CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

					ND TRANSMITTAL E SURVEY AGENCY		ID: MF85 Facility ID: 00775
MEDICARE/MEDICAID PROVIDER (L1) 245361 2.STATE VENDOR OR MEDICAID NO (L2) 134543500 FEEE/CTIVE DATE CHANGE OF ON		3. NAME AND ADD (L3) MEEKER MA (L4) 600 SOUTH I (L5) LITCHFIELI	ANOR REHABIL DAVIS AVENUE D, MN	ITATION	(L6) 55355	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation 7. On-Site Visit	7 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
 EFFECTIVE DATE CHANGE OF OV (L9) 	VNERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey After C	Complaint
6. DATE OF SURVEY 09/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 90 (L37) (L38) 16. STATE SURVEY AGENCY REMAR 17. SURVEYOR SIGNATURE Brenda Fischer, U 19. DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Pa 2. Facility is not Eligible	(L39) EKS (IF APPLICABLE S Init Superviso PART II - TO	B. Not in Comp Requirements at ICF (L42) HOW LTC CANCELLA Date: 0 BE COMPLETED 20. COMI	cee With uirements Based On: cceptable POC cliance with Program nd/or Applied Waive IID (L43) ATION DATE):	(L19)	2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S) 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): 18. STATE SURVEY AGENCY Kate JohnsTon, OFFICE OR SINGLE ST	7. Medical Director SNF) — 7. Medical Director SNF) — 8. Patient Room — 9. Beds/Room (L12) (L15) YAPPROVAL Program Special STATE AGENCY nancial Solvency (HCFA-2572) atrol Interest Disclosure Stmt (HCI	Date: 1St 09/16/2016 (L20)
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2 ²	4. LTC AGREEME	NT	26. TERMINATION ACTION	1:	(L30)
OF PARTICIPATION 10/01/1986	BEGINNING I	DATE	ENDING DATE		VOLUNTARY 01-Merger, Closure		Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension of B. Rescind Susp	of Admissions:	(L25) (L44) (L45)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminat 04-Other Reason for Withdrawal	ion <u>OTHER</u>	Meet Agreement er Status Change
28. TERMINATION DATE:	29	INTERMEDIARY/CA	ARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	DETERMINATION O	F APPROVAL DAT	Е	Posted 09/23/20	16 Co.	

(L33)

DETERMINATION APPROVAL

09/09/2016

(L32)



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.

Meeker Manor Rehabilitation Center, Llc September 16, 2016 Page 2

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



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.

Meeker Manor Rehabilitation Center, LLC September 16, 2016 Page 2

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

		P051	-CERI	IFICATION	NKE	VISII RE	=PORI					
	R / SUPPLIER / CLIA /	MULTIPLE CONS	TRUCTION						DATE C	F REVIS	IT	
	CATION NUMBER	A. Building							9/12/20	146		
245361	Y1	B. Wing						Y2	9/12/20	710	Y3	
NAME OF	FACILITY				STREET ADDRESS, CITY, STATE, ZIP CODE							
MEEKEF	R MANOR REHABILITATI	ON CENTER, LLC	0	600 SOUTH DAVIS AVENUE								
					LITCHF	IELD, MN 55355						
program, corrected provision	ort is completed by a qual to show those deficiencied and the date such corre number and the identificate ey report form).	es previously repo ctive action was a	rted on the ccomplishe	CMS-2567, Statem d. Each deficiency	nent of D should I	eficiencies and be fully identifie	Plan of Cor d using either	rection, that have er the regulation o	been or LSC			
ITE	M	DATE	ITEM			DATE	ITEM			DATE	i	
Y4		Y5	Y4			Y5	Y4			Y5		
ID Prefix	F0257 483.15(h)(6)	Correction	ID Prefix	F0279 483.20(d), 483.20(k))(1)	Correction	ID Prefix	F0309 483.25		Correc	ction	
Reg. #	400.10(11)(0)	Completed	Reg. #	400.20(d), 400.20(k)	/(' /	Completed	Reg. #	+00.20		Comp	leted	
LSC		08/22/2016	LSC			08/22/2016	LSC			08/22/2	2016	
ID Prefix	F0334	Correction	ID Prefix			Correction	ID Prefix			Correc	ction	
Reg.#	483.25(n)	Completed	Reg. #			Completed	Reg. #			Comp	eted	
LSC		08/22/2016	LSC				LSC			-		
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correc	ction	
Reg. #		Completed	Reg. #			Completed	Reg. #			Comp	leted	
LSC		_ 	LSC				LSC			-		
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correc	otion	
Reg. #		Completed	Reg. #			Completed	Reg. #			Comp	leted	
LSC		_	LSC				LSC					
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correc	ction	

DATE DATE **REVIEWED BY REVIEWED BY** SIGNATURE OF SURVEYOR STATE AGENCY (INITIALS) BF/KJ 10562 09/16/2016 09/12/2016 TITLE DATE **REVIEWED BY** REVIEWED BY DATE CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

Completed

Reg. #

LSC

Reg. #

LSC

Completed

Form CMS - 2567B (09/92) EF (11/06)

Reg. #

LSC

7/28/2016

Page 1 of 1

EVENT ID:

MF8512

YES NO

Completed

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REV	ISIT
245361 _{Y1}	B. Wing	Y2	8/24/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER MANOR REHABILITATI	ON 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).

ITE 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 1	01	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 1	01	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 1	01	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 1	01	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 1	01	Completed	Reg. #			Completed
LSC	K0144	08/22/2016	LSC	K0147		08/22/2016	LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/KJ	DATE 09/16/2	016	SIGNATURE OF SU		0562		DATE 08/2	24/2016
REVIEWED BY CMS RO (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							s 🗆 no	

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number		Provider/Supplier Name							
245361		MEEKER MANOR REHABILITATION CENTER, LLC							
Type of Survey (select all that apply)	A B C D	Complaint Investigation Dumping Investigation Federal Monitoring Follow-up Visit Other	E F G H	Initial Certification Inspection of Care Validation Life Safety Code	I J K L	Recertification Sanctions/Hearing State License CHOW			
Extent of Survey (select all that apply)	A R B E C P	outine/Standard Survey (all proximal standard Survey (HHA or Long artial Extended Survey (HHA) other Survey	g Term						

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

FORM CMS-670 (12-91) EventID: MF8512 Facility ID: 00775 Page

HEALTH CARE FINANCING ADMINSTRATION	DEPARTS	MENT	OF	HEALTH	AND	HUMAN	SERVI	CE
	HEALTH	CARE	F	ENANCING	ADI	MINSTR/	TION	

FORM APPROVED OMB No. 0938-0391

ublic reporting burden for this collection of information is estimated to average 10 minutes per response,
ncluding time for reviewing instructions, searching existing data sources, gathering and maintaining data needed,
and completing and reviewing the collection of information. Send comments regarding this burden estimate or any
ther aspect of this collection of information, including suggestions for reducing the burden, to Office of
inancial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget,
aperwork Reduction Project(0838-0583), Washington, D.C. 20503.

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

	/					
Provider/Supplier Number 245361	Provider/Supplier Name MEEKER MANOR REHAB CTR LLC					
Type of Survey (select all that app	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 a	<pre>pply): A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facility) C Partial Extended Survey (HHA)</pre>					

SURVEY TEAM AND WORKLOAD DATA
Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number	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 (H)	ff-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	0.0
Total Clerical/Data Entry Hours	
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	

FORM HCFA-670 (12-91)

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		ICARE/MEDICA I - TO BE COM						o: MF85 acility ID: 00775
1. MEDICARE/MEDICAID PROVIDER N (L1) 245361 2.STATE VENDOR OR MEDICAID NO. (L2) 134543500 5. EFFECTIVE DATE CHANGE OF OW	О.	3. NAME AND ADDRESS OF FACILITY (L3) MEEKER MANOR REHABILITATION C (L4) 600 SOUTH DAVIS AVENUE (L5) LITCHFIELD, MN 7. PROVIDER/SUPPLIER CATEGORY			CENTER, LL		4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Survey After Con	aplaint
6. DATE OF SURVEY 07/28 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ 2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	Σ	FISCAL YEAR ENDING I	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 90 (L37) (L38) 16. STATE SURVEY AGENCY REMARK 17. SURVEYOR SIGNATURE		X B. Not in Comprehents a ICF (L42) HOW LTC CANCELL Date:	ce With quirements Based On: cceptable POC cliance with Program and/or Applied Waive IID (L43)	ers:	2. T	Technical Personnel 4 Hour RN -Day RN (Rural SNF) Life Safety Code B*	9. Beds/Room (L12) (L15)	or
Andrea Koshio			08/26/2016	(L19)		-	ogram Specialis	09/09/2016 (L20)
DETERMINATION OF ELIGIBILITY	7		D BY HCFA RE PLIANCE WITH CI		21.	Statement of Financi	al Solvency (HCFA-2572) interest Disclosure Stmt (HCFA-	-1513)
22. ORIGINAL DATE OF PARTICIPATION 10/01/1986	23. LTC AGREEMI BEGINNING I		4. LTC AGREEMENT ENDING DATE		26. TERMIN VOLUNTARY 01-Merger, Cl		INVOLUNTA	.30) ARY et Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension of B. Rescind Susp	of Admissions:	(L25) (L44) (L45)		03-Risk of Inv	tion W/ Reimbursemer oluntary Termination on for Withdrawal	OTHER	et Agreement Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C			30. REMARK	CS		
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DAT	Е	Poste	d 09/09/2016 Co.		

(L33)

DETERMINATION APPROVAL

(L32)



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Meeker Manor Rehabilitation Center, LLC August 12, 2016 Page 4

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.

Meeker Manor Rehabilitation Center, LLC August 12, 2016 Page 5

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

Meeker Manor Rehabilitation Center, LLC August 12, 2016 Page 6

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

PRINTED: 08/26/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245361	B. WING _		07/	28/2016	
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000	as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electror be used as verificated. Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.15(h)(6) COMFTEMPERATURE LITTHE facility must protect the protect of the	of correction (POC) will serve f compliance upon the otance. Because you are our signature is not required of first page of the CMS-2567 and succeptable electronic POC, and are facility may be conducted to notial compliance with the en attained in accordance with accordance with example and safe acceptable a	F 0	F 257 Comfortable & Safe Ter Levels Plan of correction for residents this survey: 1. Adjusted temperature in resiand common areas to keep be	cited with dent rooms tween	8/22/16	
	R141 stated his roo	ion on 7/25/16 at 3:25 p.m., om and the hallways, "get too tells the staff, they give him a		71-81 degrees Farenheit. Inter residents R141, 127, 17, 46, 84 see what a comfortable temper them is. Plan to address and prevent the	and 77 to rature for		
ABORATOR)	DIRECTOR'S OR PROVID	PER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE	

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

TITLE

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245361	B. WING		07/	28/2016
	PROVIDER OR SUPPLIER MANOR REHABILIT	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CC 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 257	During an observat R127 stated she ke because, "Opening refrigerator door." Fignore it." During an observat R17 was wearing a sweatshirt. R17 stathave to wear two slame and a zip up grey fl wears the fleece sw too cool in the facilic complained to the stoo hot for them. During an interview stated, "The tempe when she tells the sand a sweater. During observation R77 was being ass was wrapped in a bedown in the blanker and kept repeating. During an observat R77 was sitting on stated, "Leave me a conditioning unit in cold air. Nursing as transferred R77 and	ion on 7/25/16 at 6:22 p.m., ept the door to her room closed the door is like opening a R127 stated, "The staff kind of ion on 7/25/16 at 6:44 p.m., long sleeved shirt and a thick ted, "It's too cold. I always	F 2	deficiency with other resident 1. Will audit resident rooms a areas regularly, to make sure temperatures are maintained 71-81 degrees Farenheit. 2. All staff members to be edregards to temperature regulexpectations of keeping resident comfortable. Measures put into place to provided members re: making sure the residents are comfortable, with temperature and that temper maintained between 71-81 degrees are the resident rooms and/or commodaily x 1 week, weekly x4 we monthly. 2. Will review audit results with committee and will follow QA recommendations for further needs. DON and Administrator will be to ensure that the facility remedompliant in this area. This depends are some corrected by August 22, 2	and common e I between lucated in ation and the dents revent in the to all staff at the ith atures are egrees e: e of 20% of on areas eks, and then ith QAPI PI committee auditing re responsible lains eficiency will	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245361	B. WING		07	/28/2016
	PROVIDER OR SUPPLIER R MANOR REHABILIT	ATION CENTER, LLC	,	STREET ADDRESS, CITY, STATE, ZIP CC 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 257	environmental serve goal was to maintal temperatures at "al not aware of a facil The ED stated he wroutinely monitored rooms or common residents complain nursing staff would ED was not aware residents regarding temperatures. During an environm 7/28/16 at 11:15 a.were observed: On the 100 wing, refahrenheit (F), roor room 116 was 74.5 shut), and the 100 70 degrees F. On the 300 wing, reand the 300 wing hedgrees F. On the 400 wing, reand the 400 wing hedgrees F. During an interview environmental tour ED stated, "It is kin observed the wall as of the hallway was ED stated staff had	on 7/28/16 at 11:00 a.m., the ices director (ED) stated the in the building and room bout 70 degrees," but he was ity policy that addressed this. was not aware if the facility the temperature in resident areas, but stated if the ed about the temperature, the notify the maintenance staff. of any complaints from room or common area then the following temperatures of mental tour with the ED on m., the following temperatures of mental tour with the door wing hallway temperature was form 315 was 67.5 degrees F allway temperature was 67 of the following temperature was 70 of the following temperature was	F 2	57		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG		TE SURVEY MPLETED
		245361	B. WING		07	//28/2016
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 257 F 279 SS=D	comfort was most in the air conditioning monitoring the hally temperatures more During an interview administrator stated ongoing monitoring the building and conwould be adjusted, The facility's policy Environment dated staff and managem extent possible, the that reflect a persor These characteristic temperatures." 483.20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive plant objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-burners.	cooler, but the residents' important. The ED turned off unit and stated he would be vay and resident room closely. on 7/28/16, at 1:07 p.m., the difference to develop an plan of the temperatures in infirmed the temperatures "per resident comfort." Quality of Life-Homelike 4/14, included: "The facility ent shall maximize, to the characteristics of the facility nalized, homelike setting. IncludeComfortable (S)(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's	F 2			8/22/16

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245361	B. WING		07/2	28/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC	6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	due to the resident §483.10, including under §483.10(b)(4). This REQUIREMED by: Based on observareview, the facility finterventions were (R51) reviewed for Findings include: R51's admission reR51 had diagnoses Disease, had difficitly dependent on a whom R51's quarterly Mir 4/26/16, indicated I required extensive daily living, used a was totally dependent Review of R51's calindicated R51 had unable to wheel he	\$483.25 but are not provided is exercise of rights under the right to refuse treatment it.). NT is not met as evidenced tion, interview and document failed to ensure care plan developed for 1 of 3 residents positioning. Ecord dated 12/5/12, indicated is of osteoarthritis, Parkinson's culty in walking, and was neelchair for mobility. Simum Data Set (MDS) dated R51 was cognitively intact, assistance for activities of wheelchair for mobility, and	F 279	F279 Develop Comprehensive Car Plans Plan of correction for residents cites this survey: 1. R51 wheelchair will be evaluated therapy staff for proper positioning. Education will be provided to staff members and care card and care positioned to evaluated. Plan to address and prevent this deficiency with other residents: 1. Will audit wheelchair positioning residents, with wheelchair positioning residents, with wheelchairs, and vertheir care plan and care card interventate. 2. Will educate nurse managers or planning and care cards related to wheelchair positioning. 3. Therapy sheets, with changes, we given to nurse managers. Nurse managers.	for erify that rentions a care	
	proper positioning the wheelchair. During an observate R51 was sitting in the wheelchair had above her head, ar	re plan lacked interventions for for R51 while in her tion on 7/25/16 at 3:46 p.m., her room, in her wheelchair. It is a high back that extended had the back of the wheelchair angle to the seat of the		will place in NAR report binder for a review. If education needs to be protherapy staff will train staff. Measures put into place to prevent future: 1. Education will be provided to the managers and floor staff on wheeled positioning. Making sure that the content is to be provided to the positioning.	in the nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 279	wheelchair. R51 was behind her back the inches thick. The conserved shoulder blades. The and the crown of he back of the wheelch toward the ceiling. The supported on the behind her heels at the cushion behind her heels at the cushion behind her face pointed. During an observed wheelchair. Again, behind her lower be 3-4 inches from the her shoulders and back of the wheelchair. Again, behind her lower be 3-4 inches from the her shoulders and back of the wheelch toward the ceiling. During interview with p.m., R51 stated she had ask behind her back behas to ask to be botton of the wheelch wheelchair and nursing staff several look at her wheelch whee	as observed to have a cushion at was approximately three cushion extended from the nair to just under R51's his caused R51's shoulders er head to press against the hair and her face was pointed R51's feet were observed to e foot pedals with a pad and lower legs. Ition on 7/25/16 at 5:35 p.m., ing room and was being 1 was observed to continue to behind her back, causing her not the back of the wheelchair ed toward the ceiling. Ition on 7/26/16 at 3:35 p.m., sitting in her room in her R51 had the cushion in place ack, causing her buttocks to be a back of the wheelchair, and head were pressed into the hair with her face pointed Ith R51 on 7/26/16 at 3:41 he was not very comfortable in that she had asked the all times to have the therapist hair. R51 stated that to her do not happened. R51also ared for a smaller pillow for ecause she slides forward and	F 279	plan and care card interventions Plans to Monitor Performance: 1. Will audit a random sample of residents in wheelchairs x4 weekmonthly x3 months and then quate. Will review audit results with Committee and will follow QAPI or recommendations for further audineeds. DON and Administrator will be reto ensure that the facility remains compliant in this area. This deficible corrected by August 22, 2016	20% of as, rterly. API committee liting sponsible in a second control of the second cont	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY PLETED
		245361	B. WING			07/:	28/2016
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		600	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH DAVIS AVENUE CHFIELD, MN 55355	,	
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F 279	for R51 and used a into her wheelchair half moon shaped i upper back of the w R51's head and neand to look straight ceiling. R51 stated comfortable with th and neck. NA-A was interview NA-A stated R51 has a couple of months couldn't recall having the wheelchair or hin it. NA-A stated th R51's head was us wheelchair but it was didn't know why. Non the chair in the wastached it to the winding an interview stated she hadn't rebest use R51's when NA-B stated she was information about hin the wheelchair eid buring an interview registered nurse (Rtherapy) gets the near to use it. [R51] usual nursing assistant she bathroom door, she verified the nursing room lacked inform positioning for R51.	mechanical lift to transfer her A thick black cushion with a ndent, was attached to the wheelchair and supported ck, allowing her to sit upright ahead, instead of at the she felt so much more e cushion supporting her head red on 7/27/16 at 7:28 a.m. ad received a new wheelchair ago and NA-A said she ag received any training about ow R51 should be positioned e cushion used to support ually attached to her asn't this morning and she A-A stated when she'd seen it corner of the room she'd heelchair. Ton 7/28/16 at 9:21 a.m., NA-B eceived any training for how to be elchair when it was new. asn't aware of any written low R51 should be positioned	F 2	279			

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		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY IPLETED
MEEKER MANOR REHABILITATION CENTER, LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			245361	B. WING _		07/	28/2016
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			ATION CENTER, LLC		600 SOUTH DAVIS AVENUE	,	
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	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETION DATE
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 beingThe comprehensive care plan is holistic and individualized to the specific needs and preferences of the resident."	F 309	how to position the didn't get one for [F care plan lacked into positioning while in During an interview stated she had order R51 because she indicated written information or instruction for the not recall whether so information or instruction or	resident, but, apparently we R51]." RN-A also verified R51's terventions for proper her wheelchair. on 7/28/16 at 3:26 p.m., OT-A ered the new wheelchair for needed a larger chair. OT-A formation is given to the a resident received a new experience the staff resident however, OT-A could she had provided written for the new wheelchair. OT-A acility had changed therapy and the records from the fiverence not available to review. Ty's policy Care Planning IDT fam) dated 5/11, included; help attain or maintain the highest practicable physical, social well beingThe expectific needs and resident." CARE/SERVICES FOR EING Treceive and the facility must arry care and services to attain nest practicable physical, psocial well-being, in				8/22/16

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245361	B. WING _	·····	07/:	28/2016
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	by: Based on observat review, the facility for wheelchair position reviewed for position. Findings include: R51's admission re R51 had diagnoses. Disease, had difficuted dependent on a who R51's quarterly Min 4/26/16, indicated For required extensive daily living, used a was totally dependent. Review of R51's called indicated R51 had long unable to wheel her assistance for all lowheelchair. The called proper positioning for wheelchair. During an observat R51 was sitting in how the s	NT is not met as evidenced ion, interview and document ailed to provide proper ing for 1 of 3 residents (R51) ining. cord dated 12/5/12, indicated of osteoarthritis, Parkinson's alty in walking, and was eelchair for mobility. imum Data Set (MDS) dated R51 was cognitively intact, assistance for activities of wheelchair for mobility, and ent for locomotion. re plan dated 7/26/16, imited physical mobility, was reelf, and required extensive comotion once she was in her re plan lacked interventions for	F 30		nts cited with aluated by cioning. o staff I care plan will this ats: tioning for and verify that d interventions gers on care ated to a managers ler for them to be provided, orevent in the d to the nurse	
	wheelchair. R51 was behind her back that inches thick. The coseat of the wheelch	as observed to have a cushion at was approximately three cushion extended from the air to just under R51's nis caused R51's shoulders		positioning. Making sure that plan and care card intervent Plans to Monitor Performant 1. Will audit a random samp	t the care ions match. ce:	

AND BLAN OF CORRECTION INDESTRUCTION NUMBER:		` ') MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/2	28/2016
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
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F 309	back of the wheelch toward the ceiling. It be supported on the behind her heels are During an observating the cushion behind to press again with her face pointed behind her face pointed. During an observating the ceiling and the ceiling and the ceiling. During interview with the ceiling. During interview with p.m., R51 stated sher wheelch air and nursing staff several look at her wheelch knowledge that had stated she had asked behind her back behas to ask to be booth of the wheelch air, half moon shaped in upper back of the wheelch air, half moon shaped in upper back of the wheelch air, half moon shaped in upper back of the wheelch air.	er head to press against the hair and her face was pointed R51's feet were observed to e foot pedals with a pad had lower legs. Son on 7/25/16 at 5:35 p.m., hag room and was being I was observed to continue to be hind her back, causing her hast the back of the wheelchair had toward the ceiling. Son on 7/26/16 at 3:35 p.m., sitting in her room in her R51 had the cushion in place back, causing her buttocks to be back of the wheelchair, and head were pressed into the hair with her face pointed The R51 on 7/26/16 at 3:41 he was not very comfortable in that she had asked the all times to have the therapist air. R51 stated that to her I not happened. R51also hed for a smaller pillow for cause she slides forward and	F3	809	residents in wheelchairs x4 weeks, monthly x3 months and then quarte 2. Will review audit results with QA committee and will follow QAPI correcommendations for further auditineeds. DON and Administrator will be resp to ensure that the facility remains compliant in this area. This deficier be corrected by August 22, 2016.	erly. PI mmittee ng oonsible	

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	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 309	and to look straight ceiling. R51 stated comfortable with the and neck. NA-A was interview NA-A stated R51 has a couple of months couldn't recall having the wheelchair or he in it. NA-A stated the R51's head was usen wheelchair but it was didn't know why. Non the chair in the cattached it to the whole who in the wheelchair but it was didn't know why. Non the chair in the cattached it to the whole who in the wheelchair eil best use R51's who NA-B stated she was information about he in the wheelchair eil buring an interview registered nurse (R therapy) gets the net ouse it. [R51] usuanursing assistant she bathroom door, sho verified the nursing room lacked inform positioning for R51. provides written inform to position the didn't get one for [R	ahead, instead of at the she felt so much more e cushion supporting her head red on 7/27/16 at 7:28 a.m. ad received a new wheelchair ago and NA-A said she ago received any training about ow R51 should be positioned e cushion used to support ually attached to her asn't this morning and she A-A stated when she'd seen it corner of the room she'd neelchair. on 7/28/16 at 9:21 a.m., NA-B received any training for how to relichair when it was new. The asn't aware of any written ow R51 should be positioned ther. on 7/28/16 at 9:24 a.m., N)-A stated, "OT [occupational rew wheelchair and tells us how ally has the headrest on. The neet in the room, behind the rould have that on there." RN-A assistant care sheet in R51's ation regarding proper RN-A stated, "OT usually ormation with directions for resident, but, apparently we sterventions for proper		309			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	E SURVEY MPLETED
		245361	B. WING _		07/	28/2016
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309 F 334 SS=E	stated she had order R51 because she mindicated written infinursing staff when wheelchair, and the how to position the not recall whether sinformation or instrute to position R51 in the further stated the faproviders recently apprevious company. A policy related to verequested but not passed but not passe	on 7/28/16 at 3:26 p.m., OT-A pered the new wheelchair for seeded a larger chair. OT-A cormation is given to the a resident received a new experience the staff resident however, OT-A could she had provided written fucted the nursing staff on how the new wheelchair. OT-A could she had provided written fucted the nursing staff on how the new wheelchair. OT-A could she had provided written fucted the nursing staff on how the new wheelchair. OT-A could she had provided therapy and the records from the five were not available to review. Wheelchair positioning was the rovided. WIZA AND PNEUMOCOCCAL Evelop policies and procedures the influenza immunization, the resident's legal in the period is medically the resident has already been this time period;	F 3			8/22/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245361	B. WING _	· · · · · · · · · · · · · · · · · · ·	07	/28/2016
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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				STREET ADDRESS, CITY, STATE, ZIP CO 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 334	representative was the benefits and poimmunization; and (B) That the residinfluenza immunization contraindications of the facility must detail the tensure that (i) Before offering to immunization, each legal representative the benefits and poimmunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unle medically contrained already been immunization; (iv) The resident or representative has immunization; and (iv) The resident's indocumentation that following: (A) That the residing representative was the benefits and population or (b) That the residing pneumococcal immunication or (v) As an alternative and practitioner recognition or the pneumococcal immunication or (v) As an alternative and practitioner recognition or the pneumococcal immunication or (v) As an alternative and practitioner recognitions and practitioner recognitioner recognitions and practitioner recognitions and practitioner	ent either received the ation or did not receive the ation due to medical r refusal. evelop policies and procedures the pneumococcal resident, or the resident's execeives education regarding otential side effects of the straightful side effects of the s	F 3:	34		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	` '	SURVEY PLETED
		245361	B. WING		07/2	28/2016
-	PROVIDER OR SUPPLIER MANOR REHABILIT	ATION CENTER, LLC	6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	o o i i i i i i i i i i i i i i i i i i	resident's legal representative	F 334			
	by: Based on interview facility failed to imprelated to pneumod (PCV13) for 5 of 5 and R118) whose vereviewed. Findings include: The Center for Disa (CDC) information vaccination include older who have not and who have prevedoses of PPSV23 [vaccine 23] should dose of PCV13 should	v and document review, the lement their facility policy coccal conjugate vaccine residents (R37, R45, R49, R77 raccination histories were ease Control and Prevention regarding pneumococcal d: "Adults 65 years of age or previously received PCV13 iously received one or more pneumococcal polysaccharide receive a dose of PCV13. The ould be given at least 1 year most recent PPSV23 dose." unizations report undated, ar old resident had not ovax. Additional review of record did not reflect any offer unizations report undated, ar old had received a e on 4/12/13 however, there is to whether a PCV13 had tlined in the CDC guidelines.		F334 Influenza & Pneumococcal Immunizations Plan of correction for residents citer this survey: 1. Will review residents (R37, 45, 44 and 118), vaccination record in MIIC with primary care provider. Will offer PCV13 vaccine to residents if warraper recommendations of CDC. 2. Will update Point Click Care Immunization tab with vaccine date and/or declination. Plan to address and prevent this deficiency with other residents: 1. For all current and new residents facility, their vaccination record will reviewed and pneumococcal vaccin offered as indicated and recommer CDC. 4. Will educate nursing staff on CD recommendations and facility policy pneumococcal vaccination. Measures put into place to prevent future: 1. Education will be provided to nurstaff on the CDC recommendations facility policy for pneumococcal vaccination.	9,77 C and er anted s in be ne nded by C y for in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/2	28/2016
MEEKER MANOR REHABILITATION CENTER, LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			,	
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 334	R49's Clinical Immundicated the 91 year Pneumovax on 5/8/indication as to who offered as outlined R77's Clinical Immundicated the 98 year Pneumovax on 2/27 indication as to who offered as outlined R118's Clinical Immundicated the 97 year Pneumovax on 11/27 indication as to who offered as outlined During interview on assistant director of at the present time, offering the PCV13 that it was their interest to receive this vaccifall. The ADON statt the clinic prior to ad had previously been there were not contreceiving the vaccification and previously been there were not contreceiving the vaccification of the facility's policie pneumococcal vaccion 2011. They had no recommendations of PCV 13. The ADON recently undergone their policies were	unizations report undated, ar old had received a 08 however, there was no other a PCV13 had been in the CDC guidelines. unizations report undated, ar old had received a 7/13 however, there was no other a PCV13 had been in the CDC guidelines. unizations report undated, ar old had received a 26/05 however, there was no other a PCV13 had been in the CDC guidelines. 7/27/16 at 1:06 p.m., the interest in the CDC guidelines. 7/27/16 at 1:06 p.m., the increase (ADON) stated that the facility was not currently vaccine. The ADON stated in for everyone who would like ination to be given it this by ed she would be contacting ministration to determine what in given and to assure that raindications for residents eation however, the ADON	F3	334	2. For nursing staff who did not attain-service, information regarding the recommendations and facility policing pneumococcal vaccination will be not to them by August 19, 2016 Plans to Monitor Performance: 1. Will audit a random sample of 2 residents, pneumococcal vaccination record in PCC weekly x4 weeks, make that the pneumococcal vaccination date and/or was offered. 3. Will review audit results with QA committee and will follow QAPI confered and Administrator will be responsible to ensure that the facility remains compliant in this area. This deficient be corrected by August 22, 2016.	of on control of the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			TE SURVEY MPLETED	
		245361	B. WING		07	/28/2016	
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZI 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		, 01/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 334		age 15 at policies is currently in	F3				

F5361025

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245361 B. WING 07/27/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **600 SOUTH DAVIS AVENUE** MEEKER MANOR REHABILITATION CENTER, LLC LITCHFIELD. MN 55355 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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

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

TITLE

Facility ID: 00775

(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.

CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		SECTION DESITION ATION MUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - Main Building 01			E SURVEY PLETED
		245361	B. WING			07/	27/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		600 SOU	ADDRESS, CITY, STATE, ZIP CODE ITH DAVIS AVENUE IELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	C	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU PROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
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.</mailto:angela.kappenman@state.mn.us></mailto:marian.whitney@state.mn.us>		KO	00			
	constructed in 19 constructed in 19 building and both sprinkler protected Type V(000) cons The facility has a detection in the corridors which is department notific	The original building was 78, with building additions 79 and 1988. The original building additions are fully fire d, and were determined to be of truction. fire alarm system with smoke prridors and spaces open to the monitored for automatic fire eation. The facility has a ds and had a census of 71 at					
K 017	The requirement NOT MET as evice	/. at 42 CFR Subpart 483.70(a) is	K	017			8/22/16
SS=F	Corridors are sep	arated from use areas by walls					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		SURVEY PLETED
		245361	B. WING		07/2	27/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 017	rating. In fully sprin partitions are only of smoke. In non-sextend to the under above the ceiling, at the underside of permitted by Code waiting areas, dining may be open to compectified in the Comperated from compectified in the Comperated from compectified in the Comperated from compectified in the Comperated with a rating. In fully spring partitions are only of smoke. In non-sextend to the underside of permitted by Code waiting areas, dining at the underside of permitted by Code waiting areas, dining areas, din	least 1/2 hour fire resistance klered smoke compartments, required to resist the passage prinklered buildings, walls rside of the floor or roof deck Corridor walls may terminate ceilings where specifically. Charting and clerical stations, ag rooms, and activity spaces rridor under certain conditions de. Gift shops may be rridors by non-fire rated walls ally sprinklered.) 19.3.6.4, 19.3.6.5 is not met as evidenced by: arated from use areas by walls t least 1/2 hour fire resistance and stations, required to resist the passage sprinklered buildings, walls be reside of the floor or roof deck (Corridor walls may terminate of ceilings where specifically charting and clerical stations, and rooms, and activity spaces or ridor under certain conditions and compartments. The passage of the floor or roof deck (Corridor walls may terminate of ceilings where specifically compared to resist the passage of the floor or roof deck (Corridor walls may terminate of ceilings where specifically compared to resist the passage of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of ceilings where specifically compared to resist the passage of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor or roof deck (Corridor walls may terminate of the floor	KO	K017 Life Safety Code St Description of what has, of correct the deficiency. 1. Smoke barrier wall local street has holes in the correct have been orced. Date of Completion: 8/2 3. Administrator and Environment of Services Director will be a correction and prevention occurrence.	ated on first necrete that will rials to fill holes dered. 26/16 ronmental esponsible for	

Facility ID: 00775

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
	245361		B. WING			07/27/2016	
NAME OF PROVIDER OR SUPPLIER				ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ATION CENTER, LLC			00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 017	Continued From pa	age 3	K	017			
	around pipes and	•					
	Enviromental Serv Administrator (BG)						0/00/40
	NFPA 101 LIFE SA	FETY CODE STANDARD	K	018			8/22/16
SS=F	required enclosure hazardous areas s as those construct core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist tho impediment to open devices that pushed or pulled a provided with a medoor closed. Dutch permitted. Door framade of steel or owith 8.2.3.2.1. Roll CMS regulations in 19.3.6.3	orridor openings in other than as of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ance between bottom of door is not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is the closing of the doors. Hold release when the door is are permitted. Doors shall be eans suitable for keeping the adoors meeting 19.3.6.3.6 are ames shall be labeled and ther materials in compliance er latches are prohibited by a all health care facilities.					
	Based on observation had several corridor requirements of N Code" 2000 edition deficient practice of	is not met as evidenced by: ation and interview, the facility or doors that did not meet the IFPA 101 "The Life Safety or (LSC) section 19.3.6.3.2. This could affect 30 of 71 residents, etermined number of staff, and			Construction of the content of the c		ge C
	visitors if smoke fr	om a fire were allowed to enter rridors making it untenable.			207, 214, 114 have been adjusted properly latch to the door frame. T	and he	
	Findings include:	-			Activities Director door to the corribeen adjusted and latches to the frame. These have been complete	door	
		tions and staff interview during ween 8:30AM to 6:30 PM on			7/29/16. A monthly audit has been to check each door leading to cor	created	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L. CIDENTIEIOATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			SURVEY
		245361	B. WING			07/2	7/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 018	114 did not positive tested during the factorion documents and tour. This deficient concent and tour. Administrator (BG) NFPA 101 LIFE SACT Access to exits share adily visible sign way to reach exit is occupants. Doors, not a way of exit than exit have a sign way to reach exit is occupants. Doors, not a way of exit than exit have a sign 18.2.10.1, 19.2.10 affect all of the 71 undetermined nums moke from a fire	or to resident room 207, 214, ely latch into the frame when acility tour. or to the activities director off en tested during the facility dition was verified by ice director (JB) and b. AFETY CODE STANDARD all be marked by approved, s in all cases where the exit or s not readily apparent to the passages or stairways that are not designating "No Exit".	K	018	facility. 2. Completion Date: 7/29/16 3. Administrator and The Environment Services Director will be responsible make sure audits are completed more make sure audits are completed more makes sure audits are completed more makes. K022 Life Safety Code Standard Description of what has been, or will done to correct the deficiency. 1. The activities and both sun rooms now have approved visible exit/no smoking signs. Completed on 7/29/12. Date of Completion: 7/29/16 3. Administrator and the Environment Services Director will be responsible correction and prevention of future occurrence.	be sexits	8/22/16
		tions and staff intended to deal					
	based on observa	tions and staff interview during					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/27/2016	
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH DAVIS AVENUE 1TCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 022	07/27/2016, reveal the following require proper signage: 1) Activities room. 2) Both sun rooms This deficient cond	ween 8:30AM to 6:30 PM on led red exits did not have the	К	022			
K 025 SS=E	Administrator (BG) NFPA 101 LIFE SA Smoke barriers sh least a one half ho constructed in acc barriers shall be po- atrium wall. Windo fire-rated glazing of steel frames. 8.3, 19.3.7.3, 19.3 This STANDARD Based on observate facility failed to ma walls that were charequirements of NI Code" 2000 edition 8.3. This deficient residents as well a staff, and visitors to from one smoke of Findings include: Based on observate Based on observate	all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke ermitted to terminate at an two shall be protected by or by wired glass panels and 1.7.5 is not met as evidenced by: ation and staff interview, the sintain 2 of 4 smoke barrier ecked in accordance with the FPA 101 "The Life Safety in (LSC) sections 19-3.7.3 and it practice could affect 30 of 71 is an undetermined number of by allowing smoke to propagate ompartment to another.	K	025	K025 Life Safety Code Standard Description of what has been, or widone to correct the deficiency. 1. The smoke barrier wall located be activity room had penetrations four around pipe and conduit. Fire resist materials have been ordered. All pipe and conduit leaving room will be sewith a completion date of 8/26/16. 2. Completion date: 8/26/16. 3. Administrator and Environmental Services Director will be responsible correction and prevention of future occurrence.	by the d stant pes saled	8/22/16

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′			ATE SURVEY OMPLETED
		245361	B. WING			7/27/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH DAVIS AVENUE TCHFIELD, MN 55355	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	room had penetrat section of conduit	age 6 ier wall located by the activity ions found around a pipe and that was passing through the we the ceiling tile over the	K	025		
K 027	department had a above the ceiling to the ceiling t	ier wall located by the laundry 3 inch diameter hole found les over the double doors. lition was verified by ice director (JB) and AFETY CODE STANDARD	K	027		8/22/16
SS=E	20-minute fire prot 10-inch thick solid protective plates the from the bottom of Horizontal sliding of Doors are self-close accordance with 1	smoke barriers have at least a ection rating or are at least bonded wood core. Non-rated hat do not exceed 48 inches the door are permitted. doors comply with 7.2.1.14. Sing or automatic closing in 9.2.2.2.6. Swinging doors are ng with egress and positive uired. 19.3.7.5, 19.3.7.6,				
	This STANDARD Door openings in 20-minute fire prof 10-inch thick solid protective plates the from the bottom of Horizontal sliding of Doors are self-close accordance with 1 not required to swellatching is not requestion.	is not met as evidenced by: smoke barriers have at least a section rating or are at least bonded wood core. Non-rated hat do not exceed 48 inches the door are permitted. doors comply with 7.2.1.14. sing or automatic closing in 9.2.2.2.6. Swinging doors are ing with egress and positive uired. 19.3.7.5, 19.3.7.6, sient practice could affect 30 of			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 I-will be planed down to properly close wir a completion date on 8/26/16. A monthl audit has been developed to check each fire door for proper closing and latching. 2. Date of Completion: 8/26/16	th y 1

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			JIVID IVO.	0930-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION 6 01 - Main Building 01		SURVEY PLETED
		245361	B. WING		07/2	27/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 027	of staff, and visitor	age 7 ell as an undetermined number s if smoke from a fire were e exit access corridors making	K 027	3. Administrator and Environmen Services Director will be responsi correction, future auditing and pre of future occurrence.	will be responsible for auditing and prevention	
	the facility tour bet 07/27/2016, revea 1) Smoke barrier not close when tes This deficient cond	doors in the North Hall would sted. dition was verified by ice director (JB) and				
K 029 SS=C	One hour fire rated fire-rated doors) of extinguishing system and/or 19.3.5.4 protection the approved autooption is used, the other spaces by stated ones. Doors are field-applied protections.	AFETY CODE STANDARD d construction (with o hour r an approved automatic fire em in accordance with 8.4.1 btects hazardous areas. When matic fire extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or ctive plates that do not exceed bottom of the door are 2.1	K 029			8/22/16
	This STANDARD	is not met as evidenced by: iled to provide proper protection		K029 Life Safety Code Standard	d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION IG 01 - MAIN BUILDING 01		SURVEY PLETED
		245361	B. WING _		07/	27/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP C 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 029	throughout the faci	age 8 zardous areas located lity in accordance with NFPA ty Code" 2000 edition (LSC)	K 02	Description of what has bee	Description of what has been, or will be done to correct the deficiency.	
	the facility tour beto 07/27/2016, reveal	tions and staff interview during ween 8:30AM to 6:30 PM on ed the corridor door to the o latch when tested during the		room has been adjusted on now latches to the door frar monthly audit has been creeach door to corridor. 2. Date of Completion:7/29/3. Administrator and Enviro Services Director will be recorrection, future auditing a of future occurrence.	7/29/16 and me properly. A ated to check 116 nmental sponsible for	
K 051 SS=C	Enviromental Serv Administrator (BG) NFPA 101 LIFE SA A fire alarm system components approaccordance with N and NFPA 72, Nati provide effective woulding. Fire alarm transmission paths Initiation of the fire means and by any alarm, detection do Manual alarm boxe egress near each boxes in patient skrequired at exits if located at all nurse notification is provisignals. In critical conficient. The fire	lition was verified by ice director (JB) and it. AFETY CODE STANDARD In is installed with systems and oved for the purpose in FPA 70, National Electric Code onal Fire Alarm Code to varning of fire in any part of the many system wiring or other are monitored for integrity. It alarm system is by manual required sprinkler system evice, or detection system. The eping areas shall not be manual alarm boxes are es's stations. Occupant ided by audible and visual care areas, visual alarms are alarm system transmits the ly to notify emergency forces in		51		8/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			SURVEY PLETED	
		245361	B. WING			07/2	/27/2016	
	PROVIDER OR SUPPLIER R MANOR REHABILIT	TATION CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETION DATE	
K 051	activates required records are mainta 18.3.4, 19.3.4, 9.6 This STANDARD Based on observate facility failed to insignate NFPA 101 "The edition (LSC) section as the NFPA 72 "Nedition section 2-3 could adversely affalarm system that notification and enthus negatively affawell as an undeter visitors. Findings include: Based on observate facility tour bet 07/27/2016, reveat conditions of the maintain the second terms of the second terms of the maintain the second terms of the sec	control functions. System sined and readily available. is not met as evidenced by: stion and staff interview, the stall and maintain the fire alarm nee with the requirements of the Life Safety Code" 2000 ons 19.3.4.1 and 9.6, as well lational Fire Alarm Code" 1999.5.1. These deficient practices feet the functioning of the fire could delay the timely nergency actions for the facility ecting 20 of 71 residents, as mined number of staff, and tions and staff interview during ween 8:30AM to 6:30 PM on led the following deficient nanual pull stations. The pull neest exit and the Main	K	051	K051 Life Safety Code Standard Description of what has been, or we done to correct the deficiency. 1. The fire pull stations on the Nor exit and main entrance were obstrous A sign has been place for the location our concierge cart. Staff education been provided on 8/18/16 of policity procedures of fire pull station. Authority from then on. 2. Completion Date: 8/18/16 3. Administrator and Environment. Services Director will be responsity correction and prevention of future occurrence.	thwest ructed. tion of n has es and dits will th and		
K 052 SS=F	A fire alarm system be, tested, and main NFPA 70 National National Fire Alarm	dition was verified by rice director (JB) and h. AFETY CODE STANDARD in required for life safety shall aintained in accordance with Electric Code and NFPA 72 in Code and records kept readily tem shall have an approved		052			8/22/16	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V = / · · · = · · · · · · V = / · · · · · · · · · · · · · · · · · ·			E SURVEY IPLETED
		245361	B. WING_		07/	27/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP C 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 052	applicable requirent 9.6.1.4, 9.6.1.7, This STANDARD in A fire alarm system be, tested, and man NFPA 70 National I National Fire Alarm readily available. The approved maintent complying with approved maintent complying approved maintent complying approved maintent complying with approved maintent complying with approved maintent complying app	age 10 nent of NFPA 70 and 72. is not met as evidenced by: n required for life safety shall intained in accordance with Electric Code and NFPA 72 n Code and records kept the system shall have an ance and testing program blicable requirement of NFPA 9.6.1.7, These deficient versely affect the functioning of em that could delay the timely tergency actions for the facility ecting 71 of 71 residents, as mined number of staff, and	K 0	Description of what has been done to correct the deficient. 1. The sealed lead-acid bas Simplex fire panel has been 8/16/16. 2. Date of Completion: 8/16 3. Administrator and Environments of the services Director will be re-	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	the facility tour bets 07/27/2016, reveal conditions: Replacement of se not occured in the This deficient cond Environmental Serv Administrator (BG) NFPA 101 LIFE SA Where required by facilities shall be prapproved, supervisin accordance with systems are equip switches which are the building fire ala	lition was verified by ice director (JB) and		56		8/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION NG 01 - Main Building 01		E SURVEY PLETED
		245361	B. WING _		07/3	27/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 056	shall be permitted protection in specir regulations prohibi NPFA 13 This STANDARD Based on observate facility faille to ensist system is installed 101 "The Life Safe section 19.3.5.1 arfor the Installation edition sections 5-Findings include: Based on observate facility tour bet 07/27/2016, revea conditions: 1) The area locate not provided with four four configurating sprinkler heads loop provide coverage. This was also revenot corrected. Report Sprinkler protes the sprinkler report was dated 11/2/20 This deficient conditions are specified to the sprinkler conditions.	to be substituted for sprinkler fic areas where State or local t sprinklers. 19.3.5, 19.3.5.1, is not met as evidenced by: Itions and staff interview, the ure that the automatic sprinkler in accordance with the NFPA ty Code" 2000 edition (LSC) and the NFPA 13 "The Standard of Sprinkler Systems" 1999 4 and 5-5. Itions and staff interview during ween 8:30AM to 6:30 PM on led the following deficient It in above the sump pump is irre sprinkler protection. The contain and coverage of the cated in the area cannot to the area of the sump pump. It is easied in the sprinkler report and port was dated 11/2/2015. It is was also revealed in the and not corrected. Report	K 05	K056 Life Safety Code Standard Description of what has been done to correct the deficient. 1. The location above the not have proper fire sprintly Simplex Grinell is schedu proper sprinkler protection pumps and under mezzar 2. Completion Date: 8/26/3. Administrator and Enviservices Director will be recorrection and prevention occurrence.	een, or will be ency. sump pump did kler protection. led to install n above sump nine by 8/26/16/16 ronmental responsible for	
K 062 SS=F		AFETY CODE STANDARD ic sprinkler systems are	K 0	62		8/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/2	27/2016
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355	- N.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 062	continuously maint condition and are in periodically. 19.7.5 This STANDARD Based on docume with staff, the facilit maintain the autom accordance with the Code" 2000 editior "The Standard for Systems" 1999 edi 5-5.6, and 6-1.1.5. not ensure that the function properly a event of a fire and residents as well a staff, and visitors to Findings include: Based on observatine facility tour bett 07/27/2016, reveal conditions: 1) There is a dirty substantial to the facility failed pip inspection. 3) There was storatinches of the fire soffice.	ained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: entation review and interview ty has failed to properly natic sprinkler system in the NFPA 101 "The Life Safety in (LSC) section 19.3.5.1, and the Installation of Sprinkler ition section 3-2.7.2, 3-2.6.3, This deficient practice does a fire sprinkler system will not is fully operational in the could negatively affect 71 of 71 is an undetermined number of	K	062	Description of what has been, or done to correct the deficiency. 1. The sprinklers in the walk in cothe kitchen has been cleaned. 2. Simplex Grinell has been contained set up an inspection date to completed by 8/26/16 to perform year internal pipe inspection. 3. The therapy office was assess items were removed from shelf to there is 18 inches from fire sprink were will audit 100% of resident rooms/office spaces to ensure items are 18 inches from fire spring 5. Education will be provided on 8 and ongoing during monthly fire conducted will audit a random sample of residents rooms 4x a week for 3 then quarterly to make sure items placed more than 18 inches away sprinkler head. 7. Date of Completion:8/26/16 8. Administrator and Environment Services Director will be respons correction and monitoring to prevene the service of the service o	acted be the 5 ed and be ensure clers. nklers. 8/18/16 drills. 20% months are y from a tal ible for	

PRINTED: 08/23/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245361 B. WING 07/27/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **600 SOUTH DAVIS AVENUE** MEEKER MANOR REHABILITATION CENTER, LLC LITCHFIELD, MN 55355 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 062 | Continued From page 13 K 062 This deficient condition was verified by Environmental Service director (JB) and Administrator (BG). K 076 NFPA 101 LIFE SAFETY CODE STANDARD 8/22/16 K 076 SS=D 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: K076 Life Safety Code Standard Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. Description of what has been, or will be done to correct the deficiency. (a) Oxygen storage locations of greater than 1. The North and South Lane oxygen 3,000 cu.ft. are enclosed by a one-hour rooms will be reorganized. The oxygen separation. supplier has been contacted and will pick (b) Locations for supply systems of greater than up extra supplies in oxygen rooms. The 3,000 cu.ft. are vented to the outside. supplier will be given a par level for tanks 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), left on hand. The oxygen supplier will 18.3.2.4, 19.3.2.4 leave an empty rack for used tanks. Oxygen tags will be left and stored in the Findings include: oxygen room completed by 8/26/16. Education regarding proper oxygen Based on observations and staff interview during storage was provided to staff at a the facility tour between 8:30AM to 6:30 PM on mandatory staff meeting on 8/18/16. 07/27/2016, revealed 2. Completion Date: 8/26/16. the following deficient conditions: 3. Administrator and the Director of Nursing will be responsible for correction 1) On the North and South Lanes, Oxygen tanks were not seperated between empty and full. and monitoring to prevent re-occurrence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/2	27/2016
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	Enviromental Servi Administrator (BG) NFPA 101 LIFE SA Medical gas storag precautionary sign, ft, that is conspicut gate of the storage shall include the fo CAUTION, OXIDIZ WITHIN, NO SMO 8-3.1.11.3 (NFPA 9	ition was verified by one director (JB) and FETY CODE STANDARD The areas shall have a greadable from a distance of 5 to busly displayed on each door or room or enclosure. The sign allowing wording as a minimum: The GAS(ES) STORED KING. 18.3.2.4, 19.3.2.4,		1141	Education will be provided at month drills. Audits will be conducted. Dai week, Weekly x 1 month.	led at monthly fire ducted. Daily x 1	
	precautionary sign, ft, that is conspicute gate of the storage shall include the formal control of the storage shall include the formal control of the storage shall include the formal control of the storage shall include the sall of t	tions and staff interview during ween 8:30AM to 6:30 PM on			Example 12 Notes 12 N	ing and of they will vill be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			SURVEY PLETED
		245361	B. WING			07/2	27/2016
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		600	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH DAVIS AVENUE CHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Continued From pa		K 1	41			
K 144 SS=F	Generators inspec	FETY CODE STANDARD ted weekly and exercised	K 1	44			8/22/16
	under load for 30 n in accordance with 3-4.4.1 and 8-4.2 (110)	ninutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA is not met as evidenced by:					
	Generators inspect under load for 30 n in accordance with	s not met as evidenced by sted weekly and exercised ninutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA			K144 Life Safety Code Standard Description of what has been, or with the deficiency.	will be	
	Findings include:	v and record review between M on 07/27/2016, revealed the			1. A generator checklist has been After weekly inspections the checkly be used and kept in a file. 2. A load bank test was completed 8/2/16 on the emergency generat Generators will be inspected week exercised and documented in account of the complete in a complete in account of the complete in a c	klist will d on or. kly and	
	revealed the facility	w of all available the emergency generator, did not document the required emergency generator.			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	nental ble for	
	revealed the facility of the KW of the	w of all available the emergency generator, the facility did not meet 30% enerator and failed to have the he emergency generator.			recurrence.		
K 147	Environmental Ser Administrator (BG)	lition was verified by vice director (JB) and AFETY CODE STANDARD	K 1	47			8/22/16
SS=E		d equipment shall be in ational Electrical Code. 9-1.2					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			SURVEY PLETED
		245361	B. WING _		07/2	27/2016
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 147	(NFPA 99) 18.9.1, 7 This STANDARD i Electrical wiring ar accordance with Na (NFPA 99) 18.9.1, 7 Findings include: Based on observat the facility tour betw 07/27/2016, revealed 1) The Therapy Ro a power strip. 2) Room 214 had a power strip. 3) The Activities Diplugged into a powar adapter. 4) The sump pump extension cord.	19.9.1 s not met as evidenced by: nd equipment shall be in ational Electrical Code. 9-1.2 19.9.1 ions and staff interview during ween 8:30AM to 6:30 PM on ed the following: om had an extension cord into a power strip plugged into a rector Office had a power strip er strip and a multi-plug was plugged in with an ition was verified by vice director (JB) and	K 14	Description of what has be done to correct the deficie 1. An electrician installed a therapy room on 8/2/16 2. One power strip was reroom 214. Audits will be cresident rooms monthly. 3. Power strip was remove office. An electrician installed a near the sump pump on 8.5. Staff education on 8/18, of use of power strips/extethe nursing home setting a staff meeting 6. Completion Date: 8/18/7. Administrator and the Environmental Services Diresponsible for correction to prevent recurrence.	een, or will be ncy. an outlet in the moved from done for all ed from activities alled a new a new outlet 1/2/16. 1/16 for policies ension cords in at a mandatory 1/6 he irector will be	



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

Meeker Manor Rehabilitation Center, LLC August 12, 2016 Page 2

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

PRINTED: 08/26/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00775 07/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **600 SOUTH DAVIS AVENUE** MEEKER MANOR REHABILITATION CENTER, I LITCHFIELD, MN 55355 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a

Minnesota Department of Health

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

notice of assessment for non-compliance.

the Minnesota Department of Health Informational Bulletin 14-01, available at

obul.htm The State licensing orders are delineated on the attached Minnesota

You have agreed to participate in the electronic receipt of State licensure orders consistent with

http://www.health.state.mn.us/divs/fpc/profinfo/inf

INITIAL COMMENTS:

08/22/16 **Electronically Signed**

STATE FORM MF8511 If continuation sheet 1 of 16

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONTILCTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	LLILD
		00775	B. WING		07/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER I	TH DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to e Minnesota Departm On 7/25/16-7/28/10 Department's staff, the following correction that you and identify the date	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 5, surveyors of this visited the above provider and ation orders are issued. Four electronic plan of have reviewed these orders, e when they will be completed.	2 000			
2 560	Plan of Care; Contents comprehensive plate objectives and time long- and short-terrand mental and psycidentified in the content assessment. The companies of the content include the increquired by Minnes subdivision 14, para This MN Requirements. Based on observation review, the facility for the content of	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b). ent is not met as evidenced on, interview and document ailed to ensure care plan developed for 1 of 3 residents	2 560	Corrected		8/22/16

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	8/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0172	0,2010	
MEEKER	R MANOR REHABILIT	ATION CENTER I	H DAVIS AV				
		LITCHFIE	LD, MN 553				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 2	2 560				
	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.						
	4/26/16, indicated F required extensive	imum Data Set (MDS) dated R51 was cognitively intact, assistance for activities of wheelchair for mobility, and ent 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.						
	R51 was sitting in h The wheelchair had above her head, an was at a 90 degree wheelchair. R51 was behind her back that inches thick. The consent of the seat of the wheelch shoulder blades. The and the crown of he back of the wheelch toward the ceiling. I	ion on 7/25/16 at 3:46 p.m., ther room, in her wheelchair. If a high back that extended do the back of the wheelchair angle to the seat of the as observed to have a cushion at was approximately three rushion extended from the rair to just under R51's his caused R51's shoulders are head to press against the mair and her face was pointed R51's feet were observed to be foot pedals with a pad and lower legs.					
	R51 was in the dini assisted to eat. R5 have the cushion be	ion on 7/25/16 at 5:35 p.m., ng room and was being I was observed to continue to ehind her back, causing her nst the back of the wheelchair					

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_	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/28/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
MEEKEF	MANOR REHABILIT	ATION CENTER I	TH DAVIS AV LD, MN 553				
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2 560	Continued From page 3						
	with her face pointe	ed toward the ceiling.					
	R51 was observed wheelchair. Again, behind her lower ba 3-4 inches from the her shoulders and h	ion on 7/26/16 at 3:35 p.m., sitting in her room in her R51 had the cushion in place ack, causing her buttocks to be back of the wheelchair, and nead were pressed into the nair with her face pointed					
	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.						
	nursing assistant (N for R51 and used a into her wheelchair half moon shaped i upper back of the w R51's head and negand to look straight ceiling. R51 stated	ion on 7/27/16 at 7:15 a.m., NA)-A provided personal cares mechanical lift to transfer her. A thick black cushion with a ndent, was attached to the wheelchair and supported ck, allowing her to sit upright ahead, instead of at the she felt so much more e cushion supporting her head					
	NA-A stated R51 had a couple of months couldn't recall having the wheelchair or hin it. NA-A stated the	ed on 7/27/16 at 7:28 a.m. ad received a new wheelchair ago and NA-A said she ag received any training about ow R51 should be positioned e cushion used to support ually attached to her					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` '			(X3) DATE SURVEY COMPLETED	
7.110 1 12/114	or connection	is Entri North is the North Entri	A. BUILDING:			
		00775	B. WING		07/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ALION CENTER I	TH DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 4 asn't this morning and she	2 560			
	didn't know why. N	A-A stated when she'd seen it corner of the room she'd				
	stated she hadn't re best use R51's whe NA-B stated she wa	on 7/28/16 at 9:21 a.m., NA-B eceived any training for how to eelchair when it was new. asn't aware of any written				
	in the wheelchair ei	low R51 should be positioned ther.				
	registered nurse (R	on 7/28/16 at 9:24 a.m., iN)-A stated, "OT [occupational ew wheelchair and tells us how				
	to use it. [R51] usus nursing assistant sl bathroom door, sho verified the nursing	ally has the headrest on. The neet in the room, behind the ould have that on there." RN-A assistant care sheet in R51's				
	positioning for R51, provides written info	ation regarding proper RN-A stated, "OT usually bromation with directions for resident, but, apparently we				
	didn't get one for [F	R51]." RN-A also verified R51's terventions for proper				
	stated she had orde R51 because she r	on 7/28/16 at 3:26 p.m., OT-A ered the new wheelchair for needed a larger chair. OT-A formation is given to the				
	nursing staff when wheelchair, and the how to position the	a resident received a new therapists educate the staff resident however, OT-A could the had provided written				
	information or instruto position R51 in the	ucted the nursing staff on how ne the new wheelchair. OT-A acility had changed therapy				
	providers recently a	and the records from the were not available to review.				

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00775	B. WING 07/28		8/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKEF	MANOR REHABILIT	ATION CENTER I	TH DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	age 5	2 560			
	(interdisciplinary teat "Care is planned to resident's/patient's mental and psychos comprehensive car individualized to the preferences of the SUGGESTED MET	THOD 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					
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on a preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident				8/22/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00775	B. WING		07/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ALION CENTER I	TH DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 6	2 830			
	by: Based on observat review, the facility f wheelchair position reviewed with whee	ent is not met as evidenced ion, interview and document failed to provide proper ling for 1 of 2 residents (R51) elchair positioning needs.		Corrected		
	Findings include:					
	R51 had diagnoses Disease, had diffict	ecord dated 12/5/12, indicated s of osteoarthritis, Parkinson's ulty in walking, and was neelchair 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.					
	indicated R51 had unable to wheel he assistance for all lo wheelchair. The ca	are plan dated 7/26/16, limited physical mobility, was rself, and required extensive ocomotion once she was in her are plan lacked interventions for for R51 while in her				
	R51 was sitting in h The wheelchair had above her head, ar was at a 90 degree wheelchair. R51 wa behind her back that inches thick. The of seat of the wheelch	tion on 7/25/16 at 3:46 p.m., her room, in her wheelchair. d a high back that extended he the back of the wheelchair angle to the seat of the as observed to have a cushion at was approximately three cushion extended from the hair to just under R51's shoulders				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00775	B. WING		07/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER I	TH DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	and the crown of he back of the wheelch toward the ceiling. be supported on the behind her heels ar During an observat R51 was in the dini assisted to eat. R5 have the cushion behead to press agair with her face pointed. During an observat R51 was observed wheelchair. Again, behind her lower basisted toward the ceiling. During interview with p.m., R51 stated sher wheelch air and nursing staff several look at her wheelch knowledge that had stated she had ask behind her back behas to ask to be booth During an observat nursing assistant (N for R51 and used a into her wheelchair half moon shaped i upper back of the weelch in the wheelchair half moon shaped in upper back of the weelchair half moon	er head to press against the hair and her face was pointed R51's feet were observed to e foot pedals with a pad and lower legs. ion on 7/25/16 at 5:35 p.m., ng room and was being 1 was observed to continue to ehind her back, causing her nest the back of the wheelchair ed toward the ceiling. ion on 7/26/16 at 3:35 p.m., sitting in her room in her R51 had the cushion in place ack, causing her buttocks to be back of the wheelchair, and head were pressed into the hair with her face pointed th R51 on 7/26/16 at 3:41 he was not very comfortable in that she had asked the altimes to have the therapist hair. R51 stated that to her d not happened. R51also ed for a smaller pillow for recause she slides forward and	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00775	B. WING		07/2	8/2016
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOUT	DRESS, CITY, S TH DAVIS AV LD, MN 553	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	comfortable with the and neck. NA-A was interview NA-A stated R51 has a couple of months couldn't recall having the wheelchair or he in it. NA-A stated the R51's head was used wheelchair but it was didn't know why. No on the chair in the cattached it to the whole of the whole	she felt so much more e cushion supporting her head ed on 7/27/16 at 7:28 a.m. ad received a new wheelchair ago and NA-A said she ag received any training about ow R51 should be positioned e cushion used to support ually attached to her asn't this morning and she A-A stated when she'd seen it corner of the room she'd neelchair. on 7/28/16 at 9:21 a.m., NA-B eceived any training for how to be elchair when it was new. asn't aware of any written ow R51 should be positioned ther. on 7/28/16 at 9:24 a.m., N)-A stated, "OT [occupational ew wheelchair and tells us how ally has the headrest on. The neet in the room, behind the ould have that on there." RN-A assistant care sheet in R51's ation regarding proper RN-A stated, "OT usually ormation with directions for resident, but, apparently we sterventions for proper				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00775	B. WING		07/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ALION CENTER I	'H DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	indicated written infinursing staff when a wheelchair, and the how to position the not recall whether sinformation or instruto position R51 in the further stated the faproviders recently a previous company. A policy related to wrequested but not positioned for optimized for optimized systems to ensure a report the monitoring committee.	needed a larger chair. OT-A formation is given to the a resident received a new a therapists educate the staff resident however, OT-A could she had provided written fucted the nursing staff on how the new wheelchair. OT-A facility had changed therapy and the records from the fiver not available to review. Wheelchair positioning was provided. THOD OF CORRECTION: The (DON) or designee could be ensure residents are properly fall body alignment. The DON or facate all appropriate staff. The fould develop monitoring ongoing compliance and	2 830			
21426	MN St. Statute 144 Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			8/22/16
	maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease ation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR).				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED
		00775	B. WING		07/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MEEKEF	MANOR REHABILIT	ATION CENTER. I	'H DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
21426	This program must infection control pla unpaid employees, residents, and volumed the shall provide regarding implements. (b) Written compliate maintained by the maintained by the shall provide regarding implements.	include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of e technical assistance intation of the guidelines.	21426			
	by: Based on interview facility failed to imp appropriate screeni conducted for 1 of 5 for TB. Findings include: E-1's start of emploration Review of E-1's peremployee had rece 6/10/13 which was (millimiters) of industep TST had been however results we buring interview on director of nursing (TST "should have administration." On 7/28/16 at 3:17	and document review, the lement interventions to ensure ing for tuberculosis (TB) was 5 employees (E-1) reviewed byment date was 6/13/16. Sonnel record revealed the ived a mantoux (TST) on negative with 0 mm ration on 6/13/16. A second administered on 7/10/16, re not read until 7/15/16. 7/28/16 at 1:30 p.m., the (DON) stated the second step been read within 72 hours of inted, "the second step		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKEF	MEEKER MANOR REHABILITATION CENTER, I 600 SOU LITCHFII					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 11	21426			
	mantoux will need t employee [E-1]. "	o be repeated for this				
	(TB) Prevention and all employees of the to employment. "Base of two components symptoms of active the presence of infective tuberculosis by adm TST or a single TB. The current CDC (Cand Prevention) recommendation and the components of two components symptoms of active the presence of infection and two components of	and procedure Tuberculosis d Control dated 6/11, indicated e facility would be tested prior aseline TB screening consists: 1) assessing for current a TB disease and 2) testing for ection with Mycobacterium ministering either a two-step blood test." Centers for Disease Control commendation include: "The mould be read between 48 and				
	72 hours after adm	inistration. A patient who does hours will need to be				
	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 (21) days	R CORRECTION: Twenty one				
	director of nursing (review tuberculosis ensure they meet a DON or designee c nursing staff regard tuberculosis screen	THOD OF CORRECTION: The (DON) or designee could screening standards to ppropriate standards. The ould educate all licensed ling the importance of sing systems, and could udits and monitoring to ensure				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY
		00775	B. WING 07/		07/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MEEKEF	MANOR REHABILIT	ATION CENTER I	TH DAVIS AV LD, MN 553			
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21426	Continued From page 12		21426			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance		21705			8/22/16
	ventilation. A nurs maintain the mecha comfortable and sa and humidity levels areas must be main C: A. For construct nursing home must of 71 degrees Fahr Fahrenheit at all tim B. For existing must maintain a m degrees Fahrenheir C. Variations of titems A and B are a based on documen This MN Requirement by: Based on observatifailed to ensure cor were maintained for R127, R17, R46, R about their room terministics. During an observating an observati	facilities, a nursing home inimum temperature of 71 to during the heating season, he temperatures required by allowed if the variations are ted resident preferences. The sent is not met as evidenced on and interview, the facility infortable room temperatures of 6 of 35 residents (R141, 84, R77) who complained		Corrected		

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. BOILBING.			
		00775	B. WING		07/2	8/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER. I	TH DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21705	Continued From pa	ge 13	21705			
	R127 stated she ke because, "Opening	ion on 7/25/16 at 6:22 p.m., ept the door to her room closed the door is like opening a R127 stated, "The staff kind of				
	R17 was wearing a	ion on 7/25/16 at 6:44 p.m., long sleeved shirt and a thick ted, "It's too cold. I always nirts."				
	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.					
	stated, "The tempe	on 7/26/16 at 9:54 a.m., R84 rature is cold," and stated staff, they give her a blanket				
	R77 was being ass was wrapped in a b down in the blanket	on 7/26/16, at 10:20 a.m., isted to the bathroom. R77 lanket, kept her head tucked t, did not make eye contact, "I'm coldI'm cold."				
	R77 was sitting on stated, "Leave me a conditioning unit in cold air. Nursing as transferred R77 and conditioning unit. R in blankets.	ion on 7/27/16, at 7:08 a.m., the toilet in the bathroom, and alone, I'm cold." The wall air R77's room was on, blowing sistant (NA)-C and NA-D d then shut off the air 77 was observed to b bundled				
	During an interview	on 7/28/16 at 11:00 a.m., the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00775	B. WING		07/2	8/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MEEKE	R MANOR REHABILIT	ATION CENTER I	TH DAVIS AV LD, MN 553				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21705	environmental servi goal was to maintal temperatures at "al not aware of a facil The ED stated he wroutinely monitored rooms or common residents complain nursing staff would ED was not aware residents regarding temperatures. During an environm 7/28/16 at 11:15 a.i. were observed: On the 100 wing, roward fahrenheit (F), room 116 was 74.5 shut), and the 100 mon 70 degrees F. On the 300 wing, roward the 300 wing hidegrees F. On the 400 wing, roward the 400 wing hidegrees F. During an interview environmental tour ED stated, "It is kin observed the wall a of the hallway was ED stated staff had conditioning unit or stated in the stated of the conditioning unit or stated in the stated in the stated staff had conditioning unit or stated in the stated	vices director (ED) stated the in the building and room bout 70 degrees," but he was lity policy that addressed this. was not aware if the facility I the temperature in resident areas, but stated if the ed about the temperature, the notify the maintenance staff. of any complaints from g room or common area mental tour with the ED on m., the following temperatures oom 102 was 71 degrees m 114 was 71.5 degrees F, 6 degrees F (with the door wing hallway temperature was oom 315 was 67.5 degrees F (allway temperature was 67	21705				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ATION CENTER I	'H DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21705	Continued From pa	ge 15	21705			
		unit and stated he would be vay and resident room closely.				
	administrator stated ongoing monitoring the building and column	on 7/28/16, at 1:07 p.m., the d the ED needed to develop an plan of the temperatures in nfirmed the temperatures "per resident comfort."				
	Environment dated staff and managem extent possible, the that reflect a person	Quality of Life-Homelike 4/14, included: "The facility ent shall maximize, to the characteristics of the facility nalized, homelike setting. cs includeComfortable				
	The environmental educate staff regard maintaining temper to meet the needs of coordinate with hou					
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				

6899

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SU COMPLE	
		00775		B. WING		07/28	3/2016
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA			
MEEKER	MANOR REHABILITATIO	N CENTER, LLC		I DAVIS AVEN D, MN 55355	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTEN	TION*****					
	NH LICENSING CO	ORRECTION ORDER					
	144A.10, this correcting pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Lere-inspection with any result in the assessment that was violated during the result in the second survey.	ther a violation has beempliance with all	ed it is d ation ce of en w. c red n will item				
	that may result from n orders provided that a the Department withir notice of assessment	·	ese le to				
	receipt of State licens the Minnesota Depart Informational Bulletin	articipate in the electro ure orders consistent v ment of Health 14-01, available at e.mn.us/divs/fpc/profin icensing orders are	vith				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00775		B. WING		07/28/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MEEKER	MANOR REHABILITATIO	N CENTER. LLC	I DAVIS AVENI D, MN 55355	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	you electronically. Ali is necessary for State enter the word "correct text. You must then in State licensure processompletion date, the corrected prior to elect Minnesota Department On 7/25/16-7/28/16, Department's staff, vist the following correction Please indicate in you correction that you had and identify the date of MN Rule 4658.0405 \$5	orders being submitted to though no plan of correction statutes/Rules, please cted" in the box available for dicate in the electronic as, under the heading date your orders will be ctronically submitting to the not of Health. Surveyors of this sited the above provider and on orders are issued. In electronic plan of the reviewed these orders, when they will be completed.	2 000			
	and identify the date when they will be completed. 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.					

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TE FORM 6899 MF8511 If continuation sheet 2 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		00775	B. WING		07	//28/2016
	ROVIDER OR SUPPLIER MANOR REHABILITATIO	N CENTER. LLC	DDRESS, CITY, STATE TH DAVIS AVENUE ELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 560	R51 had diagnoses of Disease, had difficulty dependent on a wheel R51's quarterly Minim 4/26/16, indicated R5 required extensive as daily living, used a whomas was totally dependented. Review of R51's care indicated R51 had liming unable to wheel herse assistance for all locon wheelchair. The care proper positioning for wheelchair. During an observation R51 was sitting in here the wheelchair had a above here head, and was at a 90 degree a wheelchair. R51 was behind here back that inches thick. The custous seat of the wheelchair shoulder blades. This and the crown of here back of the wheelchair toward the ceiling. R51 was in the dining assisted to eat. R51 was the cushion behind her heels and between the cushion behind here heels and between the cushion behind here were supported on the following an observation R51 was in the dining assisted to eat. R51 where cushion behind her heels and the cushion behind here were supported on the following an observation R51 was in the dining assisted to eat. R51 where cushion behind here were supported on the following and observation R51 was in the dining assisted to eat. R51 where cushion behind here heels and the cushion behind here were supported on the following assisted to eat. R51 where cushion behind here heels and the cushion behind here.	and dated 12/5/12, indicated fosteoarthritis, Parkinson's y in walking, and was elchair for mobility. The parkinson of the parkinson of the elchair for mobility, and the for locomotion. The plan dated 7/26/16, and required extensive elements of motion once she was in her plan lacked interventions for R51 while in her The on 7/25/16 at 3:46 p.m., are room, in her wheelchair in high back that extended the back of the wheelchair ingle to the seat of the observed to have a cushion was approximately three elements of the press against the ir and her face was pointed to the seat of the observed to press against the ir and her face was pointed to the park of the press against the ir and her face was pointed to the park of the park o	2 560			

Minnesota Department of Health

STATE FORM 6899 MF8511 If continuation sheet 3 of 16

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		07	//28/2016
	ROVIDER OR SUPPLIER MANOR REHABILITATIO	N CENTER. LLC	DDRESS, CITY, STATI ITH DAVIS AVENU ELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 560	with her face pointed During an observation R51 was observed sit wheelchair. Again, R6 behind her lower back 3-4 inches from the bher shoulders and he back of the wheelchait toward the ceiling. During interview with p.m., R51 stated she her wheelchair and thrursing staff several took at her wheelchaik knowledge that had n stated she had asked behind her back becahas to ask to be boost During an observation nursing assistant (NA for R51 and used a minto her wheelchair. A half moon shaped incupper back of the wheelchair. A half moon shaped incupper back of the wheelchair. R51's head and neck and to look straight al ceiling. R51 stated shromfortable with the cand neck. NA-A was interviewed NA-A stated R51 had a couple of months accouldn't recall having the wheelchair or how	toward the ceiling. In on 7/26/16 at 3:35 p.m., thing in her room in her of had the cushion in place k, causing her buttocks to be ack of the wheelchair, and ad were pressed into the ir with her face pointed R51 on 7/26/16 at 3:41 was not very comfortable in last she had asked the imes to have the therapist r. R51 stated that to her of happened. R51also for a smaller pillow for luse she slides forward and ted up regularly. In on 7/27/16 at 7:15 a.m., a)-A provided personal cares bechanical lift to transfer her at thick black cushion with a lent, was attached to the elechair and supported, allowing her to sit upright head, instead of at the left so much more cushion supporting her head. If on 7/27/16 at 7:28 a.m. received a new wheelchair go and NA-A said she received any training about w R51 should be positioned cushion used to support	2 560			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00775	B. WING		07	7/28/2016
	ROVIDER OR SUPPLIER	N CENTER. LLC	DRESS, CITY, STATE TH DAVIS AVENUE LD, MN 55355	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
2 560	didn't know why. NA- on the chair in the co- attached it to the whe During an interview o stated she hadn't rec- best use R51's wheel NA-B stated she was information about how in the wheelchair eith During an interview oregistered nurse (RN therapy] gets the new to use it. [R51] usuall nursing assistant she bathroom door, shoul verified the nursing ar room lacked informat positioning for R51. F provides written inform how to position the re didn't get one for [R5 care plan lacked inter positioning while in he During an interview o stated she had ordere R51 because she nee indicated written infor nursing staff when a i wheelchair, and the th how to position the re not recall whether she information or instruct to position R51 in the further stated the faci	n't this morning and she -A stated when she'd seen it rner of the room she'd selchair. n 7/28/16 at 9:21 a.m., NA-B seived any training for how to chair when it was new. n't aware of any written w R51 should be positioned er. n 7/28/16 at 9:24 a.m.,)-A stated, "OT [occupational wheelchair and tells us how y has the headrest on. The et in the room, behind the d have that on there." RN-A ssistant care sheet in R51's ion regarding proper RN-A stated, "OT usually mation with directions for esident, but, apparently we 1]." RN-A also verified R51's rentions for proper er wheelchair. n 7/28/16 at 3:26 p.m., OT-A ed the new wheelchair for eded a larger chair. OT-A	2 560			

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STATE FORM 6899 MF8511 If continuation sheet 5 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SUI COMPLET		
		00775	B. WING		07/28	/2016
-	ROVIDER OR SUPPLIER MANOR REHABILITATIO	N CENTER, LLC	DRESS, CITY, STA H DAVIS AVEN D, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 560	Review of the facility' (interdisciplinary team "Care is planned to he resident's/patient's high mental and psychoso comprehensive care individualized to the spreferences of the resident's preferences of the resident's preferences of the resident's preferences of the resident plans are developed a manner. The DON or appropriate staff. The develop monitoring sycompliance and report the QA committee.	s policy Care Planning IDT n) dated 5/11, included; elp attain or maintain the ghest practicable physical, cial well beingThe plan is holistic and epecific needs and sident." OD OF CORRECTION: The ON) or designee could sure comprehensive care and revised in a timely designee could educate all e DON or designee could ystems to ensure ongoing the the monitoring results to	2 560			
2 830	TIME PERIOD FOR CORRECTION: Twenty-one		2 830			

Minnesota Department of Health

STATE FORM 6899 MF8511 If continuation sheet 6 of 16

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00775	B. WING		07/28/2016
	ROVIDER OR SUPPLIER	N CENTER, LLC	NDDRESS, CITY, STAT JTH DAVIS AVENU ELD, MN 55355	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROFICIENCY)	ULD BE COMPLETE
2 830	Continued From page	6 6	2 830		
	by: Based on observation review, the facility fail wheelchair positioning reviewed with wheelchair positioning reviewed with wheelchair sadmission records and diagnoses of Disease, had difficulty dependent on a wheelchair sadmission records and diagnoses of Disease, had difficulty dependent on a wheelchair sadmission records and diagnoses of Disease, had difficulty dependent on a wheelchair sadmission and was at a wheelchair sadmission and was at a 90 degree a wheelchair. The cursue and was at a 90 degree a wheelchair. The cursue and was at a 90 degree a wheelchair. The cursue and was at a 90 degree a wheelchair. The cursue and was at a 90 degree a wheelchair. The cursue at of the wheelchair.	g for 1 of 2 residents (R51) hair positioning needs. and dated 12/5/12, indicated f osteoarthritis, Parkinson's y in walking, and was elchair for mobility. hum Data Set (MDS) dated 1 was cognitively intact, sistance for activities of heelchair for mobility, and t for locomotion. plan dated 7/26/16, hited physical mobility, was elf, and required extensive hmotion once she was in her plan lacked interventions for R51 while in her an on 7/25/16 at 3:46 p.m., ar room, in her wheelchair. In high back that extended the back of the wheelchair highe to the seat of the observed to have a cushion was approximately three shion extended from the			

Minnesota Department of Health

STATE FORM 6899 MF8511 If continuation sheet 7 of 16

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775		B. WING		07/28/2016
		***************************************		1		1 0172072010
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MEEKER	MANOR REHABILITATIO	N CENTER, LLC		I DAVIS AVEN D, MN 55355	UE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	BE COMPLETE
2 830	Continued From page	÷ 7		2 830		
	back of the wheelchar toward the ceiling. R5 be supported on the f behind her heels and During an observation R51 was in the dining assisted to eat. R51 whave the cushion behinead to press against with her face pointed During an observation R51 was observed sit wheelchair. Again, R5 behind her lower back 3-4 inches from the beher shoulders and her	n on 7/25/16 at 5:35 p.m room and was being was observed to continuind her back, causing her the back of the wheeld	nted to n., ue to ner chair n., lace to be and			
	p.m., R51 stated she her wheelchair and the nursing staff several took at her wheelchair knowledge that had n stated she had asked behind her back becahas to ask to be boosed buring an observation nursing assistant (NA for R51 and used a minto her wheelchair. A half moon shaped indupper back of the wheelchairs head and neck.	imes to have the therapher. R51 stated that to he ot happened. R51also for a smaller pillow for use she slides forward	ole in pist and n., cares r her th a e			

Minnesota Department of Health

STATE FORM 6899 MF8511 If continuation sheet 8 of 16

00775 B. WING 07/28	3/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
celling. 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.	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00775	B. WING		07/28/2016
	ROVIDER OR SUPPLIER MANOR REHABILITATIO	N CENTER. LLC	DDRESS, CITY, STAT FH DAVIS AVENU ELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
2 830	REGULATORY OR LSC IDENTIFYING INFORMATION)		2 830		
21426	(a) A nursing home production and Control and Prevention And Control programment tuberculosis in issued by the United Control and Prevention Tuberculosis Eliminat	provider must establish and nsive tuberculosis ram according to the most infection control guidelines States Centers for Disease	21426		

Minnesota Department of Health

STATE FORM 6899 MF8511 If continuation sheet 10 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		D	CONSTRUCTION		E SURVEY PLETED	
		00775	B. WING		07	7/28/2016
	ROVIDER OR SUPPLIER	ON CENTER, LLC	STREET ADDRESS, CITY, STA 600 SOUTH DAVIS AVENU LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIO	1111111	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	This program must in infection control plan unpaid employees, coresidents, and volunted Health shall provide to regarding implements	clude a tuberculosis that covers all paid and ontractors, students, eers. The Department of echnical assistance ation of the guidelines.				
	by: Based on interview a facility failed to implet appropriate screening	it is not met as evidence and document review, the ment interventions to en- g for tuberculosis (TB) we employees (E-1) reviewe	sure as			
	E-1's start of employr Review of E-1's perso employee had receive 6/10/13 which was no (millimiters) of indural step TST had been a	ment date was 6/13/16. connel record revealed the ed a mantoux (TST) on egative witih 0 mm tion on 6/13/16. A second dministered on 7/10/16, a not read until 7/15/16.				
	director of nursing (D TST "should have be administration."	/28/16 at 1:30 p.m., the ON) stated the second seen read within 72 hours m., the assistant directo	of			
	nursing (ADON) state					

Minnesota Department of Health

STATE FORM 6899 MF8511 If continuation sheet 11 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/28/2016
	ROVIDER OR SUPPLIER MANOR REHABILITATIO	N CENTER. LLC	DDRESS, CITY, STATE ITH DAVIS AVENU ELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETE
21426	mantoux will need to employee [E-1]. " The facility's policy ar (TB) Prevention and (all employees of the food to employment. "Base of two components: 1 symptoms of active To the presence of infect tuberculosis by admire TST or a single TB bloom TST or a single TS	de repeated for this ad procedure Tuberculosis Control dated 6/11, indicated acility would be tested prior eline TB screening consists) assessing for current B disease and 2) testing for ion with Mycobacterium distering either a two-step bood test." Inters for Disease Control mmendation include: "The full be read between 48 and firation. A patient who does burs will need to be for employees to be sure the tuberculin screens and the administrator or for for compliance. CORRECTION: Twenty one CORRECTION: Twenty one OD OF CORRECTION: The ON) or designee could creening standards to propriate standards. The all deducate all licensed g the importance of	21426		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.2.7.2.11.0.1.00.11.1.20.1.0.1.		IDENTIFICATION NOMBER.	A. BUILDING: _		COMPL	EIED
		00775	B. WING		07/2	8/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MEEKER	MANOR REHABILITATIO	N CENTER. LLC	H DAVIS AVEN LD, MN 55355	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From page	e 12	21426			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21705	MN Rule 4658.1415 S Housekeeping, Opera	•	21705			
	maintain the mechanicomfortable and safe and humidity levels. Tareas must be maintate: A. For construction nursing home must mof 71 degrees Fahren Fahrenheit at all times. B. For existing famust maintain a minidegrees Fahrenheit d. C. Variations of the items A and B are allowed based on documented.	g home must operate and cal systems to provide temperatures, air changes, Temperatures in all resident ained according to items A to on of a new physical plant, a naintain a temperature range theit to 81 degrees				
	Based on observation failed to ensure comforwere maintained for 6	n and interview, the facility ortable room temperatures of 35 residents (R141, R77) who complained peratures.				
	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.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED	
		00775	B. WING		07/2	8/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
MEEKER	MANOR REHABILITATIO	ON CENTER. LLC	H DAVIS AVEN LD, MN 55355	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE	(X5) COMPLETE DATE
21705	Continued From page	e 13	21705			
	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.					
	R77 was being assist was wrapped in a bla	n 7/26/16, at 10:20 a.m., ted to the bathroom. R77 nket, kept her head tucked did not make eye contact, 'm coldI'm cold."				
	R77 was sitting on the stated, "Leave me ald conditioning unit in R' cold air. Nursing assistransferred R77 and to conditioning unit. R77 in blankets.	was observed to b bundled				
During an interview on 7/28/16 at 11:00 a.m., the						

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1 1 1		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMB		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00775		B. WING		07	7/28/2016	
	ROVIDER OR SUPPLIER MANOR REHABILITATION	ON CENTER, LLC	600 SOUTH	RESS, CITY, STA Davis Aveni D, Mn 55355				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
21705	environmental service goal was to maintain temperatures at "abornot aware of a facility. The ED stated he waroutinely monitored the rooms or common arresidents complained nursing staff would ned to make the more of the state o	es director (ED) stated the building and room but 70 degrees," but he policy that addressed as not aware if the facilithe temperature in residues, but stated if the diabout the temperature of the maintenance of any complaints from from or common area are that tour with the ED of the following temperature was also followed the followed temperature was also followed temperature was also followed the followed temperature was also followed the followed temperature was also followed temperat	was this. ity dent e, the staff. n atures es F 67 es F 70 r, the is was e end The the	21705				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
7.110 1 27.11			A. BUILDING:		J CONTINUE	.125
		00775	B. WING		07/28	8/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MEEKER	MANOR REHABILITATIO	N CENTER. LLC	I DAVIS AVEN	UE		
LITCHFIELD			D, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21705	Continued From page	e 15	21705			
	the air conditioning un monitoring the hallwa temperatures more cl	=				
	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 includeComfortable 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 (14) days.	CORRECTION: Fourteen				

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