wheelchair and that she had asked the nursing staff several times to have the therapist look at her wheelchair. R51 stated that to her knowledge that had not happened. R51also stated she had asked for a smaller pillow for behind her back because she slides forward and has to ask to be boosted up regularly. During an observation on 7/27/16 at 7:15 a.m., nursing assistant (NA)-A provided personal cares for R51 and used a mechanical lift to transfer her into her wheelchair. A thick black cushion with a half moon shaped indent, was attached to the upper back of the wheelchair and supported R51's head and neck, allowing her to sit upright and to look straight ahead, instead of at the	2 830		

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2 830	Continued From page 8	2 830		

ceiling. R51 stated she felt so much more comfortable with the cushion supporting her head and neck.

NA-A was interviewed on 7/27/16 at 7:28 a.m. NA-A stated R51 had received a new wheelchair a couple of months ago and NA-A said she couldn't recall having received any training about the wheelchair or how R51 should be positioned in it. NA-A stated the cushion used to support R51's head was usually attached to her wheelchair but it wasn't this morning and she didn't know why. NA-A stated when she'd seen it on the chair in the corner of the room she'd attached it to the wheelchair.

During an interview on 7/28/16 at 9:21 a.m., NA-B stated she hadn't received any training for how to best use R51's wheelchair when it was new. NA-B stated she wasn't aware of any written information about how R51 should be positioned in the wheelchair either.

During an interview on 7/28/16 at 9:24 a.m., registered nurse (RN)-A stated, "OT [occupational therapy] gets the new wheelchair and tells us how to use it. [R51] usually has the headrest on. The nursing assistant sheet in the room, behind the bathroom door, should have that on there." RN-A verified the nursing assistant care sheet in R51's room lacked information regarding proper positioning for R51. RN-A stated, "OT usually provides written information with directions for how to position the resident, but, apparently we didn't get one for [R51]." RN-A also verified R51's care plan lacked interventions for proper positioning while in her wheelchair.

During an interview on 7/28/16 at 3:26 p.m., OT-A stated she had ordered the new wheelchair for

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2 830	Continued From page 9 R51 because she needed a larger chair. OT-A indicated written information is given to the nursing staff when a resident received a new wheelchair, and the therapists educate the staff how to position the resident however, OT-A could not recall whether she had provided written information or instructed the nursing staff on how to position R51 in the the new wheelchair. OT-A further stated the facility had changed therapy providers recently and the records from the previous company were not available to review. A policy related to wheelchair positioning was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review systems to ensure residents are properly positioned for optimal body aligment. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the monitoring results to the QA committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR).	21426		

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	00775	A. BUILDING: _____ B. WING _____	07/28/2016

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

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21426	Continued From page 10 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 implement interventions to ensure appropriate screening for tuberculosis (TB) was conducted for 1 of 5 employees (E-1) reviewed for TB. Findings include: E-1's start of employment date was 6/13/16. Review of E-1's personnel record revealed the employee had received a mantoux (TST) on 6/10/13 which was negative witih 0 mm (millimiters) of induration on 6/13/16. A second step TST had been administered on 7/10/16, however results were not read until 7/15/16. During interview on 7/28/16 at 1:30 p.m., the director of nursing (DON) stated the second step TST "should have been read within 72 hours of administration." On 7/28/16 at 3:17 p.m., the assistant director of nursing (ADON) stated, "the second step	21426		

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21426	Continued From page 11 mantoux will need to be repeated for this employee [E-1]. " The facility's policy and procedure Tuberculosis (TB) Prevention and Control dated 6/11, indicated all employees of the facility would be tested prior to employment. "Baseline TB screening consists of two components: 1) assessing for current symptoms of active TB disease and 2) testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or a single TB blood test." The current CDC (Centers for Disease Control and Prevention) recommendation include: "The skin test reaction should be read between 48 and 72 hours after administration. A patient who does not return within 72 hours will need to be rescheduled for another skin test." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the assessment process for employees to be sure the documentation of the tuberculin screens and tests are completed, the administrator or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review tuberculosis screening standards to ensure they meet appropriate standards. The DON or designee could educate all licensed nursing staff regarding the importance of tuberculosis screening systems, and could develop ongoing audits and monitoring to ensure compliance.	21426		

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21426	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure comfortable room temperatures were maintained for 6 of 35 residents (R141, R127, R17, R46, R84, R77) who complained about their room temperatures. Findings include: During an observation on 7/25/16 at 3:25 p.m., R141 stated his room and the hallways, "get too cold," and when he tells the staff, they give him a blanket.	21705		

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21705	Continued From page 13 During an observation on 7/25/16 at 6:22 p.m., R127 stated she kept the door to her room closed because, "Opening the door is like opening a refrigerator door." R127 stated, "The staff kind of ignore it." During an observation on 7/25/16 at 6:44 p.m., R17 was wearing a long sleeved shirt and a thick sweatshirt. R17 stated, "It's too cold. I always have to wear two shirts." During an observation on 7/26/16 at 9:20 a.m., R46 was wearing a long sleeved button up shirt and a zip up grey fleece sweater, and stated he wears the fleece sweater at all times because it's too cool in the facility. R46 stated he had complained to the staff but they told him it was too hot for them. During an interview on 7/26/16 at 9:54 a.m., R84 stated, "The temperature is cold," and stated when she tells the staff, they give her a blanket and a sweater. During observation on 7/26/16, at 10:20 a.m., R77 was being assisted to the bathroom. R77 was wrapped in a blanket, kept her head tucked down in the blanket, did not make eye contact, and kept repeating, "I'm cold...I'm cold." During an observation on 7/27/16, at 7:08 a.m., R77 was sitting on the toilet in the bathroom, and stated, "Leave me alone, I'm cold." The wall air conditioning unit in R77's room was on, blowing cold air. Nursing assistant (NA)-C and NA-D transferred R77 and then shut off the air conditioning unit. R77 was observed to b bundled in blankets. During an interview on 7/28/16 at 11:00 a.m., the	21705		

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21705	Continued From page 14 environmental services director (ED) stated the goal was to maintain the building and room temperatures at "about 70 degrees," but he was not aware of a facility policy that addressed this. The ED stated he was not aware if the facility routinely monitored the temperature in resident rooms or common areas, but stated if the residents complained about the temperature, the nursing staff would notify the maintenance staff. ED was not aware of any complaints from residents regarding room or common area temperatures. During an environmental tour with the ED on 7/28/16 at 11:15 a.m., the following temperatures were observed: On the 100 wing, room 102 was 71 degrees Fahrenheit (F), room 114 was 71.5 degrees F, room 116 was 74.5 degrees F (with the door shut), and the 100 wing hallway temperature was 70 degrees F. On the 300 wing, room 315 was 67.5 degrees F and the 300 wing hallway temperature was 67 degrees F. On the 400 wing, room 404 was 69.5 degrees F and the 400 wing hallway temperature was 70 degrees F. During an interview at the time of the environmental tour on the 300 wing hallway, the ED stated, "It is kind of cool." At that time it was observed the wall air conditioning unit at the end of the hallway was on and blowing cold air. The ED stated staff had probably turned the air conditioning unit on because they preferred the temperature to be cooler, but the residents' comfort was most important. The ED turned off	21705		

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21705	Continued From page 15 the air conditioning unit and stated he would be monitoring the hallway and resident room temperatures more closely. During an interview on 7/28/16, at 1:07 p.m., the administrator stated the ED needed to develop an ongoing monitoring plan of the temperatures in the building and confirmed the temperatures would be adjusted, "per resident comfort." The facility's policy Quality of Life-Homelike Environment dated 4/14, included: "The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include...Comfortable temperatures." SUGGESTED METHOD OF CORRECTION: The environmental services director (ED), could educate staff regarding the importance of maintaining temperatures at or above 71 degrees to meet the needs of residents. The ED, could coordinate with housekeeping and nursing staff to conduct periodic audits of areas residents frequent to ensure temperatures were comfortable for residents. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21705		