CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I	- TO BE COMP	LETED BY T	HE STAT	E SURVEY	AGENCY		Facility ID: 00775
MEDICARE/MEDICAID PROVIE (L1) 245361 2.STATE VENDOR OR MEDICAID N (L2) 134543500		3. NAME AND ADDRESS OF FACILITY (L3) MEEKER MANOR REHABILITATIO! (L4) 600 SOUTH DAVIS AVENUE (L5) LITCHFIELD, MN			ON CENTER, LLC (L6) 55355		4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF $ (\text{L9}) \textbf{07/14/2016} $		7. PROVIDER/SU	05 HHA	09 ESRD	<u>02</u> (L7	22 CLIA	7. On-Site Visit 8. Full Survey After (9. Other Complaint
6. DATE OF SURVEY 09/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(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 ENDIN	G DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	90 (L18) 90 (L17)	X A. In Complia Program Complian 1. B. Not in Co	IS CERTIFIED AS ance With Requirements ace Based On: Acceptable POC ompliance with Prog and/or Applied Wa	ram	2. Te 3. 24 4. 7-1 5. Lit * Code:	chnical Personnel Hour RN Day RN (Rural SNF) fe Safety Code A*		rvices Limit rector m Size
14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SN 90 (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY 1861 (e) (1) o		(L15)	
16. STATE SURVEY AGENCY REM 17. SURVEYOR SIGNATURE Brenda Fischer, Unit		Date:	2/2018	(L19)	Alison He		ement Specialis	Date: 10/02/2018 (L20)
DETERMINATION OF ELIGIBII 1. Facility is Eligible to 2. Facility is not Eligi	LITY o Participate	20. CON	MPLIANCE WITH IGHTS ACT:		21. 1. 2.	Statement of Finan	cial Solvency (HCFA-2572 Interest Disclosure Stmt (F	
22. ORIGINAL DATE OF PARTICIPATION 10/01/1986 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEM ENDING DAT		VOLUNTARY 01-Merger, Clos 02-Dissatisfaction	on W/ Reimburseme		(L30) ITARY Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE: (L27)	ALTERNATI A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)			untary Termination n for Withdrawal	OTHER 07-Provide 00-Active	r Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/	CARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	(L32)	. DETERMINATION 09/19/2018	OF APPROVAL D.	ATE (L33)	DETERMIN	IATION APPR	OVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 2, 2018

CMS Certification Number (CCN): 245361

Administrator Meeker Manor Rehabilitation Center, LLC 600 South Davis Avenue Litchfield, MN 55355

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 10, 2018 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely.

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 2, 2018

Administrator Meeker Manor Rehabilitation Center, LLC 600 South Davis Avenue Litchfield, MN 55355

RE: Project Number S5361027

Dear Administrator:

On August 13, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 18, 2018. (42 CFR 488.422)
- Per day civil money penalty. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 27, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on July 27, 2018. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On September 27, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 17, 2018 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 an extended survey, completed on July 27, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 10, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on July 27, 2018, as of September 10, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 10, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter dated August 13, 2018:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 27, 2018 be rescinded as of September 10, 2018. (42 CFR 488.417 (b))

Meeker Manor Rehabilitation Center, Llc October 2, 2018 Page 2

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

MEDIO	CARE/MEDICAL	D CERTIFIC	ATION A	AND TRANSMITTAL	ID: Q3PC		
PART I	- TO BE COMPI	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00775		
MEDICARE/MEDICAID PROVIDER NO. (L1) 245361 2.STATE VENDOR OR MEDICAID NO. (L2) 134543500	3. NAME AND ADD (L3) MEEKER M. (L4) 600 SOUTH I	ANOR REHAB DAVIS AVENU	ILITATIO	ON CENTER, LLC (L6) 55355	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 07/14/2016 6. DATE OF SURVEY 07/27/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 90 (L18) 13.Total Certified Beds 90 (L17) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 90 (L37) (L38) (L39)	X B. Not in Com Requirements a ICF (L42)	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP IS CERTIFIED AS: nee With equirements he Based On: Acceptable POC Inpliance with Programd/or Applied Wait IID (L43)	09 ESRD 10 NF 11 ICF/IID 12 RHC	02	6. Scope of Services Limit 7. Medical Director		
16. STATE SURVEY AGENCY REMARKS (IF APPLICABI	E SHOW LTC CANCE	ELLATION DATE):	:				
17. SURVEYOR SIGNATURE	Date:			18. STATE SURVEY AGENCY A	APPROVAL Date:		
Bruce Melchert, HFE NE II	0	08/31/2018	(L19)	Alison Helm, Enforcement Specialist 09/18/2018			
PART II - TO BI	E COMPLETED	BY HCFA RE	GIONAL	OFFICE OR SINGLE ST	ATE AGENCY		
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)		IPLIANCE WITH C GHTS ACT:	CIVIL	21. 1. Statement of Finan2. Ownership/Contro3. Both of the Above	I Interest Disclosure Stmt (HCFA-1513)		
22. ORIGINAL DATE 23. LTC AGREEM OF PARTICIPATION BEGINNING 10/01/1986 (L24) (L41)		4. LTC AGREEMI ENDING DATI (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursemen	05-Fail to Meet Health/Safety		
G 27)	VE SANCTIONS n of Admissions: spension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
28. TERMINATION DATE: 29	9. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
(L28)	06201		(L31)				

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted August 13, 2018

Ms. Lynn Hogendorn, Administrator Meeker Manor Rehabilitation Center, LLC 600 South Davis Avenue Litchfield, MN 55355

RE: Project Number S5361027

Dear Ms. Hogendorn:

On July 27, 2018, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> means one or more deficiencies related to participation requirements under 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on July 26, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us

Phone: (218) 302-6151 Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective August 18, 2018. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty. (42 CFR 488.430 through 488.444)
- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 27, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life, and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Meeker Manor Rehabilitation Center, LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 27, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its

NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 27, 2018 (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 27, 2019 (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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections

> Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File

PRINTED: 09/05/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245361	B. WING		07	/27/2018	
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CC 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		SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 0	000			
	Preparedness Required 7/23/18 thru 7/27/18	ments	E 0	039		9/10/18	
	RNHCIs and OPOs test the emergency	cility, except for LTC facilities, b] must conduct exercises to plan at least annually. The RNHCIs and OPOs] must do					
	The LTC facility mu the emergency plar unannounced staff	at §483.73(d):] (2) Testing. st conduct exercises to test at least annually, including drills using the emergency C facility must do all of the					
	community-based of exercise is not acceptable. If the actual natural or marequires activation of [facility] is exempt frommunity-based of full-scale exercise of the actual event. (ii) Conduct an addinclude, but is not ling (A) A second full-community-based of the actual event.	ull-scale exercise that is or when a community-based essible, an individual, a [facility] experiences an an-made emergency that of the emergency plan, the rom engaging in a or individual, facility-based for 1 year following the onset of itional exercise that may mited to the following: -scale exercise that is or individual, facility-based. ercise that includes a group					
ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE		(X6) DATE	

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

(X6) DATE

Electronically Signed

08/23/2018

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.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD			(X3) DATE SURVEY COMPLETED	
		245361	B. WING	i		07/:	27/2018
	PROVIDER OR SUPPLIE	R ITATION CENTER, LLC		600	REET ADDRESS, CITY, STATE, ZIP CODE D SOUTH DAVIS AVENUE FCHFIELD, MN 55355	,	
(X4) ID PREF I X TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	discussion led by clinically-relevant of problem staten prepared question emergency plan. (iii) Analyze the [f maintain docume exercises, and er [facility's] emerge *[For RNHCIs at §486.360] (d)(2) must conduct exercises and er [RNHC following: (i) Conduct a paper least annually. A discussion led by clinically relevant of problem staten prepared question emergency plan. (ii) Analyze the [f to and maintain dexercises, and er [RNHCI's and OF needed. This REQUIREM by: Based on intervier facility failed to er exercises to test the potential to af residing in the face. The Emergency [Findings include: The Emergency III]	a facilitator, using a narrated, emergency scenario, and a set nents, directed messages, or a designed to challenge an acility's] response to and acility's] response to and antation of all drills, tabletop mergency events, and revise the acceptance of the acceptan	E		Meeker Manor Rehab Center PO E039 PP Testing Requirements The facility will complete 2 tab exercises to test the emergency p Staff will be re-educated on erfull scale and/or table top exercise their emergency plan are complete annually An audit of full scale and/or ta exercises will be completed to ens	elle top lan nsuring es to test ed ble top	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		245361	B. WING			07/2	27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	current emergency documentation or of tested, addressedParticipation in a exercise, or if the cavailable, an indivithat utilizes planneConduct an addit second, full-scale, facility drill, or a talfacilitator, using a scenario to test theAnalyzing the facand experiences a from the review. When interviewed regional director of have not complete other full scale drill The RDO stated faroutine fire and we full scale drill or taldone. The RDO stated faroutine fire and we full scale drill or taldone. The RDO stated faroutine fire and we full scale drill along be an additional cohave to address. Hospital CAH and CFR(s): 483.73(e)	full-scale, community-based community-based is not dual, facility-based exercise of emergency procedures; and cional exercise that may be a either community or individual, ple-top exercise, led by a clinically-relevant emergency emergency plan; and cility's response to the exercises and maintain the documentation on 7/27/18, at 3:17 p.m. the foperation (RDO) stated, "we d" any table top exercise or to test the emergency plan. acility staff participated in ather drills, but stated neither a ple top exercise had not been tated there was no the full EP testing had been DO stated completing a grift would omponent the facility would be top exercises would omponent the facility would be standby power systems. The ement emergency and standby	EO		completion annually * Maintenance Director or design be responsible party * QAA will provide redirection or when necessary to ensure complet and/or continuation of monitoring pr * Completion Date: 9/10/2018	change ion	9/10/18
	power systems bas forth in paragraph	ement emergency and standby sed on the emergency plan set (a) of this section and in the dures plan set forth in					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/2	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
E 041	§483.73(e), §485.63 (e) Emergency and [LTC facility and the emergency and stathe emergency planthis section. §482.15(e)(1), §483 Emergency general must be located in a requirements found Code (NFPA 99 and Amendments TIA 1 12-5, and TIA 12-6) and Tentative Interior 12-2, TIA 12-3, and when a new structure or building 482.15(e)(2), §483 Emergency general [hospital, CAH and the emergency power and maintenance rehealth Care Facilities Safety Code. 482.15(e)(3), §483 Emergency general LTC facilities] that reto power emergency for how it will keep operational during the evacuates.	and (ii) of this section. 25(e) standby power systems. The e CAH] must implement indby power systems based on a set forth in paragraph (a) of a.73(e)(1), §485.625(e)(1) tor location. The generator accordance with the location in the Health Care Facilities d Tentative Interim 2-2, TIA 12-3, TIA 12-4, TIA in Life Safety Code (NFPA 101 in Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, are is built or when an existing	EC	41			

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		245361	B. WING		<u> </u>	07/	27/2018	
	PROVIDER OR SUPPLIER R 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)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 041	and CAHs §485.62 The standards inco section are approve reference by the Di Federal Register in 552(a) and 1 CFR paterial from the scinspect a copy at the Center, 7500 Securor at the National A Administration (NAI availability of this manalistration (NAI availability of this manalis	proporated by reference in this ed for incorporation by rector of the Office of the accordance with 5 U.S.C. part 51. You may obtain the burces listed below. You may be CMS Information Resource rity Boulevard, Baltimore, MD rchives and Records RA). For information on the laterial at NARA, call to to: a.gov/federal_register/code_of s/ibr_locations.html. In this edition of the Code are elerence, CMS will publish a lideral Register to announce of the code are elerence, CMS will publish a lideral Register to announce of the code, 2012 and 11, 2011. In amendment (TIA) 12-2 to liquist 14, 2012. In amendm	E	041				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	l` ′co	
		245361	B. WING		c	7/27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP 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 PREFI TAG		ON SHOULD BE IE APPROPR I ATE	(X5) COMPLETION DATE
E 041	2013. (xi) TIA 12-4 to NF 2013. (xiii) NFPA 110, Standby Power Sy TIAs to chapter 7, This REQUIREME by: Based on observareview the facility of electrical system in (2012) Health Card (2010) Standard for Power Systems ar implemented emerinspection/testing requirements. This 56 current resident if the generator fair outage. Findings include: Observations were tour between 9:00 Record review and environmental servation of the properties of t	PA 101, issued October 22, andard for Emergency and stems, 2010 edition, including issued August 6, 2009. INT is not met as evidenced ation, interview, and document did not provide an essential in accordance with NFPA 99. In Emergency and Standby and failed to ensure they had regency generator in accordance with the shad the potential to affect all its, as well as staff and visitors, led to operate during a power and 2/18. Interview with the vices director (ESD) revealed: interview with the vices director (ESD) stated the remissing for a number of also stated the facility needed or come in to perform an est on the generator as rator meets the standard, but	EO	E041 – Hospital CAH and Emergency Power The facility completed emergency generator inspon 8/13 for the annual load facility has completed their generator log. Staff will be re-educated the annual emergency generator inspection/testing is compannual load bank test & modes. An audit of the annual generator inspection/testir completed annually; then audit of the monthly generated monthly x 4 modeded. Maintenance Director be responsible party QAA will provide redired when necessary to ensure and/or continuation of modes. Completion Date: 9/16	an annual pection/testing d bank test. The remonthly ed on ensuring nerator leted for the nonthly generated is meeded. An eator log will be as needed. An eator log will be onths; then as or designee we ection or change completion nitoring proces	or ill ge

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BU I LD			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/	27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		600 S	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH DAVIS AVENUE CHFIELD, MN 55355	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 000	was completed by Department of Heacompliance with the 483, subpart B, recompliance. The survey resulte (IJ) and substandathe facility failed to abuse was address and comprehensive provided to the allebeing implemented administrator, regional consultante 7/26/18 at 5:06 p.m. 7/27/18, at 3:50 p.m. implemented a rencomprehensively in providing protection.	7/18, a recertification survey surveyors from the Minnesota alth (MDH) to determine be regulations at 42 CFR Part quirements for Long Term Care and in an Immediate Jeopardy and quality of care at F600 when be ensure an allegation of sexual sed including being accurately rely investigated, protection and director of operations and to prevent recurrence. The conal director of operations are to form the IJ on the IJ was removed on the IJ on	FC	000			
	on 7/27/18, for sub The facility's plan of as your allegation of Department's acce enrolled in ePOC, at the bottom of the form. Your electron be used as verification	ended survey was completed ostandard quality of care. of correction (POC) will serve of compliance upon the eptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will ation of compliance.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/:	27/2018
	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	validate that substa regulations has be your verification.	ur facility will be conducted to antial compliance with the en attained in accordance with	F(000			
F 550 SS=D	Resident Rights/Ex CFR(s): 483.10(a) §483.10(a) Reside The resident has a self-determination, access to persons	(1)(2)(b)(1)(2)	F	550			9/10/18
	with respect and di resident in a mann promotes maintena her quality of life, re	cility must treat each resident gnity and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's acility must protect and of the resident.					
	access to quality conserverity of condition must establish and practices regarding provision of services	facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all as of payment source.					
		ne right to exercise his or her tof the facility and as a citizen					
	resident can exerc	facility must ensure that the ise his or her rights without ion, discrimination, or reprisal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245361	B. WING		07/	27/2018	
	PROVIDER OR SUPPLIER R MANOR REHABILI	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 550	free of interference reprisal from the farights and to be see exercise of his or subpart. This REQUIREMED by: Based on observative review, the facility maintained when dated in large font R44) who needed Findings include: R47's admission of 6/22/18, indicated On 7/23/18, at 7:0 assisted into the date of a skin colored 4 inches on her rigulate of 7/21/18 which covered appand was easily readining room (great During observation was seated in her a 4" by 4" dressing cheek, dated, A sk (inches) by 4" was dated "7/25/18" in half the dressing.	e resident has the right to be e, coercion, discrimination, and acility in exercising his or her apported by the facility in the her rights as required under this enter in the enter rights as required under this enter in the enter rights as required under this enter in the enter rights as required under this enter in the enter right was bandages were conspicuously for 2 of 2 residents (R47 and face and leg dressings. Minimum Data Set (MDS) dated she was cognitively intact. 9 a.m. R47 was observed being lining room for breakfast. R47 is bandage about 4" (inches) by ght cheek, which had a large ritten in thick black marker proximately 50% of the dressing enter than 20 feet in distance). In on 7/25/18 at 8:00 p.m. R47 recliner in her room. R47 had g was in place on her right kin-colored bandage, about 4" is intact on R47's face and was black ink which covered about Licensed practical nurse R47's room with evening	F 5	F550 – Resident Rights/Exerci Rights R44 and R47 were reviewed dignified existence and self-determination. R44 and R47 tracer reviewed, plan of care and interventions have been updated dignified existence. R47 has be discharged. All current residents have be identified for Resident Rights and Exercise to Rights for dignified and self-determination. Resider interventions and plan of care be reviewed and updated Staff will be re-educated or resident rights and resident dignity related labeling of dressings will be corweekly x 4 weeks; then as need. Director of Nursing or designes possible party. QAA will provide redirection when necessary to ensure comand/or continuation of monitorir. Completion Date: 9/10/201	d for eatments d d to reflect een een nd existence nt's nave n ensuring nity are f dressings sident ed to mpleted ded gnee will be n or change pletion ng process		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION			E SURVEY PLETED
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	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	, ZIP CODE		
(X4) ID PREF I X TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 550	During interview of stated she though bandage "should lead to could be writted the dressing. Leattracted more att. R47's treatment a 2018, directed to cright cheek every. During interview of interim director of heard about "the offace. The DON strissue." R44's admission of A/27/18, indicated. During observation was seated in her On both R44's right tan-colored bandar (inches) by 4". The large, black font off was easily visible. R44's treatment a 2018, directed to a abrasions to shins cleanser and apple. During interview of stated the bandag got her bath tonigh dates on my band dates.	or 7/25/18, at 8:00 p.m. LPN-A to the writing on R47's face one less in size" and that the ten small and on the lower edge PN-A stated the size of the date ention to the dressing. In 7/27/18, at 2:02 p.m. the nursing (DON) stated she date" on R47's dressing on her tated "that would be a dignity Minimum Data Set (MDS) dated R44 was cognitively intact. In on 7/25/18, at 5:04 p.m. R44 wheel chair, dressed in shorts. In and left shins was a age, each approximately 4" was written in a n each of the bandages, which and seen by anyone nearby. In 7/25/18, at 5:04 p.m. R44 wheel chair record for July apply border foam dressings to and cleanse with wound y new dressing every 3 days. In 7/25/18, at 5:04 p.m. R44 wheel composition record for July apply border foam dressings to and cleanse with wound y new dressing every 3 days. In 7/25/18, at 5:04 p.m. R44 would come off when she and added "I don't like the ages." R44 stated she did not do to do that and her knees	F 5	550			

F 550 Continued From page 10 "would look better without the dates on them." R44 stated staff put the dates on them the day they change the bandages and added "they could just document the dates in my chart instead. In a subsequent interview on 7/26/18, at 10:39 a.m. R44 stated it was not the fact the date was written on the bandage, but that it was written on the bandage, but that it was written "so big" that was upsetting. R44 stated she'd be "ok" with the dates on her bandages if the date was written smaller. During interview on 7/26/18, at 12:22 p.m. the director of nursing (DON) stated the date was written smaller. During interview on 7/26/18, at 12:22 p.m. the director of nursing (DON) stated the date was written on the bandages so we know when it was changed last. The DON then stated she did not know why the nurses were writing the date so big and if it's that big, "that concerns me for dignity" and the dates should be written smaller. A policy regarding dignity was requested, but none was provide. F 561 Self-Determination The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. \$483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
MEEKER MANOR REHABILITATION CENTER, LLC [XA1] D [AND AND AND AND AND AND AND AND AND AND			245361	B. WING		07/	27/2018
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 10 "would look better without the dates on them." R44 stated staff put the dates on them the day they change the bandages and added "they could just document the dates in my chart instead. In a subsequent interview on 7/26/18, at 10:39 a.m. R44 stated staff put the dates was written on the bandage, but that it was written "so big" that was upsetting. R44 stated she'd be "ok" with the dates on her bandages if the date was written smaller. During interview on 7/26/18, at 12:22 p.m. the director of nursing (DON) stated the date was written smaller. During interview on 7/26/18, at 12:22 p.m. the director of nursing (DON) stated the date was written on the bandages so we know when it was changed last. The DON then stated she did not know why the nurses were writing the date so big and if it's that big, "that concerns me for dignity" and the dates should be written smaller. A policy regarding dignity was requested, but none was provide. Self-Determination The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. \$483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with its or her interests, assessments, and plan of care and other the rights specified in paragraphs (f) and waking times), health care and providers of health care services consistent with its or her interests, assessments, and plan of care and other the rights.			ATION CENTER, LLC	6	600 SOUTH DAVIS AVENUE	,	
"would look better without the dates on them." R44 stated staff put the dates on them the day they change the bandages and added "they could just document the dates in my chart instead. In a subsequent interview on 7/26/18, at 10:39 a.m. R44 stated it was not the fact the date was written on the bandage, but that it was written "so big" that was upsetting. R44 stated she'd be "ok" with the dates on her bandages if the date was written smaller. During interview on 7/26/18, at 12:22 p.m. the director of nursing (DON) stated the date was written on the bandages so we know when it was changed last. The DON then stated she did not know why the nurses were writing the date so big and if it's that big, "that concerns me for dignity" and the dates should be written smaller. A policy regarding dignity was requested, but none was provide. F 561 Self-Determination The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other	PRÉF I X	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF I X	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF) BE	COMPLETION
applicable provisions of this part.	F 561	"would look better v R44 stated staff put they change the ba just document the of subsequent intervier R44 stated it was n on the bandage, but that was upsetting. the dates on her ba smaller. During interview on director of nursing (written on the band changed last. The know why the nurse and if it's that big, "t and the dates shou A policy regarding of none was provide. Self-Determination CFR(s): 483.10(f)(1) §483.10(f) Self-dete The resident has th promote and facilita through support of not limited to the rig (1) through (11) of t §483.10(f)(1) The re activities, schedules waking times), heal care services consi assessments, and	without the dates on them." It the dates on them the day Indages and added "they could Idates in my chart instead. In a Index on 7/26/18, at 10:39 a.m. In the fact the date was written It that it was written "so big" Index stated she'd be "ok" with Indages if the date was written Index the date was written Index the date was written Indages if the date was written Indages if the date was Indages so we know when it was Index were writing the date so big It that concerns me for dignity" Indignity was requested, but Indignity was reque				9/10/18

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			E SURVEY PLETED
245361	B. WING		07/	27/2018
ON CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	•	
ST BE PRECEDED BY FULL	ID PREFI) TAG	X (EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
lent has a right to make of his or her life in the ant to the resident. Ident has a right to interact ormunity and participate in oth inside and outside the lent has a right to vities, including social, ity activities that do not of other residents in the is not met as evidenced interview and document to ensure residents were meal preference for 1 of 1 to Spanish as her primary the facility failed to ensure the choice of bathing (24) reviewed for choices. In Data Set (MDS) dated and diagnosis of dementia overe cognitive impairment. In DA-D; DA-C stated at a not are given a ticket for choose from. They can entree or alternate and y want for these meals. If his, then we or the nursing	F 5	F561 - Self Determination R9 and R24 were reviewed determination. Plan of care and interventions have been update reviewed to reflect resident's self-determination. R24 bathing preferences were reviewed, planas been updated to reflect self-determination. R9 meal proposed and care pupdated to reflect self-determination. R9 meal proposed and care for self-determination preferences, and choice of the preferences. Interventions and care have been reviewed and self-determination specific to for preferences and bathing preferences. Audits of 3 residents for reself-determination of meal preferences.	ed and g an of care eferences plan nation. peen n of bathing ir meal plan of updated. n pood rences sident erences	
		245361 B. WING CON CENTER, LLC ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) 11 Ident has a right to make of his or her life in the ant to the resident. Ident has a right to interact formmunity and participate in oth inside and outside the Ident has a right to ovities, including social, ity activities that do not of other residents in the is not met as evidenced interview and document to ensure residents were meal preference for 1 of 1 is expanish as her primary the facility failed to ensure If the choice of bathing 24) reviewed for choices. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment. In Data Set (MDS) dated had diagnosis of dementia evere cognitive impairment.	245361 245361 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355 ENT OF DEFICIENCIES STBE PRECEDED BY FULL DENTIFYING INFORMATION) PREFIX TAG PRECEDED BY FULL DENTIFYING INFORMATION) F 561 F 56	245361 B. WING STREET ADDRESS, CITY. STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355 ENT OF DEFICIENCIES ST BE PRECEDED BY PULL DENTIFYING INFORMATION) Interview and for the end to the resident. Interview and document to ensure residents were meal preference for 1 of 1 (see Spanish as her primary the facility failed to ensure the choice of bathing 24) reviewed for choices. In Data Set (MDS) dated and diagnosis of dementia were cognitive impairment. In Data Set (MDS) dated and diagnosis of dementia were cognitive impairment. In Data Set (MDS) dated and diagnosis of dementia were cognitive impairment. In Data Set (MDS) dated and diagnosis of dementia continuation of the continua

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245361	B. WING		07/2	27/2018	
	PROVIDER OR SUPPLIER	ATION 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 561	item on the menu a not working, they p ask her "see" yes it us, even though RS stated nothing during R9 was observed of table, and had just meal. She ate 1/2 and sips of her sour out menu choices, highlighted with a ghelped R9 fill the manuslator on an iPa proceeded to show with R9. DA-B place translator, and show stated "papas". RS started to laugh loce DA-B repeated the seemed puzzled, a menu had potatoes choice. In an interview on who was R9's table table mate of R9's never seen the fact whatever that thing or only a few bites, plate. They don't as next day, if they gaprobably would eat On 7/26/18 11:55 at (RN)-A stated she in the seemed she in the	and they help R9 choose food as well. If these dietary staff are oint to the food item word, and a Spanish or "no" and she tells is unable to read. DA-D and this conversation. On 07/25/18 06:01 p.m. at the finished with her evening of sandwich, 100% pear sauce and R9 menu preference was green marker. DA-B stated she and DA-B found the iPad and how she used the translator ced the word potato in the wed it to R9, and the translator divided and The property and R9 again and said "No." The 7/26/18 is highlighted as R9's menu Of 125/18 at 6:14 p.m. with R20, and mate stated, I have been a for two years now. I have always leaves it on her sk her what she wants for the ve her a choice of food, she more but they don't. On 125/18 at 6:14 p.m. with R20, and the translator of the was. R9 never eats her bread she always leaves it on her sk her what she wants for the ve her a choice of food, she more but they don't.	F 561	Director of Nursing or diresponsible party QAA will provide redired when necessary to ensure diand/or continuation of monition. Completion Date: 9/10/3	etion or change completion toring process		

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/	/27/2018	
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		600	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH DAVIS AVENUE CHFIELD, MN 55355	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 561	the dining room eafinished her meal stroganoff, 50% be her juice, and coffee. During interview of culinary services of resident get a list of evening meal the cohooses what they wegetable, bread a When a resident is a food preference residents/family. Story a few years, they preference list for choice this would loof R9's meal ticked dislikes or prefere area was left bland there was beef an and evening meal identified in the parameter of the p	on 07/26/18 at 12:21 p.m. in ating independently. She just and ate 100% cake, 50% beef read, no broccoli and 100% of the fread, no broccoli and 100% of the fread the free free free free free free free fr	F 5	661				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245361	B. WING		07	/27/2018		
	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	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 561	identified R24 had to communicate h noted to have a caurinary functions a R24 received externorm of daily living (ADI grooming and morbid obesit R24's plan of care R24 received assist related to R24's leindicated R24 required with assist hygiene, including incontinence care plan was revised of alteration in skin in on her right buttoo staff were to moni with documentation of T/23/18, at 8:4 like to receive a boweekly for both constated she reques on the floor, though and was told they R24 also stated she receiving meds, a and they stated the	S completed on 4/21/18, I intact cognition and was able er needs and wishes. R24 was atheter in place to manage and was incontinent of bowel. Ensive assist to complete tasks L's) which included personal bility. R24's diagnoses included a neurological disorder which generalized muscle weakness, y. The revised on 7/6/18, identified stance to complete her ADL's evel of strength. The care planuired extensive assistance of an in bed every two hours and as are plan also directed staff to tance to complete personal skin cleansing, and completion is every two hours. The care plan regrity related to an abrasion exist. The care plan identified tor skin integrity during cares, on weekly. 6 a.m. R24 stated she would ath more frequently than a semifort and health concerns. R24 ted a second bath from the staff the was unable to recall whom, were unable to do anything. The had asked a nurse when gain was unable to recall whom, ey didn't schedule baths, elay the request or direct her to	F 561					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTH DAVIS AVENUE TCHFIELD, MN 55355	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	at 7:21 a.m. viewed nurse (RN)-B and calmoseptine (a zin skin prior to measurements. RN removed with gently most effective remostated she only receive she would benefit fibaths for comfort at During interview on 7:30 a.m. RN-B sta R24's request for a follow up with this. I relayed any request the floor nurse or to would add a second On 7/27/18, at 11:4 was unaware of any and to her knowled Tuesdays. R24 had assistance to bather on 7/27/18, at 1:18 (DON) stated, upon that had been upda and R24 had been and would have received.	of morning cares on 7/26/18, I skin condition with registered viewed cleansing of inc based barrier cream) off of I-B stated the cream was e cleansing, however, was eved with a whirlpool bath. R24 eived one bath weekly but felt from more frequent whirlpool and cleanliness. 7/26/18, at approximately ated she was unaware of additional baths and would RN-B stated staff should have to for additional baths to either of RN-B. RN-B stated she dibath for R24. 9, R24 stated at this time she of change in her bath schedule ge was scheduled on anot received any additional at this week. p.m. the director of nursing a review of the bath schedule ted on 7/27/18 at 5:42 a.m. scheduled for a second bath serived a whirlpool this morning.	F 5	61			
	choices and was no	Coverage/Liability Notice	F 5	82			9/10/18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/2	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE .ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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
F 582	§483.10(g)(17) The (i) Inform each Med writing, at the time of facility and when the Medicaid of- (A) The items and so nursing facility serve for which the resided (B) Those other iter facility offers and for charged, and the arservices; and (ii) Inform each Medicaid services are made specified in §483.10 section. §483.10(g)(18) The resident before, or a periodically during the available in the facility's per diem radicity's per diem radicity where changes and services covered Medicaid State plan notice to residents or reasonably possible (ii) Where changes items and services facility must inform 60 days prior to imperiodicity must refund representative, or expenses and services facility must refund representative.	e facility must- licaid-eligible resident, in of admission to the nursing e resident becomes eligible for services that are included in ices under the State plan and ent may not be charged; ms and services that the ir which the resident may be mount of charges for those dicaid-eligible resident when to the items and services O(g)(17)(i)(A) and (B) of this e facility must inform each at the time of admission, and the resident's stay, of services lity and of charges for those any charges for services not icare/ Medicaid or by the ate. in coverage are made to items ed by Medicare and/or by the n, the facility must provide of the change as soon as is	F	582			

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	//27/2018	
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPR I ATE	(X5) COMPLETION DATE	
F 582	per diem rate, for tresided or reserve facility, regardless discharge notice re (iv) The facility muresident represent the resident within date of discharge (v) The terms of an behalf of an individuality must not conthese regulations. This REQUIREME by: Based on interview facility failed to time and appeal rights of Medicare A services (R42) reviewed for notification. Findings include: R39's last day of contification. Findings include: R39's last day of contification. Findings include: R39's last day of contification. R39's Notice of Medicare o	the days the resident actually d or retained a bed in the of any minimum stay or equirements. st refund to the resident or ative any and all refunds due 30 days from the resident's from the facility. In admission contract by or on dual seeking admission to the onflict with the requirements of and document review, the ely provide the required liability notices prior to discharge from the for 2 of 3 residents (R39, beneficiary protection) Overed Medicare Part A Skilled (18, as identified on the form [skilled nursing facility] tion Notification Review). Redicare Non-Coverage (form signed by the authorized 6/20/18, with a notation the entative was called on 6/19/18. In Facility Advance (SNFABN, form CMS-10055) and date from the resident or	F 5	F582 – Medicaid/Medicare Coverage/Liability Notice R39 discharged from f8/13/2018. R42 discharged 7/6/2018. Residents will continue correct/appropriate notifica Medicare coverage/liabilitie Staff will be re-educate timely Medicare notices ar Audits of 3 Medicare of forms will be completed we weeks; then as needed. Administrator or desig responsible party QAA will provide redire when necessary to ensure and/or continuation of mor Completion Date: 9/10	facility on d from facility o e to be given the ations of es. ed on ensuring e being given coverage/liability eekly x 4 nee will be ection or chang completion nitoring process	e /	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245361	B. WING		07/:	27/2018
	ROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 582	Services was 7/5/18 CMS-2005 R42's census recordischarged from the R42's medical recofamily representative Medicare Non-Coveto R42's discharge. When interviewed 7 regional director of R39's authorized rebeen contacted on skilled coverage on CMS-100055 should authorized representative R42's CMS- 10123 should have been s 7/3/18, at the latest previously responsi	evered Medicare Part A Skilled B, as identified on the form did identified R42 was a facility on 7/6/18. Indexed evidence R42 or a re was provided the Notice of erage (form CMS-10123) prior (7/24/18, at 10:49 a.m. the operations (RDO) stated presentative should have 6/18/18, regarding the end of 6/20/18. Further the did have been signed by the notative. The RDO stated could not be located, and signed by the resident on a former staff person was ble for providing resident the notices and the facility was	F 58	2		
F 600 SS=J	was requested, but Free from Abuse ar CFR(s): 483.12(a)(§483.12 Freedom fr		F 60	0		9/10/18
	neglect, misapprop	e right to be free from abuse, riation of resident property, defined in this subpart. This				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245361	B. WING		07/27/2018	8
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	ETION
F 600	corporal punishme any physical or che treat the resident's §483.12(a) The face §483.12(a) (1) Not physical abuse, co involuntary seclusi. This REQUIREME by: Based on observareview, the facility abuse were identifed appropriate action provide resident provide resident provide resident provide residents (R44) who sleep following a offered her money she did not want his staff were unaware on 15 minute check encounters between (R36). Furthermore information in the information of R44. The IJ began on 7 when R44 approace facility staff that on money in exchangeshe did not want his identify potential seconds.	limited to freedom from nt, involuntary seclusion and emical restraint not required to medical symptoms. cility must- use verbal, mental, sexual, or rporal punishment, or	F 600	Free from Abuse and Neglect R44 and R36 remain in the facil free from abuse and neglect. All sta aware of R44 and R36 specific need increased monitoring. R44 and R36 allegation of abuse has been thorou investigated Residents will remain free from and neglect within the facility includi staff being aware of specific needs increase monitoring and ensuring a thorough investigation is completed Staff will be re-educated on the Prevention/Vulnerable Adult Plan Audits of all OHFC reports and grievances specific to allegations of abuse/neglect, specific to ensuring reporting, investigation, intervention protection of residents(s) are implemented timely including increamonitoring and thorough investigation be completed weekly x 4 weeks; the every other week x 8 weeks; then m x 6 months; then as needed Administrator or designee will b responsible party	ff are ds for ghly abuse ng for Abuse 6 correct s and se on will en nonthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE DO SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	nursing (DON) were p.m. of the IJ. The I 3:50 p.m. however, the lower scope and isolated with potent harm. Findings include: R44 was sexually a into taking money in resident) to touch a the incident occurre R44's room, without R44 to become fear resulting in making Although R44 told the did not want R36 in provide adequate p sexual abuse occur R44's OBRA Admis (MDS) dated 4/27/1 cognitively intact, reof one staff with act and used a wheelch plan dated 5/02/18, depression, adjust mild cognitive impa Assessment (CAA) required assistance oriented, had deficit impulsive. R36's OBRA Admissions (R36's OBRA Admissions and complete impulsive.	bused when she was coerced exchange for R36 (male not fondle her breasts. Once ed, R36 continued to enter ther consent which caused rful, scared and afraid, it difficult for her to sleep. The facility multiple times she her room, the facility did not rotection for R44, after the red. Ision Minimum Data Set 8, indicated she was equired extensive assistance civities of daily living (ADLs), nair for mobility. R44's care indicated diagnoses including nent disorder, dementia, and itment. R44's Care Area dated 4/27/18, indicated she with ADLs, was alert and ts in judgement, and was	F 6	00	when necessary to ensure complet and/or continuation of monitoring p • Completion Date: 9/10/2018		
	extensive assistance	ognitively intact, and required se of two staff with ADLs. sehensive Care Plan dated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MUL [*] A. BU I LDI	TPLE CONSTRUC		(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07	/27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		600 SOUTH D	RESS, CITY, STATE, ZIP CODE DAVIS AVENUE D, MN 55355	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOU S-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	6/6/18, indicated he had weakness. The R36 had no behavior indicted he was ale therapy due to a fall situation. The CAA return home. A Facility Investigate Office Of Facility He 7/14/18, at 11:29 p. the nurse on duty the gone into her (R44' offered her money breast, which he did victim (R44) asked then he left the roor R44 did not want R Internal investigation Five E 6:19 p.m. indicated reviewed, and the adiscuss the inciden originally indicated she did not want R3 conversation, R44 if fact accept the \$10 the alleged perpetra and closed the door opgo down to his room R36 to his room, the allowed him to touch did not want another wished for him to stindicated on the reminute checks, R36 to his room, the minute checks, R36 to his room, the wished for him to stindicated on the reminute checks, R36 to his room, the wished for him to stindicated on the reminute checks, R36 to his room, the minute checks, R36 to his room, the wished for him to stindicated on the reminute checks, R36 to his room, the minute checks are returned to the return	ge 21 e was alert and orientated, and e care plan further indicated ors. R36's CAA dated 6/13/18, at and orientated, and received I at his previous living indicated R36 planned to ion Report submitted to the ealth Complaints (OHFC) on m. indicated R44 reported to nat another resident (R36) had so room, closed the door, and to allow him to touch her d. The report indicated the him to stop, which he did, m. The report further indicated 36 to touch her breast. An in was initiated. A Facility of any Report dated 7/23/18, at R44's care plan was administrator met with R44 to the time investigation report R44 did not accept the cash, and formed the facility she did in in cash. R44 stated she and fator (R36) went into her room, or behind them. R44 said on the door, and asked them from the door, and asked them from R44 stated she followed by closed the door, and she her breast. R44 stated she er encounter with R36, and the tay away from her. The facility fort R44 was placed on 15 was informed of R44's with him again, and R36	F 6	00			

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NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC				600 S	ET ADDRESS, CITY, STATE, ZIP CODE OUTH DAVIS AVENUE HFIELD, MN 55355	, ,,,	
(X4) I D PREF I X TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION SHOUNDS OF THE APPRIOR OF THE APPRIOR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	agreed. During interview of administrator state between R44 and 7/14/18, and she occurred. The adrinformed by the dithe incident, then State Agency (SA administrator state investigation, and offered her \$10 in Further, the admin on 15 minute cheralso place R36 or administrator state did admit to offerit touch her breasts informed R36 that happen again. Although the incid occurred on 7/14/incident in the me Review of R44's proom, and to outside shortly aft stated, "I'm going door." Staff redirecourtyard near the could be supervis would knock on the state of the state of the supervision of the state of the supervision of the supervision of the supervision of the supervision of the state of the supervision o	an 7/25/18, at 1:54 p.m. the ed there was an incident R36 that occurred on Saturday, was unsure what time it ministrator stated she was rector of nursing (DON) about reported the incident to the later that evening. The ed she completed the R44 informed her that R36 exchange to touch her breasts. histrator stated R44 was placed cks, then the facility decided to a 15 minute checks. The ed she talked with R36, and he had R44 money so he could a The administrator stated she at R44 did not want this to the ed to a 15 minute checks. The ed she talked with R36, and he had R44 money so he could a The administrator stated she at R44 did not want this to the ed to a 15 minute checks. The ed she talked with R36 and he had R44 money so he could a the ed to a 15 minute checks. The ed she talked with R36 and he had R36 and not want this to the ed to a 15 minute check and so went er R44 went outside, and outside but I'm using a different except R44 to go outside in the ed to a 15 minute check and outside but I'm using a different except R44 to go outside in the ed to a 15 minute check and outside but I'm using a different except R44 to go outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside but I'm using a different except R44 to go outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and outside in the ed to a 15 minute check and incident to the incid	F6	600			

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NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC				60	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DAVIS AVENUE TCHFIELD, MN 55355	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 600	morning, R36 was coming out of R44' busy." Staff asked her room, and R44 her case worker ar her room. R44 also or do anything else As a result of the 7 initiated monitoring residents had a Re staff were directed R44's and R36's w for their safety. R44's 15 minute m 10:30 a.m. (four da Review of R44's 15 that R36 was in R4 a.m. but identified I that time. R36's RCL indicate 7/18/18, at 10:00 a 7/23/18, at 11:15 a. implemented RCL not consistently mosafety. During an initial inte R44 stated she was wheelchair when gave her \$10. R44 for, I don't want you wanted her to show wanted to touch he giving R36 his \$10 touch her breasts.	observed by a staff member s room. R36 stated, "[R44's] R44 about R36 coming into stated she was going to see and was leaving, and so R36 left o stated R36 did not touch her,	F6	00				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	occurred. R44 also administrator were and they were both stay away from her During an additiona 7/25/18, at 5:00 p.n her room, gave her to play with her breast adown and rubbed of feel "awful". She id room again after the just comes into my door." R44 further come into her room During a subseque 10:07 a.m. regardin stated, "When he to but I cant. After the for awhile, go to tow after it happened. I I knew I should, so shut the door when made her feel "dirty and abused." R44 my room the last tir door was open and which he did, and be the room, and I clos further indicated it rupset. While R44 weyes became water was worried the income.	working the night the incident of stated the DON and the both aware of the incident, aware she wanted R36 to aware she wanted R36 to aware she wanted R36 came into \$10.00, and stated he wanted asts and she told him "no." of pulled on her shirt and and continued to pull her shirt in her breast which made her lentified R36 came into her e incident. R44 state, "[R36] room without knocking on my stated she did not want R36 to	F	600			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 600	her room. During interview 7, stated he had bee months, and the as shortly after the inc R36 stated the addinot want him to co administrator talke administrator, "OK went back into R4-7/25/18, after he with to go into her room of her room. Review of the facil R44 and R36 iden. During interview of assistant (NA)-H stand was not aware and another reside was not aware R4 monitoring. In addinursing assistant of was no direction for the properties of the stated she has wo behaviors. NA-I stand eye on R44 ever further stated she between R44 and was not certain of the stated she between R44 and was not certain of the stated she has wo between R44 and was not certain of the stated she between R44 and was not certain of the stated she she she was not certain of the stated she	/26/18, at 10:53 a.m. R36 n at the facility for several dministrator talked with him cident occurred on 7/14/18. ministrator told him that R44 did ome around her. After the ed to him, R36 said he told the C." R36 did not disclose he 4's room on 7/16/18, and vas told by the administrator not n, and he had agreed to say out lity 15 minute monitoring for tified the following: n 7/25/18, at 7:00 p.m. nursing stated she worked with R44, e of any incident between R44 ent. NA-H further stated she lity was on 15 minute checks or ition, NA-H checked her care sheet, and verified there or monitoring for R44. n 7/25/18, at 7:21 p.m. NA-I rked with R44, and R44 had no ated she was supposed to keep ery 15 or 30 minutes. NA-I was aware of an incident another resident last week, but	F 600					
	companion (RC)-A	A stated she was not aware of n R36, or if there was any						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245361	B. WING			07/	27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE 00 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 600			F 6	00			
	stated she was not	n 7/25/18, at 7:51 p.m. NA-J aware of any monitoring for not aware of any incidents any other resident.					
	stated R36 was on not aware of the re nursing assistants	n 7/26/18, at 10:58 a.m. NA-F 15 minute checks, and was ason. NA-F stated nurses and are to document the 15 minute at the nurses station.					
	stated R36 was on another resident, b	n 7/26/18, at 11:05 a.m. NA-G 15 minute checks because of ut was not sure which resident. ocuments R36's location every					
	licensed social wor Monday, 7/23/18, s of the incident betw was not involved. I like this were discu she had to step out further stated she h	n 7/26/18, at 11:09 a.m. rker (LSW)-A stated on the had heard bits and pieces ween R44 and R36, but she LSW-A further stated situations ssed at morning meeting, but the during the meeting. LSW-A had not talked to R44 after the pecause LSW-A was on leave					
	the administrator a was informed of the 9:00 p.m. when RN occurred. The DON administrator of the administrator filed a was informed of the placed R44 on 15 r	n 7/26/18, at 11:54 a.m. with and DON, the DON stated she incident on 7/14/18, around I-D informed her what N stated she informed the incident, and the a report to the SA. After she incident, the DON stated she minute checks, and a few days also needed to be placed on 15					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	told about the incid who were working to nurse (LPN)-D, and residents. The DON nurse who was car occurred, because incident confidential administrator stated minute checks, and also placed on 15 rindicated both were on 7/18/18. During interview on stated they were do to monitor her local found out about the report, and indicated resident, but was nurse and the incident gave her the mone "What is this for?" If touch her breasts, a your money" but he back. R44 indicated through her shirt, a strap, put his hand her breast. R44 strength first incident ocher again that he we touch her breasts. If don't want you to define the strength of the strength ocher again that he we touch her breasts. If don't want you to define the strength of the strength ocher again that he we touch her breasts. If don't want you to define the strength of the strength ocher again that he we touch her breasts. If don't want you to define the strength ocher again that he we touch her breasts. If the strength ocher again that he we touch her breasts. If the strength ocher again that he we touch her breasts. If the strength ocher again that he we touch her breasts. If the strength ocher again that he we touch her breasts. If the strength ocher again that he we touch her breasts. If the strength ocher again that he we touch her breasts.	ent she told the two nurses that day, licensed practical RN-B to keep an eye on both stated she did not tell the ing for R36 what actually she wanted to keep R44's il. In addition, although the d R44 was placed on 15 d a few days later R36 was minute checks, the reports e placed on 15 minute checks incident through a nursing of R44 had issues with another of sure why. 7/26/18, at 2:35 p.m. R44 happened so fast he (R36) y and she took it and said, R36 told her he wanted to and she told him, "I don't want would not take the money d he touched her breasts and then removed her shirt down her shirt and touched atted she felt assaulted, and be her with the money. After curred, R44 stated R36 told ould give her another \$10 to R44 stated she told R36, "I or this!" R44 stated she did not I confirmed the incident	F	600			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245361	B. WING_		07	/27/2018		
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP 0 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPR I ATE	(X5) COMPLETION DATE		
F 600	During interview o stated the facility's checks after their 7/23/18. RN-B sta occurred, and she administrator to st though R36 was ir minute checks we During observation until 2:20 p.m. R4-contact with R36. The facility's Abus Plan undated, indivinfliction of injury, intimidation, or purphysical harm, paidentified sexual a contact of any type also directed to the an incident, staff with protect residents of incidents of miscois being investigated to immediately representing Centernalso directed the factorial would review all interesidents. The IJ that began 7/27/18, at 3:50 p. an investigation of training was provided administrator, R42 checks, R36 was monitoring to ensure the state of the state	n 7/26/18, at 4:36 p.m. RN-B stopped R36's 15 minute morning meeting on Monday, ted no additional incidents was directed by the op the 15 minute checks, even a R44's room after the 15	F 60					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVE COMPLETED	
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F 609	mistreatment and en Prevention/Vulneral all staff were educated Prevention/Vulneral educated on the real and the administrate the Abuse Prevention specific to reporting abuse. On 7/27/18, front line staff and restated they were educated to potential for more than the severity level of potential for more tha	e free from abuse, neglect, exploitation, the facility Abuse ble Adult Plan was reviewed, ted on the Abuse ble Adult Plan, staff were ason for resident monitoring, or and DON were educated on on/Vulnerable Adult Plan president abuse and sexual from 3:15 p.m. to 3:45 p.m. nurses were interviewed, and lucated on the Abuse ble Adult policy, and the d R36's increased monitoring. It is remained at the lower scope of D which is isolated with the nan minimal harm.	F 6				9/10/18

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245361	B. WING		07/	27/2018
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	§483.12(c)(4) Rep investigations to the designated represe accordance with S Survey Agency, wi incident, and if the appropriate correct This REQUIREME by: Based on observative review the facility abuse were report hour to the State A (R44) who alleged Findings include: R44's admission Medated 4/27/18, indicated she diagradjustment disorder indicated she diagradjustment. R44' (CAA) dated 4/27/18 assistance with according impulsive R36's admission Medated she diagradjustment and orient and being impulsive R36's admission Medated she diagradjustment and orient and being impulsive R36's admission Medated she diagradjustment and orient and being impulsive R36's admission Medated she diagradjustment and orient and being impulsive R36's admission Medated she was cognitively assist of two with A Comprehensive Caweakness and was according to the shear of the	ort the results of all e administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced Ition, interview and document failed to ensure allegations of ed immediately, no later than 2 gency (SA) for 1 of 1 residents sexual abuse. Innimum Data Set (MDS) cated she was cognitively ensive assist of one with ving and used a wheelchair for are plan dated 5/02/18, noses including depression, er, dementia and mild cognitive is Care Area Assessment 18, indicated she required tivities of daily living (ADLs), and with deficits in judgement the. IDS dated 06/13/18, indicated intact and needed extensive	F 6	 Reporting of Alleged Violation R44 remains in the facility frabuse and neglect Resident allegations of abus neglect will be reported timely pervention/Vulnerable Adult Plat Staff will be re-educated on Prevention/Vulnerable Adult Plat to timeliness of reporting Audits of all OHFC reports a grievances specific to allegation abuse/neglect, specific to ensur reporting, investigation, interven protection of residents(s) are implemented timely including incomitoring and thorough investig be completed weekly x 4 weeks every other week x 8 weeks; the x 6 months; then as needed Administrator or designee w responsible party QAA will provide redirection when necessary to ensure compand/or continuation of monitoring Completion Date: 9/10/2018 	ee from se and/or er Abuse the Abuse specific and 6 s of ng correct tions and crease gation will then n monthly ill be or change oletion g process	

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F 609	R36's CAA dated 6 and orientated and at his previous livin R36 planned to return During interview 7/2 administrator stated Saturday 7/14/18, the not sure what time then stated she was she reported the indicated that night due to an A facility report sub Health Complaints (11:29 p.m.) indicated duty another reside closed the door, and touch her breast, whim to stop, which I further indicated restouch her breast. A initiated. A Facility 7/23/18, at 18:19:0 was reviewed and a discuss the inciden originally indicated accept the cash an her. After a converfacility she did in fa The victim said she went into her room, The victim said she went into her room, The victim stated perpetrator down to door and she allow and she allowed a	/13/18, indicted he was alert received therapy due to a fall g situation. The CAA indicated	F	609			

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	PROVIDER OR SUPPLIER	ATION CENTER, LLC		600	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH DAVIS AVENUE CHFIELD, MN 55355	,	
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F 609	encounter and wish facility indicated on on 15 minute check informed of the vict and he agreed. During interview on the DON and admin stated she was info 7/14/18, around 9:00 the DON returned to parade. The DON the incident and stareport. Although the facility incident that occurr time. The facility be at 9:00 p.m. and the the state agency unlater. The facility Abuse F Plan dated 7/18, incinfliction of injury, unintimidation, or pun physical harm, pain defined sexual abus contact of any type	nge 32 ned for him to stay away. The the report the victim was put as and the perpetrator was im's wishes to not meet again 7/26/18, at 11:54 a.m. with enstrator present, the DON ormed of the incident on 20 p.m. by a floor nurse, after to the facility from the town informed the administrator of ated the administrator filed the administrator filed the administrator of the ed on 7/14/18, at unknown exame aware of the allegation is incident was not reported to atil 11:29 p.m., two half hours Prevention/Vulnerable Adult dicated Abuse is the willfully nreasonable confinement, ishment with resulting in or mental aguish. The policy se at non-consensual sexual with a resident. The policy and Abuse shall be reported to	F6	009			
	OHFC (state agence later than 2 hours a abuse. Investigate/Prevent CFR(s): 483.12(c)(s §483.12(c) In response	cy) online reporting process not after forming the suspicion of Correct Alleged Violation	F 6	10			9/10/18

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245361	B. WING		07/27/2018		
	PROVIDER OR SUPPLIER	TATION CENTER, LLC	ε	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355			
(X4) ID PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ON	
F 610	survey Agency, wincident, and if the appropriate correct This REQUIREME by: Based on observareview the facility fallegations of sext (R44) who had an Findings include: R44's Minnimum I indicated she was extensive assist or living and used a vare plan dated 5 diagnosis of deme impairment. R44' (CAA) dated 4/27/ with activity of dail with deficits in judging sinclude; and the sum of	e evidence that all alleged bughly investigated. Went further potential abuse, but, or mistreatment while the	F 610	F610 – Investigate/Prevent/Correct Alleged Violation R44 remains in the facility free fabuse and neglect Resident allegations of abuse an neglect will be thoroughly investigate Abuse Prevention/Vulnerable Adult II Staff will be re-educated on the Prevention/Vulnerable Adult Plan sp to thorough investigations. IDT will rand discuss all investigations to enscorrect reporting, investigation, interventions and protection for residere implemented timely. Final review be completed and submitted by Administrator and/or facility consultated in Audits of all OHFC reports and grievances specific to allegations of abuse/neglect, specific to ensuring or reporting, investigation, interventions protection of residents(s) are	nd/or ed per Plan. Abuse ecific eview ure dent(s) v will ent(s). So		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245361	B. WING		07/:	27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC	6	STREET ADDRESS, CITY, STATE, ZIP CO 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 610	cognitively intact at two with activities of Comprehensive C weakness and was care plan further in R36's CAA dated and orientated and at his previous livin he planned to return the planned to show and touch him back his \$10.0 to show and touch him back his \$10.0 to show and touch he night the incides stated the DON are aware she wanted. A facility report sulfured the planned to touch her beast. A similar to touch her beast. A similar to touch her breast. A similar the planned the planned to touch her breast. A similar the planned the	and needed extensive assist of of daily living. R36's Initial are Plan indicated he had a salert and orientated. The indicated he had no behaviors. 6/13/18, indicted he was alert a received therapy due to a falling situation. The CAA indicated	F 610	implemented timely including monitoring and thorough inverse be completed weekly x 4 week every other week x 8 weeks; x 6 months; then as needed • Administrator or designer responsible party • QAA will provide redirection when necessary to ensure control and/or continuation of monito • Completion Date: 9/10/20	estigation will eks; then then monthly e will be on or change empletion ring process	

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/	27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE .ITCHFIELD, MN 55355		
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F 610	not accept the cash touch her. After a informed the facility \$10.00 in cash. The alleged perpetrolosing the door be said someone know them to keep it ope (R36) then suggest Victim (R44) stated perpetrator (R36) of closed the door and to touch her breast she did not want arror him (R36) to state on the report the vicination of the vici	n and did not want him (R36) to conversation, R44 then y she did in fact accept the ne victim (R44) stated she and ator (R36) went into her room, whind them. The victim (R44) cked on the door and asked en. The alleged perpetrator ted they go down to his room. If that she followed the down to his (R33's) room, they d she (R44) allowed him (R36) is. Victim (R44) did state that nother encounter and wished any away. The facility indicated ctim (R44) was put on 15 the perpetrator (R36) was tim's (R44) wished to not meet	F	510			
	informed her that F touched her breast stated she talked to touching R44's bre	ted the investigation and R44 R36 offered her \$10.00 and s. In addition the administrator of R36 and he did admit to asts and she informed him that hat to happen again.					
		ty progress notes did not t of sexual abuse that occurred R36 on 7/14/18.					
		26/18, at 10:53 a.m. R36 a at the facility for several					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245361	B. WING		07	/27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP C 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
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F 610	months and the ad the incident that oc administrator told in come around her. During interview 7/2 social worker (LSW and pieces of the ir was not involved. I like this are discuss she had to step out further stated she incident with R36. During interview 7/2 DON and adminstrator formed of the incipent. She administrator of the filed the report. She filed the report. She filed the report. She filed the report of the filed the report. She filed the incident occurr in R44's room. R44 was interviewed about the incident to between herself an incident happened and I took it and sa stated he wanted to him "I don't want hit take the money backer breasts thru he spaghetti strap and and touched her breasts thru he spaghetti strap and the	age 36 ministrator talked to him about curred on 7/14/18. The ne that R44 did not want me to I told the administrator "O.K." 26/18, at 11:09 a.m. licensed I/)-A stated she had heard bites neident on Monday and she LSW-A further stated situations sed at morning meeting but a during the meeting. LSW-A had not talked to R44 after the lator. The DON stated she was ident 7/14/18, around 9:00 med to the facility from the DON stated she informed the encident and the administrator is was aware that R36 gave ched her breasts in her room. Itated, her understanding was ed in R36's (his) room, and not led on 7/26/18, at 2:35 p.m. that occurred on 7/14/18 d R36. R44 stated the so fast he gave me the money id "what is this for?" and R36 to touch my breasts and I told is money" and he would not lock. R44 indicated he touched it shirt and then removed her libut his hand down her shirt least. R44 then stated she felt he tried to bribe her and after	F6	510		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245361	B. WING_		07/	27/2018
	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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 655	touch her breasts a the incident happer. Although the facility was completed, the thorough investigati the differences betwadministrator's inveoccurred. Also, the clear if R44 accepte R36 gave her. Also facility talked with oregarding the allegar. The facility Abuse F Plan undated, directing including but not in DON, nurse managreview all Incident F Baseline Care Plan CFR(s): 483.21(a)(S483.21 Comprehe Planning S483.21(a) Baseline S483.21(a)	gain. In addition R44 stated ned in her room. It identified an investigation are was no indication that a gion was completed to identify ween the DON's and estigation of where the incident facility's investigation was not ed or declined the money that the there was no indication the other residents, or staff ation. Prevention/Vulnerable Adult ested staff to investigate including to the administrator, per and Social worker) will Reports and investigate. 1)-(3) Insive Person-Centered Care the Care Plans facility must develop and the care plan for each resident estructions needed to provide incentered care of the resident estructions needed to provide incentered care of the resident and standards of quality care. Dan mustathin 48 hours of a resident's mum healthcare information rely care for a resident mited toed on admission orders.	F 6			9/10/18

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F 655	(C) Dietary orders (D) Therapy services (E) Social services (F) PASARR recording services (F) PA	facility may develop a are plan in place of the baseline apprehensive care planithin 48 hours of the resident's irements set forth in paragraph (excepting paragraph (b)(2)(i) of a facility must provide the representative with a summary re plan that includes but is not as of the resident. The resident we mean the facility and personnel acting cility. Information based on the details sive care plan, as necessary. ENT is not met as evidenced we and document review, the mplete a baseline care plan admission for 1 of 1 residents new admissions with	F6	\$55	F655 - Baseline Care Plan R250 initial care plan and pain management plan was reviewed ar completed. Plan of care and interve have been updated and reviewed to reflect resident's pain management All current residents who have identified for base line care plans ar management have had their care p and interventions reviewed and upon Staff will be re-educated on init	entions plan. been nd pain lans lated.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
		245361	B. WING			07/2	27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		600	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH DAVIS AVENUE CHFIELD, MN 55355		
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F 656 SS=E	identified orders for management) 50 n as needed (PRN) f mg every 6 hours F R250's undated, In Plan section for pa did not identify R25 interventions to ma R250's Pain Evalua R250 had frequent pain at a 3 out of 1 tramadol 50 mg as evaluation indicate R250's sleep, but of daily living. During interview or registered nurse (F back pain and was manage her pain. F responsible for converified it had not be have been, and verified it had not be have been and verified it had not	r tramadol (narcotic for pain nilligrams (mg) every 6 hours or severe pain and Tylenol 325 PRN for mild pain or fever. itial/ Comprehensive Care in and comfort, was blank and 50's risk for pain, a goal or inage pain. ation dated 7/21/18, identified lower back pain, rated her 0, and had been taking needed for pain. The d the pain did not interfere with lid interfere with her activities a 7/25/18, at 6:50 p.m. RN)-A stated R250 had chronic admitted with tramadol to RN-A further stated she was inpleting the baseline care plan, seen completed, but should rified it should have identified inage R250's pain.	F 6		plans and pain management Audits of 3 resident initial plans and pain management will be compressed by x 4 weeks; then as needed. Director of Nursing or designed responsible party QAA will provide redirection or when necessary to ensure complete and/or continuation of monitoring party. Completion Date: 9/10/2018	oleted e will be change ion	9/10/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION		SURVEY PLETED
		245361	B. WING	i		07/2	27/2018
	PROVIDER OR SUPPLIE	R ITATION CENTER, LLC		600	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DAVIS AVENUE TCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	medical, nursing, needs that are ide assessment. The describe the follow (i) The services the or maintain the rephysical, mental, required under §4 (ii) Any services the under §483.24, §4 provided due to the under §483.10, intreatment un	neframes to meet a resident's and mental and psychosocial entified in the comprehensive comprehensive care plan must wing - nat are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and nat would otherwise be required 483.25 or §483.40 but are not ne resident's exercise of rights cluding the right to refuse (483.10(c)(6)). The deservices or specialized ices the nursing facility will let of PASARR it must indicate its sident's medical record. In with the resident and the entative(s)-signals for admission and so a preference and potential for Facilities must document ent's desire to return to the ssessed and any referrals to note and/or other appropriate are are, in accordance with the forth in paragraph (c) of this entation interview and document entities in the comprehensive care are are in accordance with the forth in paragraph (c) of this	F	556	F656 Develop/Implement Compreh	nensive	
		r failed to develop a are for 5 of 5 residents (R25			Care Plan • R25 R38 R11 R24 and R36		

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	PROVIDER OR SUPPLIEF R MANOR REHABILI	TATION CENTER, LLC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Findings include: R25's Diagnoses identified diagnose respiratory failure, status, and also in impairment. The admission date as R25's Care Area Adated 5/21/18, ideinclude and addre problems in the codirect R25's needs loss/dementia; visurinary continence dehydration/fluid respiratory rate, 0's amount, color and appearance of stofrequency of trach change; and Track During observation tracheotomy (track receiving oxygen opresented with au amount of clear se bubble-like. Licenentered the room	Report printed 7/26/18, es which included chronic dysphasia and tracheotomy dicated severe, cognitive MDS also identified R25's 5/10/18. Assessment (CAA) Worksheet ntified the following areas to ss as actual or potential emprehensive care plan, to s in the facility: cognitive ual function; communication; e; falls; feeding tube; maintenance; pressure ulcer;	F6	\$56	Comprehensive Care Plans have be reviewed and updated. • All current residents who have identified for Comprehensive Care have had their care plans reviewed updated. • Staff will be re-educated on comprehensive care plans • Audits of 3 resident comprehencare plans will be completed weekly weeks; then as needed. • Director of Nursing or designed responsible party • QAA will provide redirection or when necessary to ensure complete and/or continuation of monitoring properties. Completion Date: 9/10/2018	been Plans, and asive y x 4 will be change ion	

245361 B. WING	2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE	
MEEKER MANOR REHABILITATION CENTER, LLC LITCHFIELD, MN 55355	
	(X5) OMPLETION DATE
Subsequently provided R25 with suctioning of the trach. R25's Initial/Comprehensive Care Plan with a listed goal dated of 5/10/18, was a computer-generated document that identified numerous care and problem areas, and under each care area listed various, pre-written, scripted interventions, some of which were checked to include for R25's care. The document also included space to detail interventions not listed on the pre-printed form. R25's care plan included resident-specific interventions related to tracheostomy care. R25's care plan, as presented in the electronic heath record, identified a target date of 5/10/18, or more than two and one-half months after the start of the re-certification survey on 7/23/18. R25's care plan lacked specific, measurable, target goals and future dates for each of the care areas included in the care plan. Further, R25's care plan lacked inclusion or instruction to include physician's orders that further directed R25's tracheostomy care. When interviewed on 7/26/18 at 10:41 a.m., registered nurse (RN)-B stated after reviewing R25's care plan in the computer, that R25 did not really have a current target, and R25's care plan "was not right." RN-C stated when a resident was admitted, assessments and data collection was done to complete our initial care plans, and stated "we can use that care plan for R25 was listed as	

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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r E S III F C C T C C T C C T C C T C C T C C T C C T C C T C C T C T C C T C C T C T C T C T C C T T C T C T T C T T T T C T T C	During interview of stated a resident's included the plan, pertinent labs, the and "really any information of the content of t	rysicians orders, "but it should." n 7/26/18, at 11:41 a.m., RN-C comprehensive care plan the doctor's orders, and nursing assistant care sheets, ormation to direct one's care." omprehensive care plan ace by day twenty-one. Report printed 7/26/18, identified included congestive heart on and end-stage renal dimission Minimum Data Set 138 had intact cognition and the facility on 6/22/18. R38's ment (CAA) Worksheet dated ctivities of Daily Living (ADL) as /need to include on the care ed for supervision with be	F 65	96		

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F 656	home, and was in a heart attack, an following the incide out of the building. During observation exited his room, however, howev	the facility for "rehab" following d that he felt much better now lent. R38 also stated he went to get dialysis. In on 7/24/18, at 3:10 p.m. R38 holding on the handles of a hir, ambulated down the hallway om area. R38 was able to walk maintain balance, and showed or discomfort, and exhibited no	F 65	5		
	stated R38's care was his original, it target date for R2 current. When interviewed interim director of was some misund can use the initial stated initial/compgood start, but the	on 7/26/18, at 10:41 a.m. RN-B plan in the electronic record nitial care plan. RN-B stated the 5's care plan goals was not I on 7/27/18, at 11:44 a.m., the nursing (DON) stated there derstanding as to how long we care plan document. The DON orehensive care plans were a at residents' comprehensive to be in place by day 21 after a				

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F 656	resident admission	page 45 on. The DON stated and of the residents' care plan were d had goal target dates that were	F6	\$56			
	indicated R11 ext impairment and r complete her ADI personal cares. F included anemia, diabetes, dement	change MDS dated 4/30/18 nibited severe cognitive eceived extensive assistance to L's including mobility and R11's medical diagnoses chronic kidney disease, tia, and generalized weakness. evised on 7/23/18, identified R11					
	wounds on right f directed staff to ir interventions whice watching television family/friends condirected staff to not the use of a flow Activity, Cry, Conpain assessment stated resident wordered by prima	ration in comfort related to foot and coccyx. R11's care plan implement non-pharmacological ch included: reposition, on in her room, warm blanket, impany, music. The care plan nonitor R11's level of pain with sheet or FLACC (Face, Legs, solability)/Dementia scale, with a per protocol. The care plan as to receive medications as ry provider and staff were to fectiveness of the medication,					
	as well as potenti encourage reside encourage rest postaff to turn and re two and a half ho not slide to decre	al side effects. Staff are to ent to verbalize discomfort, and eriods. The care plan directed eposition resident every two to urs. Staff were directed to lift, ase friction. Staff were also trage resident to lie on sides					

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F 656	while in bed and of On 7/23/18, at 7:1 dining room and we resident and inquiprogressed, FM-A was crying becaumoan. At 7:27 a.m was deleased because of the amount of the company of the second of the amount of the amount of the company of the second of the amount of the company of the eleased o	offload bottom. 15 a.m R11 was observed in the was vocalizing moaning sounds. FM)-A was heard responding to ired if she was hurting. As meal asked R11 at 7:23 a.m. if she se she hurt. R11 continued to in. was heard asking R11 if she se she hurt, to which R11 FM-A was heard telling R11 she meds but they "Must not be quick and then get you laid observed to be reclined back in FM-A assisted her to eat. At is heard moaning out loud and greyes with a tissue. R11 was defined by FM-A at 7:30 B5 a.m. R11 was observed in inch was in a low position with a learn R11 made moaning wever did not verbalize response beriencing pain. R11 was resting d, brows furrowed, and lips 130 a.m. R11 was observed and displayed facial grimacing, d forehead furrowed, moisture corner of her eyes. Resident mic moaning noises, without		856			

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	PROVIDER OR SUPPLIER	TATION CENTER, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DAVIS AVENUE TCHFIELD, MN 55355		
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F 656	indicated: "Resider and rated 4/10 at w sleep and daily actindicated R11 had at 8:00 a.m. and ar assessment identif for Morphine 10 moneded, however, imedications were rassessment period included adminsitration monitoring for effects igns and symptom needed. The assessment was mould update the contractions were contracted to be interventions were on 7/25/18, at 2:14 wheelchair with her R11's eyes were contracted to provide cares, and pattern. Hospice not this time. Nursing at the provide cares, and pillow to provide fulto cry out with most room to provide as to place the mechal continued to displaintensified with phy transferred to the bear was removed. R11 open area present noted to be in placed ceased moaning with any increased positioned, RN-B at the side of th	nt states pain is occasionally vorst, and does interfere with ivities." The assessment scheduled methadone 10 mg and 5 mg at 4:00 p.m. The ied R11 had additional orders g and Tylenol 650 mg as t was indicated these	Fé	856			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/	27/2018	
	PROVIDER OR SUPPLIE	ITATION CENTER, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE O SOUTH DAVIS AVENUE TCHFIELD, MN 55355	, , , , ,		
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F 656	but did not identify offered to remove intensified with the pillow down and a blanket was place support/pressure level. R11 stated crying out/moaning pain, however, R7 with moaning. HI arms, offering wo of RN-B of recent RN-B stated she room. During interview from 7/25/18, at 2:46 probserved to be unverbalizations/vooffacial expression, repositioning, offer nurse if this was recomfort. NA-G was	y where pain was located. RN-B pillows and vocalizations is. HN provided prompts to shift assure heel was floating. A	F	656				
	p.m. R11 began facial grimaces, b	observation on 7/25/18, at 2:46 to cry out loudly, tearing up, with rows and forehead furrowed ntinuous moaning sound.						
	(LPN)-A entered r liquid and stated I PRN (as needed 2:49 p.m. R11 cor quivering and tea offered to provide	17 p.m. licensed practical nurse from to administer morphine R11 had not had not received morphine for several days. At a ntinued to cry out with lips rs present in both eyes. LPN-A R11 assist to contact family						

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245361	B. WING	<u> </u>		07/2	27/2018
	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 656	and tears were pres LPN-A placed a cal held the phone to Robserved to have lip forehead furrowed. closed and R11 was vocalizations and to me, help me, help rat this time, the hear R11 was lying on he her right leg, and H shoulder and arm in p.m. R11 continued commented with part consistently take he management. At 2: by staff, R11 spoke LPN-A checked to sphone and identified phone. R11 continuatione, of pain, and constated R11 also had when asked what in effective. LPN-A was interventions to be medication administ a family friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R11 comformation of pain and consistently friend (FF) indicated FF-A may provided R	ammm", with lips quivering, sent in corners of both eyes. I to FM-A at 2:51 p.m. LPN-A at 1's left ear and R11 was os pursed, brows and R11's eyes were squinted as actively crying with ears present. R11 stated "Helpme" crying out into the phone. ad of the bed was elevated, er back, pillows were under N and LPN-A were rubbing her n comforting motion. At 2:55 to call out. LPN-A ain management R11 did not er methadone for pain 58 a.m. while being comforted in to telephone "It hurts." see if FM-A remained on the ed to call out, in an amplified ontinued to moan. LPN-A did Ativan for symptom control interventions have been	F	356			

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	PROVIDER OR SUPPLIE	R ITATION CENTER, LLC		STREET ADDRESS, CIT 600 SOUTH DAVIS AV LITCHFIELD, MN (TY, STATE, ZIP CODE VENUE	
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F 656	On 7/25/18, at 3:2 massage hands a vocalizations dec frequency. R11 r she was sad or in hands and offere the Hail Mary and with facial expres decreased furrow tears. On 7/25/18, at 3:3 room and informs methadone was given. LPN-A stat contacted regard awaiting a script. monitored by the pharmacy. A review of the min correspondence R11 had last received a refusal of methadore was given. The dorefusal of metha	page 50 26 p.m. HN continued to and lower arms and resident reased in intensity and responded "Both" when asked if a pain. HN continued to massage d to pray with R11. R11 started d continued to repeat this prayer, rision becoming more relaxed, ring of brows, and absence of a p.m. LPN-A returned to the red HN the last dosing of given the previous evening and reformethadone had not been red pharmacy had also by the red pharmacy had been with red pharmacy had been with had been	F	556		

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F 656	resting more comformation in the low position, head of her bed rasurveyor and state. On 7/26/18, at 10:4 bed, under covers R11's facial express furrowed brows, so pursed lips. Traine was in with resider routinely scheduled dose of morphine in doing well. R11 reswhen asked. On 7/26/18, at 11: conversation FM-A 7/19/18 and again R11's pain on 7/22 FM-A reported R11 was having pain in back. R11 stated it stated R11 was ob a half hours, startic contacted staff and FM-A stated staff and FM-A stated staff and they had discuunaware of any ch stated she was at a.m. and R11 was table. FM-A descril "Kind of moaning" wrong R11 stated in the stated in the stated in the stated in the stated she was at a.m. and R11 was table. FM-A descril "Kind of moaning" wrong R11 stated in the stated	ortably at this timeupon a resident was observed in bed resting on her back with the ised, and R11 looked to d "Good morning". FF-A 45 a.m. R11 was observed in and was noted to be free from quinted/tearful eyes, and d medical assistant (TMA)-A at and stated R11 had received d methadone and an additional for pain management and was sponded she was "Pretty good." 24 a.m. during telephone a stated she been with R11 on on 7/22/18. FM-A described /18 as "really bad". On 7/22/18 I was crying, and stated she her buttocks, her legs, and her awas from laying all day. FM-A served to cry for about two and ng at lunch. FM-A stated she direquested transfer into bed. Stopped by a few times, but so when I am there they just let d the nurse on Sunday had used medications on occasion assed alternate routes, but was anges made in plan. FM-A the facility on 7/23/18 at 7:00 was crying at the breakfast bed R11 to be sitting there and when asked was was her "Butt hurt". FM-A stated if bing pain, she should have	F6	56				

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F 656	received meds. I inquired of her re soothing. FM-As watched old time show. Stated R1 and has been out aware of music ir not aware R11 ha on 7/25/18. FM-A very effective for like to use morph the way it made has contacted the adulthird week in Jun the fact R11 would be fact R11 would be for pain manager R11 was recorded 15th to the 25th op.m. shift. R11's p.m. shift for the to one. R11's pain 11:00 p.m. to 6:00 recorded at zero which time the path of the pain on 7/27/18, at 1:10 nursing (DON) steeperience pain to the pair on 7/23/18, the Dexpectation Hosp R11's increased parts of the pair on 7/23/18, the Dexpectation Hosp R11's increased parts of the pair on R11's increased parts of the P11 increased parts of the R11's	page 52 FM-A stated staff have not garding things R11 would find tated R11 previously had television like the Andy Griffith 1 enjoyed country western music to music activites, but is not her room. FM-A stated she was ad not received her methadone a stated methadone has been R11, and historically, R11 did not line as needed as she didn't like her feel. FM-A stated she had ministrator approximately the e regarding transfer of R11 and ld call out in pain with moment. The eatment administration record ment was reviewed and noted d as exhibiting no pain from the of July on the 6:00 a.m. to 2:30 pain levels from the 2:30-10:00 same period was rated with zero in monitoring sheet from the 0 a.m. pain levels were all with the exception 7/26/18 at ain level was recorded at one. The ecorded on the pain monitoring to be in conflict to observations provided by FM-A and HN. The acting director of ated if a resident was noted to with movement, the staff could be fore going to reposition. Upon a assessment being completed by Stated it would be her bice would be contacted with presence of pain to review ons and modify plan of care as	F	556			

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F 656	indicated. On 7/27/18, at 3:3 she had spoke to The administrator FM-A's concerns comfort for R11. it was difficult to a vocalizations as I vocalizations in a The administrator concerns with conturning and repost R24's annual MD identified R24 had to communicate I noted to have a curinary functions R24 received extra of daily living (AD turning and repost R24's diagnoses neurological disorgeneralized must obesity. The Care worksheet complimas at risk for prerisk factors, incluneurological diserspasms. The CA assist to turn and addition to use of and cushion in will R24's plan of care	B5 p.m. the adminstrator stated FM-A regarding R11's status. It stated she had discussed regarding management of The administrator stated at times determine underlying cause for R11 has made moaning positive manner with pet visits. It stated FM-A did express infort interventions and with ditioning of resident. S completed on 4/21/18 do intact cognition and was able inter needs and wishes. R24 was atheter in place to manage and was incontinent of bowel. Densive assist to complete tasks at L's) which included transfers, ditioning, and personal cares. Discincipled diabetes, arthritis, a reder which affected mobility, and even the diabetes, and morbid the Area Assessment (CAA) detended on 5/4/18 indicated resident dessure ulcers related to multiple ding obesity, diabetes, asses, chronic pain, and muscle A indicated R24 would receive reposition every two hours, in pressure relieving mattress, neelchair.	F	656			
	R24 received ass related to R24's le	istance to complete her ADL's evel of strength. The care plan pured extensive assistance of					

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	27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE DO SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	every two hours are to provide. The car provide with assist hygiene, including incontinence cares plan identified R24 Ostomy, Continence Hospital for wound plan was revised of alteration in skin in on her right buttool staff were to monit with documentation identify weekly would alterated Wound On 7/23/18 at 8:44 generally in bed by to turn and repositilight on. R24 stated it was painful to lay extended period of The nursing assist the heading Offloa. The care sheet did indicator of every the although other resinclude the recommendation was months of June and unavailable for 14 days possible. On	o turn and reposition in bed as necessary, in additional re plan also directed staff to ance to complete personal skin cleansing, and completion every two hours. The care went to the WOC (Wound, be) nurse at Meeker Memorial follow up and PRN. The care n 7/10/18 to identify an tegrity related to an abrasion ks. The care plan identified or skin integrity during cares, n weekly. The care plan did not and care services provided by Care. a.m. R24 stated she is 19:30 p.m. but is not assisted oned until she puts her called she had skin breakdown and in the same position for an itime. ant care sheet identified under d Reposition "Assist of two." In not provide a frequency we hours repositioning, dents care directions did mended time frame. sing assistant care is completed for R24 for the d July and documentation was days during this period of 56 12 occasions it was noted to ur hours between checks or	F	\$56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245361	B. WING			07	/27/2018
	PROVIDER OR SUPPLIE R MANOR REHABILI	TATION CENTER, LLC		600	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH DAVIS AVENUE CHFIELD, MN 55355	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 656	On 7/26/18 at 7:4 plan instructed the least every two he requested. RN-B had not been turn frequency as "R2 however, stated to During interview of director of nursing outlined turning an hours. The DON preferred not to be was the facility regarding benefits	O a.m. RN-B stated the care e staff to turn and reposition at ours and more often as stated she was unaware R24 ed and repositioned at this 4 has never come to me", ne care plan should be followed. On 7/27/18, at 1:18 p.m. the g stated the plan of care for R24 and repositioning every two went on to state if a resident e turned or repositioned then it is sponsibility to educate the client is of repositiong and to review efits. This discussion should be	F	856			
	he had weakness R36's CAA dated decisions and waneeds. R36's CA mood or behavior R36's Initial Comp 6/06/18, indicated pleasant and cool indicated he was activities they offer socialization and R44's Minimum D indicated she was A facility investigation	orehensive Care Plan dated he was alert and orientated, perative. The care plan further further encouraged to attend or in helping him with					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		E SURVEY PLETED
		245361	B. WING	_		07/:	27/2018
NAME OF I	PROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
				60	00 SOUTH DAVIS AVENUE		
MEEKER	MANOR REHABILITA	ATION CENTER, LLC		L	ITCHFIELD, MN 55355		
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	1				BEHOLINGTY		
F 656	nurse on duty anoth into her (R44) room money to allow him did. Victim (R44) a did, then he left the indicated R44 does breast. An Internal Facility Investigation 7/23/18, at 18:19:07 was reviewed and a discuss the incident originally indicated and did not want him conversation, R44 if fact accept the \$10 and the alleged per room, closing the dialect (R44) said someone asked them to keep perpetrator (R36) this room. Victim (R44) want another encoustay away. The fact victim (R44) was put the perpetrator (R36) (R44) wishes to not agreed. During interview 7/2 stated R36's care pubehaviors and should add the control of the control	indicated R44 reported to her resident (R36) had gone and closed the door, and offered to touch her breast, which he sked him to stop, which he room. The report further not want him to touch her investigation was initiated. An five day report dated indicated R44's care plan administrator met with R44 to the investigation report R44 did not accept the cash in to touch her. After a informed the facility she did in an accept the cash in the investigation report R44 did not accept the cash in the touch her. After a informed the facility she did in an accept the cash in the touch her into her cor behind them. The victim is knocked on the door and in the interest of the investigation in the interest of the interest	F	656			

Although R36 exhibited behaviors of sexual

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F 656	indicate this. R44's Admission Reindicated she had meakness and mild R44's CAA dated 5/2 in ADL's due to need dressing, bathing, gaddition the CAA in urinary incontinence of urin R44's Initial Compression of the completed she was awanot completed. RN the care plan must then she was told sindicated she was told sincontinence.	ecord printed 7/26/18, najor depression, muscle cognitive impairment. 7/05/18, indicated she triggered eding extensive assist in grooming and transfers. In dicated she triggered in e due to having occasional ite. essive Care Plan dated she needed assist in ADL's and e care plan dated 5/02/18, iter assistance needed in	F6	56		
	completion of reside was requested, but Activities Daily Livin CFR(s): 483.24(a)(he development and ent comprehensive care plans none was provided. ng (ADLs)/Mntn Abilities 1)(b)(1)-(5)(i)-(iii) on the comprehensive sident and consistent with the	F 6	76		9/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 676	resident's needs a provide the necessensure that a residually living do not of the individual's of the individual's of that such diminution includes the facility §483.24(a)(1) A retreatment and servor her ability to carliving, including the of this section §483.24(b) Activition The facility must paccordance with pactivities of daily living grooming, and orativities of daily living sativities	and choices, the facility must sary care and services to dent's abilities in activities of diminish unless circumstances clinical condition demonstrate on was unavoidable. This y ensuring that: sident is given the appropriate vices to maintain or improve his rry out the activities of daily ose specified in paragraph (b) es of daily living. rovide care and services in aragraph (a) for the following ving: iene -bathing, dressing, Il care, bility-transfer and ambulation, mination-toileting, ng-eating, including meals and munication, including all communication systems. ENT is not met as evidenced	F6	776	E676 Activities Daily Living/ Maint		
	the facility failed to	ation, interview and document implement a therapy			F676 Activities Daily Living/ Mainta Abilities R23 was reviewed for restorati		

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F 676	Findings include: R23's significant of (MDS) dated 4/17 moderate cognitive functional limitation lower extremity. Rassistance with midiagnosis of arthrif (ADL) Care Area (A/30/18, identified 4/9/18, and was sereceiving physical a goal to utilize her of the company of the com	sistently for 1 of 1 residents d staff assistance with walking. Change Minimum Data Set /18, identified R23 had e impairment, and had a in in range of motion to one 23 needed extensive obility. The MDS identified a tis. R23's activities of daily living Assessment (CAA) dated R23 fractured her right hip on urgically repaired. R23 was and occupational therapy with er walker again. O a.m. R23 was seated in a room. She had a seated four the corner of her room. R23 oke her right hip a few months posed to be walked twice a day staff were not walking her as a secommendations dated 5/9/18, walk R23 with her four wheeled the one staff member twice daily. Evised on 7/21/18, identified R23 ance of one to walk. R23 has a ion program, which directed twice a day to promote daily maintain and improve her		376	nursing ambulation. Plan of care ar interventions have been updated at reviewed to reflect restorative nursi ambulation. • All current residents who have identified for restorative nursing ambulation have had their plan of cand interventions reviewed and upor each will be re-educated on prodocumentation of restorative nursing ambulation • Audits of 3 restorative nursing ambulation will be completed week weeks; then as needed • Director of Nursing or designed responsible party • QAA will provide redirection or when necessary to ensure complete and/or continuation of monitoring p • Completion Date: 9/10/2018	nd ng been sare dated. oper ng ly x 4 e will be change ion	

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F 676	- May 2018, identifit to walk were docun - June 2018, identifit to walk were docun - July 2018, identifit walk and were docu During interview on assistant (PTA)-As recommendations a staff and the nursin with the therapy recommendations of the supposed to walk F day shift and once a stated R23 "probable day. The staff were only occasionally didocumented reside charge nurse know During interview on stated if the nursing applicable in the nursing applicable in the nursing applicable in the nursing applicable in the nursing assistants of the supposed to walk F day shift and once of the staff were only occasionally didocumented reside charge nurse know During interview on stated if the nursing applicable in the nursing applicable in the nursing applicable to wants of the supposed for the supposed fo	ed 16 out of 24 opportunities nented as not applicable. iied 12 out of 29 opportunities nented as not applicable. ed 19 out 37 opportunities to umented as not applicable. 7/26/18, physical therapy tated the physical therapy were given in writing to nursing g staff were to follow through commendations. 6 a.m. nursing assistant ursing assistants were 823 twice a day, once on the con the evening shift. NA-A ly" did not get walked every to offer walking to her and d she refuse. The aids then nt refusal and were to let the 1. 7/26/18, at 3:01 p.m. NA-B g assistants chart not ursing rehab section it meant it d was not completed. 20 17/26/18, at 3:03 p.m. 21 18/28 at 3:03 p.m. 22 23 was on a ded walking program. The were to let her know if they alk R23 or if she refused so a deep put in the residents chart. The R23 was not walking as applicable meant the task as applicable meant the task.	F6	76			
F 686		Prevent/Heal Pressure Ulcer	F 6	86			9/10/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	resident, the facili (i) A resident rece professional stand pressure ulcers a ulcers unless the demonstrates tha (ii) A resident with necessary treatment with professional promote healing, new ulcers from of This REQUIREMI by: Based on observ review, the facility comprehensive as related to pressur pressure ulcer interested to pressure development of m residents (R24, R pressure ulcers. T R24 and R11 who ulcers as a result adequate interver Findings include: Pressure Ulcer st Pressure Ulcer Ac Stage 1 Pressure erythema of intace	ntegrity essure ulcers. exprehensive assessment of a ty must ensure that- ives care, consistent with dards of practice, to prevent end does not develop pressure individual's clinical condition to they were unavoidable; and pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent leveloping. ENT is not met as evidenced ation, interview, and document endited to conduct a essessment/reassessment enders and implement erventions to reduce the risk of enultiple pressure ulcers for 2 of 2 11) who were reviewed for This resulted in actual harm for developed multiple pressure of friction and shear without entions. ages defined by the National divisory Panel (NPUAP): Injury: Non-blanchable to skin	F 686	F686 Treatment/Svcs to Prevent/he Pressure Ulcer R24 was reviewed and assesserisk of pressure ulcers. R24 has be reviewed and plan of care and interventions have been updated to pressure ulcer interventions. R11 had ischarged. All current residents who have identified for pressure ulcers, interventions and plan of care have reviewed and updated to reflect preulcer interventions. The DON or designee will province-education to all appropriate staff comprehensive assessments/reassessments and pressure ulcer interventions to reduct of skin breakdown.	ed for en reflect as been essure ide on	
	review, the facility comprehensive as related to pressur pressure ulcer into development of more residents (R24, R pressure ulcers. TR24 and R11 who ulcers as a result adequate interver Findings include: Pressure Ulcer st Pressure Ulcer Acceptable 1 Pressure erythema of intact Intact skin with a serial related to the pressure under the serial resident and the ser	failed to conduct a ssessment/reassessment e ulcers and implement erventions to reduce the risk of nultiple pressure ulcers for 2 of 2 11) who were reviewed for This resulted in actual harm for developed multiple pressure of friction and shear without ations. ages defined by the National dvisory Panel (NPUAP):		Pressure Ulcer R24 was reviewed and assesser risk of pressure ulcers. R24 has been reviewed and plan of care and interventions have been updated to pressure ulcer interventions. R11 had ischarged. All current residents who have identified for pressure ulcers, interventions and plan of care have reviewed and updated to reflect preulcer interventions. The DON or designee will province-education to all appropriate staff comprehensive assessments/reassessments and pressure ulcer interventions to reduce the reducation of	ed for en reflect as been essure ide on	

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F 686	pigmented skin. Ferythema or char or firmness may in changes do not in discoloration; the pressure injury. Stage 2 Pressure loss with exposed Partial-thickness dermis. The would moist, and may a ruptured serum-fivisible and deeper Granulation tissurpresent. These in adverse microclir the pelvis and should be solved in the ullepibole (rolled wo Slough and/or es of tissue damage areas of significat wounds. Underm Fascia, muscle, the and/or bone are robscures the extendistriction of tissue discolutions with the present of tissue discolutions. Underm Fascia, muscle, the and/or bone are robscures the extendistrictions skir full-thickness skir	Presence of blanchable ages in sensation, temperature, precede visual changes. Color aclude purple or maroon se may indicate deep tissue. Injury: Partial-thickness skin dermis loss of skin with exposed and bed is viable, pink or red, lso present as an intact or lled blister. Adipose (fat) is not ar tissues are not visible. e., slough and eschar are not juries commonly result from mate and shear in the skin over ear in the heel. Injury: Full-thickness skin loss is of skin, in which adipose (fat) cer and granulation tissue and bund edges) are often present. Char may be visible. The depth varies by anatomical location; and adiposity can develop deep anining and tunneling may occur. Endon, ligament, cartilage not exposed. If slough or eschar ent of tissue loss this is an escure Injury.	F	pre ass inte cor X 2 QA	essure ulcers for comprehe sessment and proper press erventions in place, This will nducted weekly X 4, and the 2. Audit results will be reviewall Committee for further commendation. Completion Date: 9/10/20	sure ulcer Il be en monthly ewed by		

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	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP 0 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 686	Stable eschar (i.e. erythema or fluctu limb should not be R24's annual Mini 4/21/18, identified was able to comm The MDS identifie indwelling urinary urinary functions, and identified diagnosed disorder which affirmuscle weakness identified R24 was pressure ulcers, a devices for R24's identified as received than for foot proble identify R24 had a R24's Care Area Adated 5/4/18, indicentified ressure ulcers rethat included obesidiseases, chronic CAA indicated R24 to turn and reposition wheelchair.	dry, adherent, intact without ance) on the heel or ischemic e softened or removed. mum Data Set (MDS) dated R24 had intact cognition and funicate her needs and wishes. It describes a set of the result of the res	F 6					
	received assistand to her level of stre R24 required exte	ce to complete her ADLs related ngth. The care plan indicated nsive assistance of two staff to a in bed every two hours, and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ()		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 686	as necessary. The provide R24 with as hygiene including s of incontinence car plan identified R24 Continence (WOC) wound follow up, as plan was revised or abrasion on R24's identified staff were during cares, and to documentation. The identification of wee provided by Integra consultant). The nursing assistate heading Offload The care sheet lack hours repositioning. During observation nursing assistant (Name to provide cleansing turning onto the left coccyx, gluteal clef extending down frowere covered with to wash this area wapplied Calmosepti will come in to assect concerns. NA-K stasore that it bleeds" bleeding last week.	care plan also directed staff to esistance to complete personal kin cleansing, and completion es every two hours. The care went to the Wound, Ostomy, nurse at the hospital for and as needed (PRN). The care of 7/10/18, to identify an right buttocks. The care plan is to monitor skin integrity of complete weekly estare plan lacked ekly wound care services ted Wound Care (wound care and care sheet identified under a Reposition "Assist of two." and the frequency of every two as directed by the care plan. On 7/23/18, at 9:02 a.m. NA)-K provided assistance to dressing and grooming for sted peri cares, and proceeded to abdominal folds. Upon a side to complete cares, R24's to abdominal folds. Upon a side to complete cares, R24's to abdominal folds. When the cream and skin mouttocks to upper thighs white cream. NA-K proceeded with soap and water and the nurses are as if there are a sted at times the area is "So adding the areas were"	F6	86				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 686	thigh had an area appearance and morentimeters (cms) shape. R24's left in measuring approx R24 also had an aregistered nurse (If The area had appropriet appears were considered and appropriet and RN-B. Upon more as were considered and RN-B. Upon more and RN-B. Upon more and RN-B completed in follows: Left buttocks area was described by The alteration in signerizectal area was by 2.4 cm. Right buttocks are cm. During interview word and reposition and reposition and reposition and reposition until shear. To request reposition until shear.	macerated with a slough-like neasured approximately 18 by 23 cms in a triangular outtocks had a smaller area imately 13 cms by 13 cms. rea on her labia, which RN)-B described as, "Scabs." roximately a 5 cm area with s) drainage. RN-B stated these ered friction or sheering, area would not be blanchable. In on 7/26/18, at 7:21 a.m. re provided with NA-F, NA-L, emoving the incontinence ted R24's areas had a build up During provision of care, R24 rea was "Sore" and "It burns." reasurement of the areas as was 17 cm by 11.6 cm and RN-B as oval in shape. In integrity on the labia and is measured by RN-B at 3.7 cm a measured at 9.9 cm by 9.5 with RN-B (during provision of d R24 should be off loaded ving pressure from affected ioned every two to two and a commented aloud that on	F	386			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07	/27/2018	
	PROVIDER OR SUPPLIER R MANOR REHABILI	TATION CENTER, LLC		600 S	T ADDRESS, CITY, STATE, ZIP CODE OUTH DAVIS AVENUE HFIELD, MN 55355	<u>, , , , , , , , , , , , , , , , , , , </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRICED TO THE APPRICED TO THE APPRICED OF THE APPRICED O	JLD BE	(X5) COMPLETION DATE	
F 686	Immediately followskin measuremen RN-B reviewed the directed staff to the every two hours a RN-B stated the plant would cause increheat, which would letting it dry out," in pressure. RN-B stand being reposition informed her of the Areview of the Interproximately 7:4 following findings: 6/5/18: R24 was identified thickness buttock 1 week. The would was not healed, a (cm) length by (X) squared (sq) cm. 6/12/18: A single partial this listed with measurement amount of second reviewed.	wing the provision of cares and ts on 7/26/18, at 7:21 a.m. e plan of care for R24 which rn and reposition R24 at least nd more often as requested. resence of an incontinence pad tased moisture sweat/body "keep the wound moist, not ncreasing effects of friction and tated she was unaware of R24 oned, adding R24 had not is concern. The egrated Wound Care (Wound WCC) progress note was N-B on 7/26/18, at 5 a.m. which identified the distribution of the measured 9 centimeters of the measured 9 centimeters of the wound was rements recorded of 2 cm th; with an area of 4 sq cm. A derous drainage (clear, thin, was noted, with the peri-wound with t	F	586				
	A single partial thi listed with measur	ckness buttock wound was rements recorded of 0.5 cm ridth; with an area of 0.25 sq						

1 ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 686	and the surroundin dictation identified, 6/26/18: A single partial thic listed with measure length X 0.5 cm wicm. Again, scant sand the surroundin dictation identified, 7/3/18: R24 was now iden wounds. Right buttocks: Pawith a status of noin length by 3 cm in Left buttocks: Mixe healed. Measurem in width. Wound state week of 7/10/1 7/17/18: Right buttocks: Mixe status denoted as Left buttocks: Mixe Deteriorating. A monot documented by 7/24/18: Right buttocks: Pa Not healed. Measuref buttocks: Mixe Deteriorating.	erous drainage was observed ag skin was normal. The "The wound is improving." skness buttock wound was ements recorded of 0.5 cm dth; with an area of 0.25 sq erous drainage was observed ag skin was normal. The "The wound is improving." tified to have two buttock rtial thickness mixed disease thealed. Measurement of 1 cm width. End pressure/ friction area, not lents of 1 cm in length by 5 cm atus: Deteriorating. by WCC was not completed on 8.	F 68	36				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 \ /	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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F 686	deterioration in skir should have been of causes of the deter A review of the facing Pressure Wound E 5/29/18, to 7/26/18 5/29/18: Coccyx: (site unspere completed of the widentified" was recompleted of the widentified was recompleted of the widentified of the	condition, an assessment done to address the potential rioration. Ity documents titled, Weekly valuation, were reviewed from which identified the following: ecified): Shearing with noments. No staging was ound. A "Date wound orded of 5/22/18. Further, has improved and not as reduced." cified): Shearing with noments. No staging was ound. Further, "Sheering [sic] and more pink, less painful for cified): Shearing with noments. No staging was ound. Further, "Sheering [sic] ize and now only over the not past the buttock." cified): Shearing with noments. No staging was ound. Further, "Sheering [sic] ize and now only over the not past the buttock."	F6	886			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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F 686	Three wounds we Coccyx (Site uns cm. Stage 2 Coccyx (Site uns cm. Stage 2 Coccyx (Site uns measurement) Si Narrative note inc being healed, wit areas on her left 7/10/18: No documentation Addressed skin coccyx (Site uns 14 cm Narrative note ide two to transfer wite identify frequency offloading. 7/20/18: Buttocks (Site uns identify frequency offloading. 7/20/18: Buttocks (Site uns identify frequency offloading. 7/24/18: Buttocks (Site uns identify frequency offloading. 7/26/18: Right buttocks: Prediction of the community of the community identified). Left buttocks: Prediction of the community identified). Narrative note incrisk and benefits	pere now listed. pecified): Sheering: 1 cm x 3 pecified); Sheering: 1 cm x 5 pecified): Sheering: (no tage 1 dicates that coccyx is close to h the exception of two open coccyx. In to reflect areas on coccyx. In the refl	F	586			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 686	A review of the nudocumentation was months of June and documentation was during this period occasions it was rehours between characteristic refusing to be turn. On 7/27/18, at 1:1 open areas were 7/26/18, by RN-B stated she was ur turned and reposit however, stated sto do so at times. should be reflected DON stated when assessment for prompleted, and stong completed, and stong is the reviewed the 7/26/18, which incompleted is the reviewed the 7/26/18, which incompleted is the reviewed the 7/26/18, which incompleted is the reviewed the routine reposition, decomfort if not rout of routine reposition, and stated commentation of reposition, and stated commented if this review of risks an positioning is a reskin care concern	<u> </u>		886			

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F 686	been completed, no care plan prior to 7/ The WCC was calle regarding R24's ski returned the phone The WCC stated sh care, and received 6/5/18. The WCC s caused by a mix of shearing. The WCC had deteriorated as notes, and there we involved for R24. The frequency of repositioning R24, a while laying on her	ed on 7/27/18, at 2:46 p.m. n condition. The WCC call on 8/1/18, at 4:45 p.m. ne does consultation for skin a consultation for R24 on tated R24's skin condition was things: pressure, friction, and consultation stated the pressure ulcer identified in the progress are multiple areas that were his was related to lack of tioning R24, the process of and items underneath R24 bed or up in her wheelchair.	F6	86			
	indicated R11 exhibitimpairment and recomplete her ADLs personal cares. R1 anemia, chronic kiddementia, and geneidentified R11 was in pressure ulcer or good development of add R11 had an unhealer R11's most severe noted to be eschart identified as having and bed, and receive Review of the Hosp	ange MDS dated 4/30/18, bited severe cognitive seived extensive assistance to including mobility and 1's diagnoses included liney disease, diabetes, eralized weakness. The MDS dentified as having a Stage 1 reater, was at risk for ditional pressure ulcers, and led Stage 1 pressure ulcer. In stage of pressure ulcer was a pressure reduction chair ared pressure ulcer care.					

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F 686	R11's care plan rewas at risk for alte immobility, incontindiagnosis of hyperstaff to turn and reand a half hours. Solide to decrease for to encourage R11 to offload the preseplan identified that regarding on her the right side of the position. Review of the facili indicated R11 receand had, "Pressure coccyx. Resident from the coccyx is smaller awas being repositions as needed (PRN). incontinent of bow incontinence pad to the documentation treatment for the coccy, with two pillosupport her foot of	vised on 7/24/18, identified R11 ration in skin integrity related to hence, weight loss, and tension. The care plan directed position R11 every two to two staff were directed to lift, not riction. Staff were also directed to lie on her side while in bed sure on her bottom. The care the care plan was updated sure ulcer on the coccyx on and repositioning was 8 (during survey) from every 2 2 hours. In on 7/23/18, at 8:33 a.m. R11 bed on her back with a mat on a bed, with the bed in the low eity progress note of 7/23/18, ived a bed bath that morning er ulcers on right heel and and is light red in color." R11 oned every 2- 21/2 hours and The note indicated R11 was all and bladder, and wore an oral aide in keeping the skin dry. In did not reflect a plan of occyx pressure ulcer. In on 7/24/18, at 2:28 p.m. R11 are room resting on her her lows under her right leg to for the bed. There were no in place to attempt to alleviate.	F	886			

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F 686	A review of the WC indicated R11 had a 1 cm x 1 cm as WC assessment by the however, the WCC visit. The narrative Mepilex (soft silicon trauma to the press R11's coccyx, and Additional intervent included for staff to two and a half hour pressure reduction hospice recommencares, and weekly The WCC docume to lay down in bed. During observation was seated in her velevated on foot relevated to transconstant, rhythmic was present in room in response to R11 reposition R11's rig continued to cry outhen entered the roassistance to transcontinued with a coassisted to transfer mechanical lift. An room and hospice runsure if this was rebowel incontinence brief beincontinence brief beincontinence brief beincontinent of bowel area present on he	age 73 CC wound note of 7/24/18, a reddened area on her coccyx CC had noted per the narrative nurse manager on 7/17/18, a did measure the wound at the note directed staff to apply a ne foam dressing minimizes sure ulcer) dressing border to change every three days. A did measure the WCC or reposition R11 every two to res, air mattress to bed, cushion in wheelchair per adations, daily skin checks with skin assessments by nurse. That into indicated R11 preferred on 7/25/18, at 2:14 p.m. R11 wheelchair with her legs sts. R11 was sitting with her a furrowed, and moaning in a pattern. The hospice nurse m. NA-G entered R11's room crying out. NA-G proceeded to that leg, however, R11 the with a moaning noise. RN-B form to provide NA-G fer R11 into bed. R11 onstant moan while being to the bed with the use of acidic odor was noted in the registered nurse (HRN)-A was elated to the pressure ulcer or registered R11's recovery with no dressing in the did this area was not present and requested R11's recovery with no dressing in the did this area was not present.	F6	886			

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F 686	when she last say on the incontinent HRN-A as circular measured 2.5 cm two areas on the HRN-A stated it at The area on the I and the second might side of the control of th	w R11. The coccyx had drainage ce brief which was described by r, blood tinged drainage and by 2 cm. The coccyx also had left side which were moist and appeared, "as if it could slough." eft measured 2.5 cm by 1 cm, measured 1.8 by 0.6 cm. On the occyx there was an open area with a center bridge of sloughing 0.3 cm in width and 1.0 cm in ted the WCC had instructed area open without placement of HRN-A placed an Allevyn sacral g that removes fluid) to the open cyx. Once R11 was positioned, where her pain was. RN-B e some of R11's pillows and his of pain intensified. HRN-A was to shift the pillow down and	F	686				
	7/25/18, at 2:46 puncomfortable as verbalizations/voo and facial expres assist to reposition would advise the providing comfort positioning for are but did not indica alleviate pressure she was unsure of On 7/25/18, at 3:3 and requested or coccyx. RN-B sta	following provision of cares at o.m. NA-G stated R11 was a evidenced by calizations, moving in the chair, sions. NA-G stated she would on, offer to lay down, and then nurse if this was not beneficial in at NA-G stated the importance of eas identified on R11's right foot the any specific interventions to e on R11's coccyx. NA-G stated of specific interventions for this. 36 p.m. HRN-A met with RN-B ders for wound care to R11's atted the WCC followed the care needs. HRN-A stated the						

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F 686	area on R11's coor recent visit. A copy Interdisciplinary Te 7/20/18, indicated was healed at that On 7/26/18, at 11:2 stated R11's pain I bad." On that day, observed crying or hurt once she had stated R11 cried or half hours on 7/22/by propelling her in the wheelchair were R11 ceased crying family request. This three hours between staff will usually no R11 when family is 7/23/18, at 7:00 a. and moaning while expressed pain in had spoken to the repositioning for R and had agreed up reposition her ever stated earlier in Juperiod of one weel return visit, she ob "bedsore." On 7/27/18, at 1:3' aware R11 had a runaware of any op DON stated with o open area of the c should be contacted.	cyx had been healed with most of the Hospice am (IDT) note identified on a wound on R11's buttocks	F6	586			

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F 686	program to assure anything should be noted on 3/29/18, at the length of time parea of the body) at R11. The DON statt tolerance assessment completed with the area, a significant of into Hospice. The Edidentified triggers for she was unaware of R11's family. On 7/27/18, at 3:35 she had spoken to concerns about R1 and R11's pain mar stated she had follow the concerns related. The administrator is determine the undervocalizations at time vocalization in a poop of 7/27/18, at 2:46 review current skin treatment for R11. If form the WCC on 8 stated she had initial most recently on 6/R11's Stage 3 press 2.5 cm by 2.5 cm. To by the WCC was be measurement of 7/measurement as a on R11's coccyx. A obtained with HRN-	age 76 completion, and determine if done differently. The DON a tissue tolerance (to determine ressure can be tolerated to an assessment was completed for ed a subsequent tissue ent should have been development of a pressure change, and with enrollment DON state R11 met all three or evaluation. The DON stated of any concerns addressed by a p.m. the administrator stated FM-A regarding the family's 1 not being positioned timely, agement. The administrator owed up with staff regarding dot turning and repositioning. Stated it was difficult to enlying cause of R11's es, because R11 made similar sitive response to pet visits. In p.m. The WCC was called to conditions, and plan of A phone call was returned by 1/1/18, at 4:45 p.m. The WCC atted wound care consultation 12/18. Initial measurements of sure ulcer on the coccyx were the narrative note of 7/24/18, as don't he nurse manager's 17/18, which indicated wound 1 cm x 1 cm reddened area areview of measurements. A on 7/25/18, at 2:14 p.m. observed to have had	F 6	886			

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F 686	drainage on the incidescribed by HRN-drainage, and meast coccyx also had two were moist and HR could slough." The cm by 1 cm, and the cm. On the right sict open area was 2.5 of slough present m 1.0 cm in length. The cause of the pressuand stated it was in every two hours. The were caused from so in bed on her back, important to reposit utilize the pressure	ontinence brief which was A as circular, blood tinged sured 2.5 cm by 2 cm. The areas on the left side which N-A stated it appeared, "as if it area on the left measured 2.5 e second measured 1.8 by 0.6 de of the coccyx there was an by 1.7 cm with a center bridge measuring 0.3 cm in width and he WCC stated the underlying are ulcers was from pressure, apportant to reposition R11 he WCC stated these areas sitting in wheelchair, and laying The WCC stated it was also in R11 every two hours, reduction mattress on the are reduction cushion in her	F6	86		
	Wound Manageme updates with ongoir relayed to the providid not identify specimplemented if the deteriorating. Increase/Prevent D CFR(s): 483.25(c)(1) §483.25(c) Mobility. §483.25(c)(1) The fresident who enters range of motion docrange of motion unl	racility must ensure that a sthe facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range	F 6	88		9/10/18

1 \ /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		E SURVEY IPLETED	
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F 688	motion receives ap services to increase prevent further dec §483.25(c)(3) A respectives appropriate assistance to main the maximum practicular reduction in mobility. This REQUIREMED by: Based on observed the facility failed to program for upper a implemented for 1 dimited range of modern program for upper a implemented for 1 dimited range of modern program for upper a implemented for 1 dimited range of modern program for upper a implemented for 1 dimited range of modern program for upper a implemented for 1 dimited range of modern program for upper a fact that it is a fact that it	sident with limited range of propriate treatment and erange of motion and/or to rease in range of motion. Sident with limited mobility se services, equipment, and tain or improve mobility with ticable independence unless a y is demonstrably unavoidable. NT is not met as evidenced tion, interview and document ensure a range of motion and lower extremities was of 2 residents (R35) who had tion. Indated, identified diagnoses e weakness and muscle and Minimum Data Set (MDS) of R35 had moderate cognitive range of motion of her upper side, and no nursing am. R35's rehabilitation Care CAA), 6/13/18, identified R35 f motion program. on 07/23/18 at 11:39 a.m. with the daround and under the arm Her right hand was closed and and pulled inward towards the	F 68	F688 Increase/Prevent Decre ROM/Mobility R35 was reviewed for ran treatment, plan of care and inhave been updated and review reflect range of motion plan. All Current residents who identified for range of motion have had their interventions a care have reviewed and upda The DON or designee will re-education to all appropriate range of motion plan of care planor Procedures The DON or designee will audits for 3 residents for their motion programs that will be oweekly X 4, and then monthly results will be reviewed by QA Committee for further recomm Completion Date: 9/10/20	ge of motion terventions wed to have been treatments and plan of ted. provide e staff on ber Meeker complete range of conducted X 2. Audit Planendations.		
		B p.m. R35 was in her in her right					

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F 688	hand closed and has plints or suppused her left hand her right hand laid R35 was observed 07/25/18 at 7:04 p (NA)-J. NA-J place and hooked it to a NA-J instructed R EZ stand so she of transferred with the NA-J my right hand she was unable to stand, but was about the stand. Nabathroom for ever NA-J washes R35 perineal care. After gown on R35 and with the EZ stand no attempts to pror R35's upper extree During interview of stated R35 had no personal cares, and stands for a few in strengthening. Nacomplete range of the rapy provided to The quarterly rest identified R35 had (AROM), lower ex (UE), with particip 7 days in assessminutes document	ner wrist bent inward. There was orts on her right hand. She I to eat her evening meal, while I on her lap. I d during evening cares on o.m. with nursing assistant sed a sling under R35's arms mechanical lift (EZ stand). 35 to grasp the handles of the could hold herself while being see mechanical lift. R35 tells and does not do too much and or grasp the handle of the EZ le to use her left hand to hold A-J then transfers R35 to the ning cares using the EZ stand. I then transfers R35 to the ning cares using the EZ stand. I washing NA-J placed a clean transferred R35 back to bed During this time NA-J made ovide any range of motion to mities. In 7/25/18 07:33 p.m. NA-J to behaviors and they provide all and use the EZ stand so she ninutes during cares for A-J stated she does not for motion for R35 and thought		888			

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F 688	offered. Exercise movement and procontinue with plant assessments identified physicand osteoarthritis. implement active and upper extrem to attend exercise There was no mether right hand. Review of the facilidentified AROM L May thru July 2016 following: May 2018 report id 30 times out of 62 1-15 minutes of times and 10 times, as June 2018 report 23 times out of 60 2-20 minutes of times. July 2018 to date received AROM 3 and ranged from 2	was effective in maintaining event further decline, will There were no other attified since 3/12/18. 27/18 identified a problems all mobility related to dementia, Staff were directed to range of motion (AROM) lower ities twice a day and encourage in activities when scheduled. Intion of splints or supports for all JE/LE daily up to 8 minutes. The reports identified the dentified R35 received AROM apportunities, and ranged from the for AROM. R35 refused and not applicable 10 times. Identified R35 received AROM apportunities, and ranged from the for AROM. R35 refused and was not applicable 12 (7/26/18) identified R35 O times out of 52 opportunities, 2-15 minutes for AROM. R35 times, and was not applicable	F 68	8				
	therapist (PT)-A st	n 7/26/18 09:00 a.m. physical tated they don't have R35 on nd any functional maintenance						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			I ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245361	B. WING	_	07	/27/2018		
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F 688	program would be On 07/26/18 09:03 registered (OTR)-/ the exercise group R35 because she would not be effect During interview of who provided more completed AROM and ready for the of each arm and leg, extremity. She doe wrists, she only do legs. On 07/26/18 11:14 get R35 dressed th AROM, for R35's that along with doing A hand. They should repetitions of each was unaware the N AROM to R35's has should be doing th On 7/26/18 11:25 at therapy assistant (hand which was cl curled in towards the R35's hand and was but it "was tight." If open her right han herself. COTA-A si therapy and do so splint to keep it str	completed by nursing. a.m. occupational therapist A stated some residents go to but this would not work for can not follow the program and tive. 7/26/18 10:47 a.m. NA-D, ning cares for R35, stated she while she gets R35 dressed lay. She stretches and extends doing 10 repetitions on each as nothing with her hands or es AROM with her arms and a.m RN-A stated when NA's ney are expected to provide upper and lower extremities ROM of her elbow, wrist and be completing at least 5-10 movement everyday. RN-A NA's were not completing and or wrists and stated they	F6	88				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	assessment of R3 decreased right wifurther decline. Plappropriate splint is positioning and es. Although R35 was twice a day by NA' implemented. Pain Management CFR(s): 483.25(k) §483.25(k) Pain M The facility must exprovided to reside consistent with proting the comprehensive and the residents' This REQUIREME by: Based on observative review, the facility medications to alloadministered as on pain and discomfor R250) reviewed for resulted in actual indemonstrated sevon multiple occasion.	therapist completed an 5 on 7/26/18, which identified rist ROM and was at risk for an to fit resdient with to promote correct wrist tablish a wearing schedule. It o received AROM for UE/LE s, this was not being lanagement. Insure that pain management is nts who require such services, ofessional standards of practice, to person-centered care plan, goals and preferences. ENT is not met as evidenced ation, interview, and document failed to secure adequate pain ow prescribed medication to be redered to prevent episodes of our for 2 of 2 residents (R11, or pain management. This narm for R11 who ere physical symptoms of pain		F697 - Pain Management R250 was reviewed for painterventions have been updareviewed to reflect the pain mplan. R11 was discharged. All Current residents who identified for pain management their interventions and plan of reviewed and updated. The DON or designee will re-education to all appropriate pain management and proper	nd ated and anagement have been nt have had f care have I provide e staff on	9/10/18	
		/18, identified diagnoses that chronic kidney disease,		on ordering and obtaining pai from pharmacy per Meeker M			

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F 697	diabetes, dementia The MDS also indice assistance to comp (ADLs) and was se R11 was identified effective 4/25/18. A Assessment (CAA) identified R11's level limited her day to desevere, and was not assessment indicate pain in her right leg was also noted to he CAA identified pain enrolled in Hospice care was palliative. R11's care plan revexperienced alterate pressure ulcers on R11's care plan indenon-pharmacologic repositioning, televity blanket, family/frier addition, the care pressure ulcers on R11's level of pain FLACC (Face, Leg. Consolability)/Demensessment per promiter for the effect as well as potential encourage R11 to verest periods. The cand reposition R11 hours, and to lift, not assessment per promiter for the effect as well as potential encourage R11 to verest periods. The cand reposition R11 hours, and to lift, not assessment per promiter for the effect as well as potential encourage R11 to verest periods. The cand reposition R11 hours, and to lift, not assessment per promiter for the effective for the effecti	cated R11 required extensive blete activities of daily living verely cognitively impaired. as enrolled in Hospice a corresponding Care Area completed on 5/14/18, all of pain impacted her sleep, ay activities, was rated as oted to occur frequently. The ted R11 experienced vascular and pain in her heel. R11 have pain in her buttocks. The had improved since R11 had at the desired outcome for with symptom relief. Tised 7/23/18, indicated R11 tion in comfort related to her right foot and coccyx. icated staff were to implement the interventions including ision in R11's room, warm also company, and music. In all an directed staff to monitor with the use of a flow sheet or so, Activity, Cry, entia scale, with a pain otocol. The care plan indicated cations as ordered by the hysician), and staff were to ctiveness of the medications side effects. Staff were also to verbalize discomfort, and use are plan directed staff to turn every two to two and a half of slide her to decrease ourage R11 to lie on her sides	F	397	Procedures. The DON or designee will com audits for 3 residents for proper paramanagement and 3 staff members interviewed on proper procedures for management and reordering/obtain pain medications from pharmacy. The conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for for recommendation. Completion Date: 9/10/2018	n will be or pain ing his will	

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F 697	R11's pain evaluati identified R11 had over the last five dathe pain had impact to day activities, and At the time of the a Fentanyl and Norce manage her pain. Were to administer monitor for effective indicated staff were and symptoms of point of the control of	on completed on 4/30/18, experienced pain frequently ays. The evaluation indicated ted her sleep, limited her day d was rated by R11 as severe. ssessment, R11 was using a (narcotic pain medications) to The assessment indicated staff medications as ordered and to eness. The assessment also at to monitor for increased signs and intervene as needed. If a.m. R11 was observed in the sing moaning sounds. Family sponded to R11 and inquired was hurting. As the meal lasked R11 at 7:23 a.m. if she are she hurt." R11 continued to FM-A was heard again asking any because she hurt, to which es." FM-A was heard telling working. Let's eat quick and own." R11 was reclined back in FM-A assisted her to eat. At heard moaning out loud, and R11's eyes with a tissue. R11 fithe dining room by FM-A at a fa.m. R11 was observed made moaning vocalizations, erbalize a response when was experiencing pain. Of a.m. R11 was observed R11 displayed facial	F	697				

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F 697	furrowed with mo R11 was making without discernible A review of the el assessment was registered nurse indicated R11 expand right foot. The states pain is occupant daily activitie indicated R11 recopain medication) a.m., and 5 mg as for morphine (narmg as needed. Hindicated the medicated for use administration of monitoring for effective and sympton needed. The assessment did represent the sympton of the sym	er eyebrows and forehead isture in the corner of her eyes. rhythmic moaning noises,	F	697			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZII 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
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F 697	she would advise The HD stated wh Hospice and has i expectation of Hoscontact the 24-hou of the pain, so evacurrent intervention subsequent develor of care for R11. On 7/24/18, at 2:2 room resting on he was resting quietly expressions. On 7/25/18, at 2:1 wheelchair with he rests. R11's eyes of furrowed, and R11 rhythmic pattern. Hoursing assistant provide cares, and pillow to provide fut o cry out with a mourse (RN)-B entered assistance. NA-G a mechanical lift scontinued to construct with physical move her bed, and the normoved. An acid room and HRN-A related to R11's for incontinence, so her incontinence is provided by NA-G incontinence of bootstates.	age 86 of the office, but the HD stated her of the call and follow up. en a resident is enrolled in increased pain, it was the spice for the nursing facility to ur nurse call line to advise them illuation and coordination of ins could be done, with opment of an appropriate plan. 8 p.m. R11 was observed in her er bed lying on her back. R11 with relaxed facial. 4 p.m. R11 was observed in her er legs elevated on the foot were closed, her brows were was moaning in a constant, HRN-A was present in the room. (NA)-G entered the room to a placed R11's right leg on a sull leg support. R11 continued oaning sound. Registered and RN-B assisted with placing ling under R11, while R11 cantly moan which intensified ement. R11 was transferred to nechanical lift sling was ic odor was noted in R11's was unsure whether it was ot wound, or bowel IRN-A requested staff check orief. Incontinence care was and RN-B with no noted owel. R11 had an open area on of dressing in place. HRN-A	F6	697		

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F 697	last seen R11 for Wound Care Consthem to leave the a dressing. HRN-Dressing (foam mbreathes) to the a R11 had ceased nwere obtained, but vocalizations which movement. R11 wbody in a semi-fet repositioned, RN-was located. R11 vocalizations and was located. RN-R11's vocalization suggestions to shi R11's heel was flooprovide less supported by the provide less support	as not present when she had evaluation. RN-B stated their sultant (WCC) had instructed area open without placement of A placed an Allevyn Sacral oisture absorbing dressing that ffected areas on the coccyx. In provide the coccyx of the coccy	F 6	97			
	evidenced by verb moving in chair, a stated she would a offer to lay R11 do if those measures	palizations, vocalizations, and facial expressions. NA-G assist with repositioning R11, awn, and would advise the nurse were not beneficial in providing a observation at that time. R11					

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F 697	began to cry out lou facial grimaces of h furrowed. R11 also moaning sound. On 7/25/18, at 2:47 (LPN)-A entered R2 morphine liquid. Whad previously recell LPN-A stated R11 h liquid for several da continued to cry outears present in bot to provide R11 assi continued to cry reslips continued to cry reslips continued to quin the corners of bot o FM-A at 2:51 p.m R11's left ear and Flips, and to furrow heyes were squinted crying with vocalizar cried into the phoneme." At this time, the elevated, R11 was under her right leg, observed to rub R1 comforting motion. call out. LPN-A stat take her methadone management. The been informed of R11's rat 2:58 p.m. while is	ge 88 adly, tear up, and displayed per brows and forehead being emitted a continuous p.m. licensed practical nurse of the period of the perio		397			

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F 697	LPN-A stated R11 I symptom control w have been effective family friend (FF)-A indicated FF-A ma provided R11 commot was put on as a dis LPN-A was not awa non-pharmacologic to provide R11 commot received her mobecause there had LPN-A was unsure morphine had been would follow up with During a visit with FHRN-A stated this wobserved R11 expends been notified by observed. HRN-A s FM-A, R11's primar facility on R11's pair R11's methadone had ago, and stated she the hospice pharmaneed to increase R However, HRN-A s informed R11 had rethat the facility was supply. HRN-A stated the facility to advise take the medication exhibiting increased supply of methador had increased the overified with FM-A to was available. HRN was available.	had Ativan (anti-anxiety) for hen asked what interventions e. LPN-A stated R11 had a who visited frequently, and by be more aware of what ort. LPN-A stated the television straction, but was not helpful.	F6	97			

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F 697	medications if need stated the facility in for administration of the continuation of t	ded, and if alerted. HRN-A of having methadone available was "concerning." Dep.m. HRN-A continued to and and lower arms, and R11 ecrease both the intensity and ocalizations. R11 responded, if she was sad or in pain. The or massage R11's hands and a R11. R11 started verbalizing a discontinued to repeat this stall expression becoming more ed by decreased furrowing of sence of tears. Dep.m. LPN-A returned to the HRN-A the last dose of en given the previous evening, raining dose of methadone had a stated the pharmacy had been the medication and was tion. LPN-A stated the was monitored by facility staff farmacy, and stated R11's D)-A had been in the facility grounds, but staff had not prescription for the methadone. Dep.m. HRN-A stated the facility or ordering the methadone.	F	697			
	in correspondence	dication administration sheet, with the narcotic count book, yed methadone on 7/24/18 at					

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F 697	refusal of methador 7/24/18. A review of the medindicated a refusal however, the individindicated a count of 7/24/18, dose. A review of the Medfor 7/25/18, identified mg/ml, 0.5 ml (10 ml, 0.5 ml) (10 ml) for pain medicated a second management. LPN should be delivered on 7/26/18, at 7:00	mentation also reflected ne dosing the morning of dication sheet for 7/25/18, of morning dose of morphine, dual narcotic record for R11 f zero following the 4:45 p.m. dication Administration Record ed R11 received morphine 100 ng) at 3:00 p.m. and again at nanagement. p.m. LPN-A stated R11 had dose of morphine for pain A stated the methadone I in time for the evening dose. a.m. FM-A was at the	F6	97		
	resident's bedside. resting on her back raised. R11 stated, she had been with stated R11 was restime. On 7/26/18, at 10:4 bed, and was noted expression was not brows, squinted/teat Trained medication R11, and stated R1 scheduled methado morphine for pain r	R11 was observed in bed, with the head of her bed "Good morning." FM-A stated R11 since early morning, and ting more comfortably at this 5 a.m. R11 was observed in to be awake. R11's facial ted to be free from furrowed arful eyes, and pursed lips. assistant (TMA)-A was in with 1 had received her routinely one, and an additional dose of nanagement and was doing R11 responded she was,				

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F 697	During conversation HRN-A stated she facility the prior evithe second PRN donotified R11 was a was offered to the HRN-A stated R11 shallow breathing morphine. HRN-A shallow breathing dosing of morphine R11 had taken onlineeded throughou stated R11 being difference for her for doses of morphine HRN-A stated she with FLACC and wascore of eight to not indicating severe proported on 7/26/18, at 11:2 from FM-A. FM-A stated she wallegs and back, and stated R11 had be for about two and a contacted staff and into bed. FM-A statemes, but added, they just let us be. Sunday told me [R on occasion and the routes." FM-A state 7/23/18, at 7:00 a.	on on 7/26/18, at 10:58 a.m. had been contacted by the the ening after R11 had received ose of morphine, and was ctively dying. A Hospice visit facility and the facility declined. was demonstrating increased following the second dose of stated R11's lethargy and may have been related to the e. HRN-A stated historically, y one dose of morphine as the course of a day. HRN-A out of methadone made a huge for pain, and receiving two impacted her response. used a dementia scale for pain rould have classified R11 as a ne on a scale of one to ten,	F 6	97		

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F 697	R11 was asked will "butt hurt" and was was experiencing pain medication, a her what types of FM-A stated R11 ptelevision like the R11 enjoyed coun FM-A said R11 ha FM-A was unawar provided in her rocaware R11 had not 7/25/18, and state effective for R11 h R11 did not like to because she did made her feel. FW the administrator a June regarding trawould call out in p	of moaning." FM-A stated when hat was wrong, R11 stated her is crying. FM-A stated if R11 pain, she should have received and stated staff had not asked things R11 might find soothing. Dreviously had watched old time Andy Griffith show, and stated try western music. Although deen out to music activities, he of whether R11 had music form. FM-A stated she was not not received her methadone on did the methadone had been very historically. FM-A further stated use morphine as needed not like the way the medication II-A stated she had contacted approximately the third week in ansferring R11, because R11 ain with moment. FM-A stated en much better about trying to	F6	597			
	for pain managem R11 was recorded 15th to the 25th of 2:30 p.m. shift. R1 2:30-10:00 p.m. for with zero to one. If the 11:00 p.m. to 6 pain levels were a exception of 7/26/ was recorded at of On 7/27/18, at 1:3 (DON) stated if a	atment administration record tent was reviewed and noted as exhibiting no pain from the fully during the 6:00 a.m. to also pain levels from the part the same period was rated at 1's pain monitoring sheets for 6:00 a.m. shift, indicated R11's at which time the pain level ne. 7 p.m. the director of nursing resident was noted to with movement, staff could try to					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER R MANOR REHABILIT	TATION CENTER, LLC		6	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	<u>, </u>	
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F 697	reposition. When the 7/23/18, was review stated she would be regarding R11's increview current interest of care as necessary with the level of paradministration reconstrative notes and The DON stated the correspond with the DON stated she were everywhere was informed the afternoon. The substances are ore through a routine restaff note the suppose to advise them of the time they were outwas to be called and The DON further of the need for a present had left the facility of the administrator FM-A's concerns recomfort for R11. The twas difficult to defor vocalizations as vocalizations in a part of the administrator expressed concerns the supposed to the administrator expressed concerns and the supposed to the su	sesisting the resident to the pain assessment completed wed with the DON, the DON expect Hospice to be contacted creased presence of pain, to rventions and modify her plan ary. A review was completed in recorded on the treatment ord in comparison to the dimedications administered. The assunaware R11 had not ing dose of methadone until she was out of methadone in DON stated controlled dered from the pharmacy efill process. The DON stated if ly is down to a one day supply, and to fax and call the pharmacy his. The DON stated at the of medication, the pharmacy and a plan of action coordinated. Confirmed she was unaware of scription form from MD-A until lity following rounds. To p.m. the administrator stated a FM-A regarding R11's status. Stated she had discussed egarding management of the administrator stated at times etermine the underlying causes as R11 had made moaning positive manner with pet visits. The with R11's comfort exially when turning and	F	697			

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED		
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F 697	R250's undated A R250 was admitted R250's admission identified orders for management) 50 severe pain, and PRN, for mild pair R250's undated, If Plan section for paid not identify R2 interventions to m R250's Pain Evaluated Pain a 3 out of 10 had been taking T pain, and indicate her sleep but did it daily living. On 7/23/18, at 11: lying in her bed. A had chronic lower 6 out of 10. R250 throbbing, and stated it had been any Tramadol and it he stated it had been any Tramadol been facility staff she we stated other medicated of the right had seen and the stated of the right had seen any Tramadol been any Tramadol been any Tramadol been facility staff she we stated other medicated other medicated her right had grimaced. Once seen and the stated of the right had grimaced. Once seen and the stated of the right had grimaced. Once seen and the stated of the right had grimaced. Once seen and the stated of the right had grimaced. Once seen admitted the stated of the right had grimaced. Once seen and the stated of the right had grimaced. Once seen and the stated of the right had grimaced. Once seen and the stated of the right had grimaced. Once seen and the stated of the right had grimaced. Once seen and the stated of the right had grimaced. Once seen and the stated of the right had seen and the	dmission Record identified d to the facility on 7/12/18. orders signed 7/12/18, or Tramadol (narcotic for paining every 6 hours PRN for Tylenol 325 mg every 6 hours or fever. Initial/ Comprehensive Care ain and comfort was blank and 50's risk for pain, any goals, or anage pain. Itation dated 7/21/18, indicated to lower back pain, and rated her The evaluation indicated R250 aramadol 50 mg as needed for d the pain did not interfere with enterfere with her activities of that time, R250 stated she back pain, and rated her pain a described the pain as ted she had been prescribed elped relieve her pain, but 4-5 days since she received ause she had been told by as out of the medication. R250 cations did not help, so she had	F 6	97		

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F 697	longer grimacing. Swhat was going on was now rating her stated her pain was lying in bed most of her pain. R250's MAR for Jureceived 15 doses 7/12/18, until 7/17/ Tramadol 50 mg with the stated R250 was winteraction with her she would let the transmitted interview or stated. During interview or stated R250 was winteraction with her she would let the transmitted interview or stated.	She stated she had not heard with her pain medication and pain at a 7 out of 10. She better with movement, and f the day did not help relieve ly 2018, identified R250 of Tramadol 50 mg from 18. No further doses of	F	597			
	reviewed with LPN have any Tramado no longer had an o stated R250 had cl was unaware of whinterventions were R250. LP:N-A state for pain medication added staff should pain when they gav During interview or stated R250 had cl admitted with Tram RN-A stated she withe baseline care p	5 p.m. the medication cart was A. LPN-A stated R250 did not I on the medication cart, and order for Tramadol. LPN-A pronic lower back pain. LPN-A part non-pharmacological supposed to be attempted with the R250 had not been asking as for about the last week, and be asking R250 to rate her pain medications. 1. 7/25/18, at 6:50 p.m. RN-A pronic back pain, and had been pain as responsible for completing alan, and verified it was not said a baseline care plan					

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F 698 SS=D	should have been of interventions for paraware until that after complaining of back medications, or that RN-A stated she leephysician and caller medication. RN-A stated in the stated if there were additional pain medication when the stated if there were additional pain medication pain medication when the facility could hat manage R250's paramanage R250	developed to include in control. RN-A was not control. RN-A was not control and requested pain to take pain, had requested pain to take the take to do not be condered to the pain to take the take take take take take take take tak	F 698		e n eker

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F 698	R100's face shee admitted to the act of stage 4 chronic central line access inserted in the suchest) for dialysis R100's initial comidentified Chronic dialysis on Tuesd interventions identified Chronic dialysis occurs a unit. If case of ca catheter, clamp to and send to emerelevated tempera There was no oth care plan about Find Review of the Dialettified the nurse top form, and the the bottom of the communication for and 7/24/18, the find R100 had an acceptant with a soft (presence of blood dialysis access gublood flow to ensure During interview of practical nurse (LR100's central line mergency situat the dialysis center of what the policy central line dialysis	t undated, identified he was gency on 7/18/18, with diagnosis c kidney disease, and had a s (artificial tube surgically bclavian artery through the	F	\$98	audits for 3 residents for Dialysis Emergency Services (if applicable) staff members will be interviewed or proper procedures for Dialysis Emergency, this will be conducted we 4, and then monthly X 2. Audit reside be reviewed by QAPI Committee for further recommendation. • Completion Date: 9/10/2018	on ergency ekly X ults will	

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F 698	typically on the sour She stated there was nursing station of withe nursing station dialysis protocols. dialysis patients in the was unable to find a surface of the state of the state of the protocols, undated, catheter Care, to ke MD and dialysis nursing welling in the residual catheter. If dressing falls off, cleanse sit sterile dressing, not place, and contact of findings. The policy there was blood least the station of the state of the sta	ge 99 th end of the nursing home. as a reference book at the hat to do. LPN-C looked at for a three ring binder, and There was no protocols for the reference book and LPN-C any other dialysis protocols. Tion was discussed with N)-A on 7/26/18 at 11:30 a.m., ocol should be in the book and that information for a The protocols of the reference book and LPN-C any other dialysis protocols. Tion was discussed with N)-A on 7/26/18 at 11:30 a.m., ocol should be in the book and that information for a The protocol of the proto	F 6	98			
	Nurse Aide Peform CFR(s): 483.35(d)(7) §483.35(d)(7) Regu The facility must co of every nurse aide months, and must p	ular in-service education. mplete a performance review at least once every 12 provide regular in-service	F 7	30			9/10/18
		the outcome of these training must comply with the					

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F 730	by: Based on interview facility failed to ens reviews were comp of 3 nursing assistate whose files were reaffect all 56 resider home and who coustaff. Findings include: A facility provided, uidentified the follow staff with their start NA-C was hired of full time basis; NA-D was hired of full time basis; NA-E was hired of full time basis. During the recertification full time basis. During the recertification full time basis. When interviewed or respective employed performance review NA-C, NA-D, and Narovided. When interviewed or regional director of the facility transition management compannual evaluations. The facility identifie	83.95(g). NT is not met as evidenced and document review, the ure annual performance pleted on an annual basis for 3 ants (NA-C, NA-D, NA-E) eviewed. This had potential to onts who resided in the nursing lid receive care from these annual basistant (NA) dates: on 5/24/17, and worked on a con 6/30/16, and worked on a con 6/29/16, and worked on a con 6/29/18, to con 6	F 7	30	F730 – Nurse Aide Perform Review hr/yr In-Service NA-C, NA-D, NA-E will receive a annual performance review. All employees who have compleyear or more of employment will receive an evaluation and then annually thereafter. All employees will receive evaluation annually going forward Staff will be re-educated on ensignemployee annual evaluations are completed. Audits of 3 employee evaluation be completed weekly x 4 weeks; the needed. Human Resources Director or designee will be responsible party QAA will provide redirection or completed weekly to ensure completic and/or continuation of monitoring processing the party. Completion Date: 9/10/2018	eted a eive e an uring s will en as	

AND BLAN OF CORRECTION LINE IN THE CATION AND AREA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
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	anniversary came uno other plans in plevaluations up more A facility policy on Not provided.	ord when their yearly up. RDO clarified their were ace to catch the past due e timely being implemented.	F 7			
	Posted Nurse Staff CFR(s): 483.35(g)(§483.35(g) Nurse S §483.35(g)(1) Data must post the follow basis: (i) Facility name. (ii) The current data (iii) The total number by the following cat unlicensed nursing resident care per sl (A) Registered nurse (B) Licensed practivocational nurses (C) Certified nurse (iv) Resident census §483.35(g)(2) Posti (i) The facility must specified in paragradily basis at the begin (A) Clear and reada (B) In a prominent presidents and visito §483.35(g)(3) Publistaffing data. The	Staffing Information. requirements. The facility ving information on a daily e. er and the actual hours worked egories of licensed and staff directly responsible for nift: ses. cal nurses or licensed as defined under State law). aides. is. ing requirements. post the nurse staffing data aph (g)(1) of this section on a eginning of each shift. bated as follows: able format. blace readily accessible to	F7	32		9/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
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F 732	available to the pull exceed the community of the posterior of the posteri	blic for review at a cost not to unity standard. lity data retention a facility must maintain the staffing data for a minimum of equired by State law, whichever of the staffing data for a minimum of equired by State law, whichever of the staffing data for a minimum of equired by State law, whichever of the staff posting and document failed to consistently include on the daily nurse staff posting. See staff posting was not minent location and accessible ead. This had the potential to the tresidents, their families and on 7/23/18, at 7:31 a.m. the costing was posted on the uilding at approximately 4-5 which was unable to be one seated in a wheelchair, and the date, census; and direct shifts, numbers and total hours on 7/24/18, at 9:14 a.m. the lig the daily census.	F 7	F732 – Posted Nurse S The facility has move nursing staffing post to a location and to appropriate height. The facility has a daily census. Staff will be re-educate the daily nursing staffing completed timely and act to the facilities daily census. Audits of the facilitie hours posting to be comweeks; then as needed. Administrator or des responsible party QAA will provide red when necessary to ensu and/or continuation of m Completion Date: 9/	ed the daily a centralized ate wheelchail dded the facinated on ensuring post is ecurately specials additionally and the differential or chire completion on the completion of	ir ilities ring cific g y x 4	

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F 732	responsible for upd staff posting. She of posting in advance knowledge no one of census or makes so changes needed. Further from time off she trafter the fact. SC-C displayed on one upon to centrally located height where a personal director op nurse staff posting census information not in a prominent I could be viewed by facility did not have posting. Drug Regimen Rev CFR(s): 483.45(c) (1) The of the resident's medical director op nurse staff posting census information not in a prominent I could be viewed by facility did not have posting. Drug Regimen Rev CFR(s): 483.45(c) (1) The of the resident's medical director op nurse staff posting census information not in a prominent I could be viewed by facility did not have posting. Drug Regimen Rev CFR(s): 483.45(c) (1) The of the resident's medical director op nurse staff posting census information not in a prominent I could be viewed by facility did not have posting. Drug Regimen Rev CFR(s): 483.45(c) (1) The of the resident's medical director op nurse staff posting census information not in a prominent I could be viewed by facility did not have posting. Drug Regimen Rev CFR(s): 483.45(c) (1) The of the resident's medical director op nurse staff posting census information not in a prominent I could be viewed by facility did not have posting.	ating and posting the nurse completes the nurse staff of her days off and to her else in the facility adds the taffing changes if there were further, when she returned ited to update the postings a stated the posting was nit and not the other and was d. Further it was posted at a son in a wheelchair could not 7/26/18, at 2:41 p.m. the terations (RDO) stated the was required to have the posted daily. The posting was ocations and at a height that a person in a wheelchair. The a policy on the nurse staff iew, Report Irregular, Act On 1)(2)(4)(5) regimen Review. drug regimen of each resident at least once a month by a st. review must include a review	F 73			9/10/18

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F 756	(ii) Any irregularitied during this review separate, written rattending physicial director and direct minimum, the resident's medical irregularity has beaction has been tabe no change in the physician should of the resident's medical irregularity has beaction has been tabe no change in the physician should of the resident's medical irregularity has beaction has been tabe no change in the physician should of the resident's medical irregularity has been tabe no change in the physician should of the resident's medical irregularity medical from the process and side in the process	for an unnecessary drug. es noted by the pharmacist must be documented on a eport that is sent to the n and the facility's medical or of nursing and lists, at a dent's name, the relevant drug, the pharmacist identified. physician must document in the record that the identified en reviewed and what, if any, sken to address it. If there is to ne medication, the attending locument his or her rationale in	F 75	F756 Drug Regimen Revieurregular R29 was reviewed for precommendations, rational and recommendations have implemented timely. Plan of	oharmacist was recorded e been			
	medication use. Findings include: NOT ACTED UPC	N: nimum Data Set (MDS) dated		 interventions have been up reviewed to reflect pharmal recommendations. All current residents whidentified for pharmacist recommendations, recommendational was recorded time 	cist no have been nendations			
		R29 had dementia with a		interventions and plan of ca				

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F 756	severe cognitive im Diagnosis Report phad numerous med anxiety disorder, hig depressive disorder R29's Order Summidentified R29 had eseveral psychotropical Celexa (an antide everyday, Lorazepam (an arorally, " as neede [BID]." R29's Consultant PReview dated 5/14/pharmacist (CP) did Non-antipsychotic Phis [R29's lorazepad duration, unless the treatment by provided documenting intended the physician to relorazepam therapy evaluation/rationale was going to be conlabeled, "Follow-Up physician to circle if recommendation we completed in, " Addays." However, nedid the report have physician to demonand/or addressed. R29's subsequent F	pairment. In addition, R29's rinted 7/27/18, identified R29 lical diagnoses including gh blood pressure, and major respectively. The present of the pressure o	F 7	756	reviewed and updated. • Staff will be re-educated on provide review of pharmacist recommendations are completed timely. • Audits of 3 pharmacy recommendations will be completed weekly x 4 weeks; then as needed. • Director of Nursing or designed responsible party. • QAA will provide redirection or when necessary to ensure complete and/or continuation of monitoring p. • Completion Date: 9/10/2018	tions d e will be change tion	

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F 756	lorazepam use, and re-evaluate R29's of document their clin resident if treatment As prior, a section I Taken," directed the accepted or rejected time frame to be collater than 60 days." were circled nor did from the physician reviewed and/or ad R29's additional, su Medication Review again identified the lorazepam use, and re-evaluate R29's of document their clin resident if treatment As prior, a section I Taken," directed the accepted or rejected time frame to be collater than 60 days." were circled nor did from the physician reviewed and/or ad	irregularity with R29's direquested the physician current lorazepam therapy and ical evaluation/rationale of the it was going to be continued. abeled, "Follow-Up or Action exphysician to circle if they did the recommendation with a simpleted in, " ASAP but now However, neither of these did the report have any signature to demonstrate it had been diressed. Absequent Pharmacist's dated 7/11/18, identified CP same irregularity with R29's direquested the physician current lorazepam therapy and ical evaluation/rationale of the it was going to be continued. abeled, "Follow-Up or Action exphysician to circle if they did the recommendation with a simpleted in, " ASAP but now However, neither of these did the report have any signature to demonstrate it had been diressed.	F	756			
	registered nurse (R was originally order continued to use th looking at the Medi (MAR). RN-B state to CP's identified of therapy despite severally or the state of the state o	on 7/27/18, at 10:28 a.m. IN)-B stated R29's lorazepam red in April 2018, and she e as-needed lorazepam when cation Administration Records at their had been no follow-up oncerns with R29's lorazepam reral months of it being I-B added, "We're not					

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F 756	sure these identified upon timely to make safe. During interview or interim director of rebeen a "lack of following the pharmacy recorded and it was "not appropriate should have occurred the resident." During telephone in p.m. CP stated the communicating with identified irregularity expressed some "kenneded, and their sare addressed "needed,	and it was important to make ad irregularities were acted the sure the resident is kept in 7/27/18, at 2:17 p.m. the nursing (DON) stated there had ow through" with making sure immendations were addressed propriate." DON explained this red as it was "what's best for interview on 7/27/18, at 2:32 facility should be the physician to ensure the ties are addressed timely. CP poetter communication" was systems to ensure the reports ed to be worked on." ENTED RATIONALE: The physician orders for	F 7	56		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245361	B. WING		07	/27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP 0 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREF I X TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 756	Review dated 3/16 pharmacist (CP) in R29's dual Tyleno "Suggested Cours" "Please consider oneeded] orders." Action Taken," inst they accepted or a This was circled a physician. This was circled a physician. This wunit coordinator (Hexplanation or diction why this recommendation of the second potential to doses of Tylenol. The recommendation of the second physician regarding despite being ider pharmacist as a part of the second physician regarding despite being ider pharmacist as a part of the second the second physician regarding despite being ider pharmacist as a part of the second physician regarding despite being ider pharmacist as a part of the second physician regarding despite being ider pharmacist as a part of the second physician regarding despite being ider pharmacist as a part of the second physician regarding despite being ider pharmacist as a part of the second physician regarding despite being identification. When interviewed RN-B stated she are accepted CP's record facility was not "for needed education." During interview of DON stated the later the second physician regarding the second physician regar	Pharmacist's Medication 6/18, identified the consulting dentified an irregularity with I orders and listed a, se of Action" which directed, discontinuing one of the [as A section labeled, "Follow-Up or tructed the physician to circle if rejected the recommendation. Is "Rejected" and signed by the as dated 5/17/18, by the health of the statement of the statement, "*(1) Per regulatory explanation of why the statement, "*(1) Per regulatory explanatio	F 7	56		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION 3		E SURVEY PLETED
		245361	B. WING_		07/2	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 756	faxed it back to the rationale.	ge 109 physician asking for the pharmacy recommendations	F 75	5		
	was requested, how	vever, none was received. ree from Unnecessary Drugs	F 75	7		9/10/18
	Each resident's dru	essary Drugs-General. g regimen must be free from . An unnecessary drug is any				
	§483.45(d)(1) In exduplicate drug thera	cessive dose (including apy); or				
	§483.45(d)(2) For 6	excessive duration; or				
	§483.45(d)(3) With	out adequate monitoring; or				
	§483.45(d)(4) With use; or	out adequate indications for its				
		e presence of adverse ch indicate the dose should be nued; or				
	stated in paragraph section. This REQUIREMED by: Based on observareview, the facility forder was followed monitor diuretic me	combinations of the reasons as (d)(1) through (5) of this NT is not met as evidenced tion, interview and document ailed to ensure a physician's and obtain daily weights to dication use for 1 of 1 resident unnecessary medication.		F757 Drug Regimen is Free frounnecessary Drugs R 44 Drug Regimen and Ur Drugs was reviewed for physici for daily weights to monitor diur medications. R44's plan of care	nnecessary an orders etic	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION (SURVEY PLETED
		245361	B. WING			07/2	27/2018
	PROVIDER OR SUPPLIER R MANOR REHABILI	TATION CENTER, LLC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREF I X TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 757	Findings include: R44's admission M 4/27/18, included failure, hypertensi MDS also indicate R44's current phys were reviewed and and to notify the d (pounds) in 24 hor two diuretic medic failure and high bl tablet 2 mg (millig and Spironolactor day. During observation was seated in her presented a calm sign of pain or dis- on her lower extre there was no obse lower legs or ankle During interview o talked about her s medications, inclu medication, and th blood work. R44 s weigh me everyda R44's weights from reviewed. The ele identified R44's we documented per th dates: 6/1/18, 6/5/6/16/18, 6/17/18, 7/2/2/18, 7/2/2/18, 7/2/2/18, 7/2/2/18, 7/2/2	Minimum Data Set (MDS) dated diagnoses of congestive heart on and renal insufficiency. The d R44 was cognitively intact. Sician's orders dated 6/17/18, d directed to obtain daily weight octor wight increases 3 lbs ars. R44's orders also included ations for congestive heart cod pressure: Bumetanide rams) orally two times a day; the tablet 50 mg by mouth once a mon 7/25/18, at 3:00 p.m., R44 wheel chair, in her room. R44 demeanor, and exhibited no tress. R44 had two bandages mities, one on each leg, and erved swelling or edema of the esc. In 7/25/18 at 3:11 p.m., R44 tay in the nursing home and her ding how often she got nat she had to frequently get tated they are supposed to	F	757	interventions have been updated and reviewed to reflect daily weights. All current residents have been identified for daily weights related to diuretic use have had their interventiand plan of care have reviewed and updated. Staff will be re-educated on propedocumentation of daily weights related diuretic use Audits of 3 resident daily weights related to diuretic use will be compleweekly x 4 weeks; then as needed Director of Nursing or designee responsible party QAA will provide redirection or cowhen necessary to ensure completic and/or continuation of monitoring properties. Completion Date: 9/10/2018	ions per red to seted will be change	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		E SURVEY PLETED
		245361	B. WING			07/:	27/2018
	ROVIDER OR SUPPLIER	ATION CENTER, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DAVIS AVENUE TCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757	R44's documented lbs (pounds) to 193 During interview on practical nurse (LPI medication to contributed they monitor checking for any swichecking blood preservestrictions, "and will LPN-D stated if R44 more over from the was to be notified. recently had any see During interview on registered nurse (R diuretic medication, daily weights. RN-A fluid overload and spoint in the hospital removed. RN-A state checking for edemonalso included daily responsibility for the make sure it is common why" the weights are When interviewed of interim director of no resident had doctor expected "they be on the state of the sure it is common why the weights are sure if they be on the sure if they be	ortunities. During July 2018, weights have ranged from 190 lbs. 7/26/18 at 8:03 a.m., licensed N)-D stated R44's received ol blood pressure. LPN-D ed R44's blood pressure by welling or edema in her legs, ssures, following the fluid e also do a daily weight." 4's weight was 3 pounds or previous weight, the doctor LPN-D stated R44 had not brious weight gains. 7/26/18, at 3:39 p.m. N)-A stated R44 was on a and had current order for a stated R44 had symptoms of shortness of breath, and at one lhad 18 pounds of fluid ated R44's monitoring included a, lungs, respiration rates and weights. RN-A stated it is the effoor nurse and charge to apleted, and "I can't explain e missing. on 7/27/18, at 2:07 p.m. the ursing (DON) stated is a cordered daily weights, she completed daily."	F 7	57			
F 842	provided.	requested, but none was Identifiable Information	F 8	42			9/10/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE COMF	
		245361	B. WING		07	/27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZI 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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	(i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use of except to the extento do so. §483.70(i) Medical §483.70(i)(1) In accordessional standamust maintain medithat are- (i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically of §483.70(i)(2) The fall information contregardless of the forecords, except wh (i) To the individual representative whe (ii) Required by Law (iii) For treatment, poperations, as pern with 45 CFR 164.50 (iv) For public healt neglect, or domesti activities, judicial ar law enforcement pupurposes, research	lent-identifiable information. It release information that is it to the public. It release information that is it to the public. It release information that is it to an agent only in Contract under which the agent It disclose the information It the facility itself is permitted It the facility itself is permitted It records. It is permitted I	F8	42		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		245361	B. WING			07/2	27/2018
	PROVIDER OR SUPPLIEI	TATION CENTER, LLC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 South Davis Avenue .ITCHFIELD, MN 55355		.,,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	a serious threat to by and in complia §483.70(i)(3) The record information unauthorized use. §483.70(i)(4) Med for- (i) The period of ti (ii) Five years from there is no require (iii) For a minor, 3 legal age under S §483.70(i)(5) The (i) Sufficient inform (ii) A record of the (iii) The comprehe provided; (iv) The results of and resident revied determinations co (v) Physician's, nu professional's pro (vi) Laboratory, ra services reports a This REQUIREMI by: Based on intervied facility failed to en pharmacist review medical record or accessible for 4 or services reports a consideration of the control of the contro	health or safety as permitted noe with 45 CFR 164.512. facility must safeguard medical against loss, destruction, or ical records must be retained me required by State law; or the date of discharge when ement in State law; or years after a resident reaches tate law. medical record must containation to identify the resident; resident's assessments; ensive plan of care and services any preadmission screening we evaluations and inducted by the State; irse's, and other licensed	F &	342	F842 Resident Records • R21, R37, R29, and R7 charts reviewed to ensure documentation monthly consulting pharmacist reviin their medical record. • All current residents have had medical record reviewed to ensure	of ews is their	
	Findings include: R21's quarterly M	inimum Data Set (MDS) dated			documentation of monthly consulting pharmacist reviews are present in medical record.	ng	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BU I LDI		E CONSTRUCTION		E SURVEY PLETED
		245361	B. WING			07/2	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	antidepressant and Diagnoses included anxiety disorder an record lacked evide had reviewed R21's record on a month! R37's quarterly MD R37 was taking ant and anticoagulant rincluded diagnoses pressure and high record lacked evide had reviewed R37's record on a month! R29's quarterly ME R29 was taking ant medications. The Manxiety disorder an record lacked evide had reviewed R29's record on a month! R7's quarterly MDS was taking insulin, diuretic and opioid included diagnoses diabetes, anxiety di R7's medical record consulting pharmac medications and mbasis. During interview on interim director of medications of the medication of t	R21 was taking antianxiety, diuretic medications. dianemia, high blood pressure, didepression. R21's medical ence the consulting pharmacist is medications and medically basis. S dated 6/28/18, identified dipsychotic, antidepressant, medications. The MDS of anemia, high blood cholesterol. R37's medical ence the consulting pharmacist is medications and medically basis. DS dated 5/25/18, identified dianxiety and antidepressant MDS identified diagnoses of didepression. R29's medical ence the consulting pharmacist is medications and medically basis. S dated 4/20/18, identified R7 antidepressant, anticoagulant, medications. The MDS of high blood pressure, isorder and depression. di lacked evidence the cist had reviewed R7's edical record on a monthly	F 8	42	Staff will be re-educated on prodocumentation of monthly consulting pharmacist reviews Audits of 3 residents proper documentation specific to pharmacise reviews will be completed weekly xweeks; then as needed Director of Nursing or designed responsible party QAA will provide redirection or when necessary to ensure complete and/or continuation of monitoring p Completion Date: 9/10/2018	sist 4 e will be change ion	
	included diagnoses diabetes, anxiety di R7's medical record consulting pharmad medications and mbasis. During interview on interim director of nwould need to conti	s of high blood pressure, isorder and depression. I depression is depression is depression. I depression is depression in the control is depression in the second on a monthly in 17/26/18, at 4:01 p.m. the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BU I LDI	TPLE CONSTRUCTION NG	ESS, CITY, STATE, ZIP CODE AVIS AVENUE		E SURVEY PLETED
		245361	B. WING			07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CI 600 SOUTH DAVIS A LITCHFIELD, MN	VENUE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	RECTIVE ACTION SHOULD RENCED TO THE APPROP) BE	(X5) COMPLETION DATE
F 842	the interim DON stathe consulting phandocumentation that and record was rev follow up and to me A policy on consulti	vere completed. At 4:46 p.m. ated it was important to have macists monthly each resident medications iewed to ensure adequate	F 8	42			
	infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the follows \$483.80(a)(1) A systematical environment of the systematica	control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements:	F 8	80			9/10/18
	staff, volunteers, vis providing services to arrangement based conducted accordin accepted national s §483.80(a)(2) Writte	I upon the facility assessment g to §483.70(e) and following					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BU I LD		E CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER R MANOR REHABILIT	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)) BE	(X5) COMPLETION DATE
F 880	possible communic infections before the persons in the facility. When and to who communicable discreported; (iii) Standard and to be followed to provide (iv) When and how resident; including (A) The type and down depending upon the involved, and (B) A requirement of least restrictive postic circumstances. (v) The circumstances. (v) The circumstances. (v) The circumstances disease or infected contact with reside contact will transmount (vi) The hand hygie by staff involved in §483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must have transport linens so infection.	reillance designed to identify cable diseases or an approach to other ity; nom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility oyees with a communicable I skin lesions from direct ints or their food, if direct if the disease; and ne procedures to be followed direct resident contact. Stem for recording incidents a facility's IPCP and the taken by the facility. Indle, store, process, and as to prevent the spread of	F8	380			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION		E SURVEY PLETED
		245361	B. WING			07/:	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH DAVIS AVENUE TCHFIELD, 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	This REQUIREMENT by: Based on observatoreview the facility facenteric precautions R3) who were place precautions. Findings include: R100's face sheet to admitted to the age retention and an incomplete R110 hospital dischidentified, he was a acute kidney injury, Methicillin-resistant (MRSA) organism infection caused by become resistant to treat ordinary states as a multi drug resingular residentified infection. R100's Initial/Complete infection of MRSA, with intermedication per phy isolation precaution protocol and sign of During interview on nurse (RN)-A stated and has an indwellimetention. During observation R100's room had a	ion, interview and document illed to follow contact and for 2 of 2 residents (R100 and e on transmission based undated, identified he was ncy on 7/18/18, with urinary dwelling urinary catheter. arge summary on 7/18/18 dmitted to the hospital for and urinary tract infection with Staphylococcus aureus in his urine. MRSA is an a type of staph bacteria that's many of the antibiotics used ph infections, and is classified stant organism. Tehensive Careplan, 7/18/18, R100 had a current infection ventions of antibiotic sician order, all staff to follow s, isolation precautions per	F 8	80	F880 Infection Control R100 has been discharged from facility. R3 has had her contact enterprecautions discontinued. No residents are currently on transmission-based precautions at time. The DON or designee will proving re-education to all appropriate staff contact and enteric precautions per Meeker Manor Procedures. The DON or designee will come audits for 3 residents for contact and enteric precautions (if applicable) a staff members will be interviewed of proper procedures for contact and precautions, this will be conducted X4, and then monthly X2. Audit rewill be reviewed by QAPI Committee further recommendation. Completion Date: 9/10/2018	this vide f on r plete nd and 3 on enteric weekly esults	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRU			TE SURVEY MPLETED
		245361	B. W i ng			07	/27/2018
	PROVIDER OR SUPPLIE	ITATION CENTER, LLC		600 SOUTH	DRESS, CITY, STATE, ZIP CO DAVIS AVENUE LD, MN 55355		
(X4) ID PREF I X TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EA	PROVIDER'S PLAN OF COR ACH CORRECTIVE ACTION SS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	bleach. There was Contact Precautions. Ever entering and leave Must: gown and gedicated or disposable equipment and set disposable equipment and set of the back of his was in the room usually a gown and them they need to about it. During observation by sical therapism with no gloves or urinary catheter thooks it onto his tubing and bag. of R100's walker around the resides soiled hands. Prand places his cliwheelchair cushies.	page 118 as sign on the door that read, ons, in addition to Standard eryone must, clean hands when ring room. Doctors and Staff glove at the door, use patient losable equipment. Clean and equipment. The back of the sign precautions and listed common RO's, which included MRSA. upplies, use dedicated or ment when available. Clean and equipment including IV pumps, es, and other electronic, supplies rior to removing from residents, assure resident is in clean disinfect assistive devices. Bew on 07/23/18 01:06 p.m. R100 with a vinyl bag that covered his er bag which was hanging from heelchair under his seat. R100 ein his room, with "stuff on" and gloves. If they don't I tell to do this and they are good on on 07/25/18 02:27 p.m. It (PT)-A entered R100's room gown on. He unhooked R100's long from the wheelchair and walker handling the catheter PT-A then touches the handles and places a transfer belts ent without first washing his r-A assists R100 to stand up, ip board on the residents on, where the resident was assisted R100 to stand with his assisted R100 to stand with his	F	380			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BU I LD		CONSTRUCTION		E SURVEY IPLETED
		245361	B. WING			07/	27/2018
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE O 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	transfer belt. PT-A his transfer belt, ar PT-A does not was catheter tubing and the room, PT-A pici it while walking with down the hallway. At 07/25/18 03:20 the physical therapclip board which wan overbed table in p.m. PT-A leaves Frolled up and unde while he cleansed PT-A stated the ga R100. He was told assistant (PTA)-A t dedicated equipme what to do with R1 since he was on conviewed the instruidentified using ded He stated there was room, and he shous anitize the gait/tra PT-A also stated he the bedside stand therapy room. He check in the future precautions are im During interview or stated all staff need when working with emptying his own i are unsure of his towar gloves, gown	walks with R100 holding onto and ambulate with resident. In his hands after touching the dicatheter bag. Before leaving the property of the R100 to the therapy room. In the R100 to the therapy room of the R100 room, was lying on a therapy department. At 3:22 R100's room and has a gait belt of this arm touching his clothing his hands with a gel sanitizer, it belt, under his arm, was from a lyesterday by physical therapy that he did not need to use that he did not need to use that for R100. PT-A was unsure constant precautions. PT-A citions on R100's door, that dicated patient care equipment as a transfer belt in R100's ld use that equipment and will exist the lean the clipboard and that it was sitting on in the will ask the nurses and double what he needs to do when	F 8	880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245361	B. WING			07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		e	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	each time, or use the is on contact preduction was disall staff need to folk door and use the defeated independent of the contact is contact is contact indicated all staff we precautions. R3's care plan date on contact isolation bacterial infection indicated all staff we precautions. R3's door to her roo "Contact Enteric Prindicated "They mu in the room and ren They must also weather and are particular to gastrointestinal organic or are easily transmonth."	re one in R100's room since recautions. 7/26/18 at 2:00 p.m. the PT-A recussed with RN-A who stated by the precautions on R100's redicated equipment. Contact Precautions, use gown and gloves when the contact with body fluids. The contact with body fluids. The care plan further recautions. The care plan further rere to follow contact. The note also st wear gloves and gown while nove them before leaving. The note also st wear gloves and gown while nove them before leaving. The reactions in the sknown or suspected to be some that are transmitted by the contact in the sknown or suspected to be some that are transmitted by the contact in the contact in the sknown or suspected to be some that are transmitted by the contact in the contact in the sknown or suspected to be some that are transmitted by the contact in the contact in the sknown or suspected to be some that are transmitted by the contact in the contact in the sknown or suspected to be some that are difficult to kill in the contact in the contact in the sknown or suspected to be some that are difficult to kill in the contact in th	F8	880			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	,	3) DATE SURVEY COMPLETED
		245361	B. WING_		07/27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	0.1.2.1.2
(X4) ID PREF I X TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 880	Continued From pa to include some of conditions."	age 121 the following common	F 880		
	1. Residents who h unknown etiology. 2. Residents who h bacterium that can diarrhea to life-thre colon).	ave acute diarrhea of ave Clostridium difficile (is a cause symptoms ranging from atening inflammation of the lorovirus or Rotavirus			
	maintenance assistand stated he was on R3's room. MAgloves and proceed linen while mountin of R3's bed. MA-A	on 7/23/18, at 9:38 a.m. tant (MA)-A entered R3's room going to put a new footboard -A did not put on a gown or ded to touch R3's bed, bed g the footboard on the frame was in R3's room for ninutes, and left the room g his hands.			
F 908 SS=F	interim director of r who go into R3's ro including dietary an	n 7/24/18, at 3:00 p.m. the nursing (DON) stated all staff from "should gown and glove" and maintenance staff. Int, Safe Operating Condition 2)	F 908	3	9/10/18
	and patient care equicondition. This REQUIREMED by: Based on observation failed to ensure the kitchen was in work	ntain all mechanical, electrical, quipment in safe operating NT is not met as evidenced tion, and interview the facility efreezer door in the main king condition to prevent ce build up in the freezer to		F908 – Essential Equipment, Safe Operating Condition All repairs will be made to the wa freezer including putting a new insula	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CON	STRUCTION		E SURVEY PLETED
		245361	B. WING			07/	27/2018
	PROVIDER OR SUPPLIER R MANOR REHABILIT	ATION CENTER, LLC		600 SOI	ADDRESS, CITY, STATE, ZIP CODE UTH DAVIS AVENUE FIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 908	safely store food for reviewed. This had residents, visitors a stored and subsequent of the findings include: On 7/23/18, at 7:02 kitchen was comple cooler/freezer com When the cooler do plastic strips (in platemperature) were behind serving carrientry door, inside the freezer door, extending about 8" wide as the cooler, the cooler above the with condensation, built up across its before to a height of height and the ice hinch at the thickest hanging plastic striffost build up on the downward; and sno strips when disturb frame was encased areas approximate crystal was observed door. Expandable door frame, some of frame and, in one sapproximately 1" are electrical box inside "caution" and was Various frozen mea	age 122 or 1 of 1 walk-in freezers of the potential to affect all 56 and staff who consumed food uently served from this freezer. It a.m. a brief tour of the facility eted, and the walk in bination unit was inspected. For was opened, hanging fine to help maintain pushed to the side and tucked fines. The freezer had its own fine cooler. On the floor, in front there was a wet area, (inches) from the door, and as about 7' (feet). The ceiling in fine freezer door was dripping The freezer door had ice/frost foottom, extending up from the finesproximately 4 inches in fouild up was approximately 1" finespectation of the freezer, finespectation of the freezer door finespectation of the inside the freezer door finespectation of the floor of th	F9	doo ope effe ope TEL item mai to b as r be r whe	or on to ensure the freezer is a crating condition. All residents have the potent ected if not provided appropriate ating equipment. Staff will be re-educated on Staff will be re-educated on Staff will be re-educated on solareas needing report or intenance. Audits of the facilities walk-ince completed weekly x 4 weekneeded. Maintenance Director or destresponsible party. QAA will provide redirection on necessary to ensure completion continuation of monitoring. Completion Date: 9/10/2018	ial to be ate using ers for freezer (s; then ignee will or change letion	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245361	B. WING_		07	/27/2018		
	PROVIDER OR SUPPLIER	TATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP 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 ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPR I ATE	(X5) COMPLETION DATE		
F 908	the door. On one of chicken dated 7/22 crystals in the bag, pork tenderloin page 2" by 4" in size) on During interview or assistant (DA)-A stice/frost build up in water on the floor at the ceiling. DA-A obeen a problem. On 7/25/18, at 6:39 was reviewed with and culinary service was present and winside the cooler. outside of the freez However, the frost the door, the door plastic strips. The gone, but the pack the ice chunks wer freezer. When interviewed the frost on the our removed, as well as CD stated maintent cleaning schedule, deficiency cited for survey. At 6:45 p.1 director (ESD) join about the intervent freezer door. The track when they can function and also control of the contr	upper shelf a bag of cubed 2/18, had chunks of ice and ice On another top shelf, two ckages had ice chunks (about	F 90	08				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245361	B. WING_		07/:	27/2018	
	ROVIDER OR SUPPLIER 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 921 SS=B	past three months to down. The ESD state the expandable foar seal the door. The Esp aware of the condition were no formalized. During interview on administrator stated and a vendor had be coordinate installatic correct the problem. A facility policy regarefrigerators and free none was provided. Safe/Functional/Sar CFR(s): 483.90(i) §483.90(i) Other Enthe facility must presanitary, and comforesidents, staff and This REQUIREMEN by: Based on observative review, the facility	I the exhaust system in the o help keep the moisture ated he was unaware when m had been placed to try and ESD stated although he was on of the freezer door, there plans to correct it. 7/27/18, at 3:31 p.m. the if the freezer had a faulty seal, een contacted who would on of a new freezer door to arding maintenance of eezers was requested, but initary/Comfortable Environ evironmental Conditions ovide a safe, functional, ortable environment for	F 9		e being any st tate the ver the	9/10/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION		E SURVEY PLETED
		245361	B. WING			07/2	27/2018
	PROVIDER OR SUPPLIE	R ITATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 921	When interviewed stated he would li in the building repexpressed it mad furnishing and ca R24's annual MD had intact cogniticat 2:28 p.m. R24 carpeting as it wanded, "Please good on 7/27/18, at 1:10 main dining room floor was carpeted dark maroon edgicarpet had numer colored stains which entire hallway applied carpet whindividual tile(s) his border. Further, shad visibly smash them which were when touched with A facility provided 7/27/18, identified used the hallway chapel services. On 7/27/18, at 1:2 observed the carpsurveyor and stat condition for apprint HK-A added the file.	I R36 had intact cognition. I on 7/24/18, at 2:27 p.m. R36 ke to see some of the carpeting blaced as it was unsightly. R36 e someone feel better if the rpet were nice looking. S dated 4/21/18, identified R24 bn. During interview on 7/24/18, stated the building needed new is so stained and soiled. R24 et clean carpet in here." If p.m. the hallway outside the and chapel was observed. The d with a light gray center and ing. The light gray area of the rous, various sized dark brown ich were present up and down . There were several tiles of the ad visible edging of a dark black several areas of the carpeting led substance(s) present on dark black in color and sticky	FS	021	Staff will be re-educated on era clean and well maintained enviror Audits of facility carpet cleanling be completed weekly x 4 weeks; then x 6 months; then as needed. 3 resinterviews of facility environment stot cleanliness of carpeting will be completed weekly x 4 weeks; then other week x 8 weeks; then month months; then as needed Maintenance Director or design be responsible party QAA will provide redirection or when necessary to ensure complete and/or continuation of monitoring processing to the complete and provide redirection or when necessary to ensure complete and provide redirection bate: 9/10/2018	onment ness to nen monthly ident pecific every ly x 6 nee will change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	X3) DATE SURVEY COMPLETED		
		245361	B. WING		07/27/2018
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 921	Continued From page 126		F 921		
F 925 SS=C	environmental serv maintenance team repairs since taking months prior. ESD maintenance crews correctly, so moisture properly which caustiles to discolor and had been discussion the carpet(s) in the been "all talk" so far place. Further, ESI like one used at sor sites, would help im A facility policy on a schedules was required. Maintains Effective CFR(s): 483.90(i)(4) Maintains program so that the rodents. This REQUIREMENT by: Based on observative review, the facility from and/or eliminate flies potential to affect a facility. Findings include:	were not cleaning the carpets re wasn't being wicked away sed the edges of the carpet curl. ESD expressed their n on improving or replacing nursing home, however, it had r with no formal plans put into 0 stated a tasking machine, me of their other managed prove the carpet appearance. arpet repair and/or cleaning uested, however, none was Pest Control Program	F 925	F925 – Maintains Effective Pest Co Program • All appropriate pest control spec flies has been resolved • The facility has a pest control co with monthly site visits and as neede • Staff will be re-educated on the control policy to ensure the facility is of pests • Audits of the facility will be comp	entract ed pest free

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/2	27/2018
	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 925	his plate while eatin had four flies on his offered to replace had one. R13 stated it and night." DA-B sin the dining room and added staff we flyswatters in the dining room area, a fly wa and upper body, arblinked her eyes we During a subseque R33 was in her room and flies were presupper body. R33 clout when flies land head, then rested the corner of her lip awaken and make On 7/23/18, at 8:18 bed with her eyes of flies were circling relanding on her face forehead, corner or lips. R11 furrowed as flies landed. Duat 11:26 a.m., flies room and continue R11's forehead and On 7/23/18, at 11:1 her room, R8 state	13 was shooing flies away from ng. An adjacent resident, R6 is plate. Dietary Aid (DA)-B nis meal, but R6 stated he was awas like this "morning, noon, stated there were flies present during the summer months, are told they can't use ining areas. I a.m. in the south hallway day as buzzing about R33's face and she crinkled her nose and hile the fly was near her face. And observation at 8:16 a.m., arm, seated in her wheelchair, sent, circling her head and losed her eyes and moaned ed on her. The flies circled her on her nose, forehead and in os, which triggered R33 to more moaning noises. B a.m. R11 was lying on her closed, glasses on, and two esident's upper body and a pursed her lips, and crease between her brow and pursed her lips uring a subsequent observation continued to be present in the d to fly about and land on	FS	925	weekly x 4 weeks; then every other x 8 weeks; then monthly x 6 months as needed specific to fly and pest of throughout the facility specific to the dining room and resident rooms • Maintenance Director or design be responsible party • QAA will provide redirection or when necessary to ensure completiand/or continuation of monitoring properties. Completion Date: 9/10/2018	s; then ontrol e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245361	B. WING			07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		6	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	,	
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 925	p.m. R20 stated the summer". As a fly shooed it away, R2 wish they could get expressed she wish someone in to man aides and nurses whas changed. On 7/24/18, at 2:36 with a purple fly swhe has been using During interview on environmental serv questioned about a seen next to the buthe pest control corfly situation and the were sprayed today fly light was installed afternoon of 7/23/1 been a fly light instamonths ago. The cawas installed 24 ho room was reviewed size flies and sever cardboard was also stated there were a ESD stated he was entryways, but was dining or resident rowas no formalized a control and insect rowal placed 10-12 fly help with fly manage.	room on 7/23/18, at 12:33 e flies have been "bad all landed on her face and 0 stated "I hate flies!" and "I them before we eat. " R20 ned the facility would get age flies. R20 stated the vere aware of flies, but nothing of p.m. R100 was in his room atter in his hand. R100 stated it to kill flies in the facility. 7/24/18, at 2:47 p.m. the ices director (ESD) was portable, hand-held sprayer siness office. The ESD stated mpany was here looking at the exterior of the main doors of the main doors of the main doors of the ESD stated there had alled in the dish room several ardboard collector strip that urs 24 hours ago in the dining and the ESD counted six-full ral gnats. The fly light collector of checked in the dish room and at least 15 flies counted. The aware only of flies near the not aware of any flies in the coms. The ESD stated there system in place for pest management. The ESD stated swatters out in the building to ement. During interview a fly ing around surveyor's	F 9	025			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BU I LD		(X3) DATE SURVEY COMPLETED		
		245361	B. WING			07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		60	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE TCHFIELD, MN 55355	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 925	During interview on nursing assistant (Nother flies and everyon NA-G stated flies has but had become incompared the past coupresidents had compared to problems interviewed to licensed practical nurse terrible in genewas really hot. LPN swatters to use. During interview on administrator stated problems with flies recently had the periods.	7/26/18, at 10:32 a.m. NA)-G stated she was aware of one was provided a fly swatter. ad been present all summer, creasingly "persistent" and ble of weeks. NA-G said blained and stated she even esidents to kill them. NA-G was aware of the problem now" but was unsure of what A-G stated big problem was ne residents' rooms. On 7/26/18, at 11:30 p.m. urse (LPN)-C stated the flies ral" but became worse when it N-C stated the staff had fly 7/27/18, at 3:31 p.m. the d they have been having in the building and had st control agency out to treat.	FS	25			

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A: BUILDING 01 - MAIN BUILDING 01 B. WING 245361 07/25/2018 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 SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 25, 2018. At the time of this survey, Meeker Manor was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a), Life Safety from Fire, and the 2012 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 (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

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

08/23/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION 1 - MAIN BUILDING 01	COMPLETED			
		245361	B. WING			07/2	25/2018	
	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	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MU FOLLOWING INF 1. A description of to correct the defice	state.mn.us and an@state.mn.us DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency.		000				
	3. The name and/responsible for coprevent a reoccur Meeker Manor is a basement. The oin 1978, with build 1979 and 1988. The building additions	or title of the person rrection and monitoring to rence of the deficiency. a one-story building with partial riginal building was constructed ling additions constructed in The original building and both are fully fire sprinkler protected, ned to be of Type V(000)						
	detection in the co corridors which is department notific	fire alarm system with smoke pridors and spaces open to the monitored for automatic fire sation. The facility has a ds and had a census of 56 at						
	NOT MET as evid	- Maintenance and Testing		353			9/10/18	

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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	5/2018
	PROVIDER OR SUPPLIE	ITATION CENTER, LLC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH DAVIS AVENUE ITCHFIELD, MN 55355	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	Automatic sprink inspected, tested with NFPA 25, St Testing, and Main Protection System maintained in a savailable. a) Date sprinkle b) Who provide c) Water system Provide in REMA any non-required system. 9.7.5, 9.7.7, 9.7.8 This REQUIREN by: Based on obsert facility failed to maccordance with (NFPA 101) and standard for testi systems. This desprinkler system allow for the spread in the system allow for th	ler and standpipe systems are land maintained in accordance andard for the Inspection, intaining of Water-based Firems. Records of system design, spection and testing are secure location and readily er system last checked disystem test in supply source. RKS information on coverage for lor partial automatic sprinkler. B, and NFPA 25 IENT is not met as evidenced evation and staff interview, the maintain the sprinkler system in the 2012 Life Safety Code NFPA 25 section 5.2.1.1.2. The ing and maintenance of sprinkler efficient condition could cause the not to function properly and ead of fire. This could affect all of and an undetermined amount of	K	353	K353 – Sprinkler System – Mainte and Testing • Quarterly sprinkler system maintenance/testing completed or 731/2018 • Staff will be re-educated on the quarterly sprinkler system maintenance/testing • Audits of the facilities quarterly sprinkler system maintenance/test	e /	
	on 07/25/2018 do the last 12 month inspection report	ur between 9:00 am to 1:00 pm ocumentation review revealed in ns no quarterly sprinkler s were available and when Environmental Service Director			be completed quarterly x 4 quarter as needed Maintenance Director of design be responsible party QAA will provide redirection or when necessary to ensure complete and/or continuation of monitoring processes to the completion of monitoring processes and/or continuation of monitoring processes to the completion of monitoring processes and processes are completed a	nee will change	

PRINTED: 08/27/2018 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 07/25/2018 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 PRFFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 353 Continued From page 3 K 353 stated they had not been completed. This deficient condition was confirmed by the Environmental Service Director. K 712 Fire Drills K 712 9/10/18 SS=F CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: K712 - Fire Drills Based on record review and staff interview the The facility will complete and facility failed to provide documentation of fire drills document fire drills at least quarterly on at least quarterly on each shift as required by the each shift Life Safety Code (NFPA 101) 2012 edition, Staff will be re-educated on fire drill section 19.7.1.4 to 19.7.1.7. This deficient documentation and schedule practice could reduce the ability of staff to Audits of the facilities fire drills will be conduct a safe and timely response to a fire emergency, which would affect all residents and completed monthly x 6 months; then as an undetermined amount of staff and visitors. needed Maintenance Director of designee will be responsible party Findings include: QAA will provide redirection or change when necessary to ensure completion On facility tour between 9:00 AM and 1:00 PM on and/or continuation of monitoring process 07/25/2018, documentation reviewed revealed Completion Date: 9/10/2018 that Fire drills were not performed during these times:

PRINTED: 08/27/2018 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 07/25/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 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 712 Continued From page 4 K 712 1) 1st quarter 1st shift of 2018. 2) 1st and 2nd shift fourth guarter 2017 This deficient practice was verified by the Environmental Service Director. K 901 Fundamentals - Building System Categories K 901 9/10/18 SS=F CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99: Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced K901 – Fundamentals – Building System Based on documentation review and staff interview, the facility failed to inspect the building Categories The facility will complete a facility risk systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. assessment Staff will be re-educated on the facility Categories are determined by a formal and risk assessment documented risk assessment procedure Audit of the facilities risk assessment performed by qualified personnel. The deficient practice could affect all residents. will be completed upon completion of the risk assessment and annually x 1 year; then as needed Findings include: Maintenance Director of designee will During documentation review between 9:00 AM be responsible party and 1:00 PM on 07/25/2018, documentation QAA will provide redirection or change review and staff interview revealed the required when necessary to ensure completion risk assessment NFPA 99 had not been started at and/or continuation of monitoring process Completion Date: 9/12/2018 the time of the survey.

PRINTED: 08/27/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY MPLETED
		245361	B. WING		07/	/25/2018
	PROVIDER OR SUPPLIER	ATION CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST 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) COMPLETION DATE
K 901	Continued From pa	age 5	К9	01		
	Environmental Ser	ition was confirmed by the vice Director Essential Electric Syste	K 9	18		9/10/18
	Maintenance and The generator or cand associated equative service within 10 secriterion is not met process shall be procapability for the life Maintenance and to transfer switches a with NFPA 110. Generator sets are under load 30 minuday intervals, and emonths for 4 continunder load conditions simulated cold start transfer of all EES competent persons stored energy power accordance with N circuit breakers are program for period components is estamanufacturer requiremaintenance and to readily available. Ecircuits are marked separate from nor the possibility of day	resting other alternate power source uipment is capable of supplying econds. If the 10-second during the monthly test, a ovided to annually confirm this e safety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised ates 12 times a year in 20-40 exercised once every 36 auous hours. Scheduled test and automatic or manual loads, and are conducted by hel. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder enspected annually, and a fically exercising the ablished according to irements. Written records of esting are maintained and ES electrical panels and anal power circuits. Minimizing image of the emergency power consideration for new				

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A BUILDING 01 - MAIN BUILDING 01 B. WING 245361 07/25/2018 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 918 | Continued From page 6 K 918 6.4.4. 6.5.4. 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced bv: K918 – Electrical Systems – Essential Based on record review and staff interview the facility failed to provide test documentation in Electric System accordance with the 2012 edition of the Life The facility completed an annual Safety Code (NFPA 101) section 9.1.3.1 and the emergency generator inspection/testing 2010 edition of NFPA 110 the Standard for on 8/13 for the annual load bank test. The facility has completed their monthly Emergency and Standby Power Systems. This generator log. deficient practice could affect the safety of all 75 Staff will be re-educated on ensuring patients and an undetermined amount of staff the annual emergency generator and visitors if the generator failed to operate inspection/testing is completed for the during a power outage. annual load bank test & monthly generator Findings include: logs. An audit of the annual emergency generator inspection/testing will be On the facility tour between 9:00 AM to 1:00 PM completed annually; then as needed. An on 07/23/2018 record review and staff interview audit of the monthly generator log will be revealed: completed monthly x 4 months; then as 1) The monthly generator log was not completed needed. for 7/18, 6/18, 5/18 and 2/18. Maintenance Director or designee will 2) Annual load bank test was not performed. be responsible party QAA will provide redirection or change This deficient conditions was confirmed by the when necessary to ensure completion Environmental Services Director. and/or continuation of monitoring process Completion Date: 9/12/2018



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 13, 2018

Ms. Lynn Hogendorn, Administrator Meeker Manor Rehabilitation Center, LLC 600 South Davis Avenue Litchfield, MN 55355

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5361027

Dear Ms. Hogendorn:

The above facility was surveyed on July 23, 2018 through July 27, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

Meeker Manor Rehabilitation Center, Llc August 13, 2018 Page 2

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 Teresa Ament, Unit Supervisor at teresa.ament@state.mn.us or (218) 302-6151.

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.

Alison Helm, Enforcement Specialist

Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

alison Helm

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: alison.helm@state.mn.us

cc: Licensing and Certification File

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
MEEKER MANOR REHABILITATION CENTER, I (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (A0) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				00775	B. WING		07/2	7/2018
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				CENTER I 600 SOU	TH DAVIS AV	ENUE		
DEFICIENCY)	PREFIX (EACH DEFICIE	ÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	LD BE	(X5) COMPLETE DATE
Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A,10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the litem that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensure orders are delineated on the attached Minnesota	NH LICENSIN In accordance we 144A.10, this compursuant to a surfound that the deference are not corrected should be made and the Minnesota Determination of corrected requirements of number and MN When a rule corrected requirements of number and MN When a rule corrected result in the asset that was violated corrected. You may request that may result for orders provided the Department notice of assess INITIAL COMMEY you have agreed receipt of State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Minnesota Department in the Informational Buttp://www.healttobul.htm The State of the Informational Buttp://www.healttobul.htm The State of the Information Informat	In 1 p for h n with a construction of the cons	*****ATTENTION NH LICENSING CORF In accordance with Minne (144A.10, this correction of coursuant to a survey. If, ound that the deficiency nerein are not corrected, not corrected shall be assivith a schedule of fines phe Minnesota Department of the rule phenomenature of the rule phenomenature of the rule phenomenature of the rule phenomenature. Lack e-inspection with any iterate of compliance. Lack e-inspection with any iterate was violated during the corrected. You may request a hearing hat may result from nonorders provided that a without may request a hearing he Department within 15 footice of assessment for NITIAL COMMENTS: You have agreed to particulate the Minnesota Department formational Bulletin 14-nttp://www.health.state.mobul.htm The State licer	esota Statute, section order has been issued upon reinspection, it is or deficiencies cited, a fine for each violation is essed in accordance promulgated by rule of ent of Health. If a violation has been diance with all provided at the tag imber indicated below. It is weral items, failure to ems will be considered to form of multi-part rule will of a fine even if the item the initial inspection was a made to days of receipt of a mon-compliance. It is greatly a considered to days of receipt of a mon-compliance. It is greatly a considered to days of receipt of a mon-compliance.	2 000	DEI MILNOT)		

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

(X6) DATE TITLE Electronically Signed 08/23/18

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	7/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER 1 600 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To assigned to Minnesota Department be state and replaces the "Incommon to the state of control or cont	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 ment of Health. 18, surveyors of this visited the above provider and tion orders are issued. our electronic plan of have reviewed these orders, e when they will be completed. The ent of Health is documenting and numbers have been orders that the prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis column als	2 000			

6899

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00775	B. WING		07/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	MANOR REHABILITA	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	Continued From pa	ge 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 285	MN Rule 4658.0100 Orientation and In-S		2 285			9/10/18
	must provide in-ser education must be a continuing compete address areas iden assessment and as must address the s determined by the rhome must provide program in rehabilit to promote ambulat living; assist in activo frange of motion, positioning; and in tincontinence.	ssurance committee, and pecial needs of residents as nursing home staff. A nursing an in-service training ation for all nursing personneltion; aid in activities of daily vities, self-help, maintenance and proper chair and bed he prevention or reduction of				
	by: Based on interview facility failed to ensi- reviews were comp of 3 nursing assista whose files were re affect all 56 residen	and document review, the ure annual performance leted on an annual basis for 3 ints (NA-C, NA-D, NA-E) viewed. This had potential to its who resided in the nursing lid receive care from these		Corrected.		
		unnamed listing dated 7/23/18, ing nursing assistant (NA) dates:				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 3 of 116

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER I 600 SOU	DRESS, CITY, S TH DAVIS AV ELD, MN 553			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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
2 285	- NA-C was hired of full time basis; - NA-D was hired of full time basis; and, - NA-E was hired of full time basis. During the recertific 7/27/18, evidence we respective employed performance review NA-C, NA-D, and National director of the facility transition management compannual evaluations.	on 5/24/17, and worked on a on 6/30/16, and worked on a on 6/29/16, and worked on a cation survey, from 7/23/18, to was requested from their e files to demonstrate a whad been completed for A-E. No evidence was on 7/27/18, at 2:02 p.m. the operations (RDO) stated when	2 285			
	review going forwar anniversary came used to other plans in place valuations up more and a facility policy on Monot provided. SUGGESTED MET The administrator, a could develop/revising procedures related nursing assistant per quality assessment could perform rando compliance.					

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 4 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOU	DDRESS, CITY, TH DAVIS AV ELD, 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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 285	'	ge 4	2 285			
2 560	Plan of Care; Contents comprehensive plan objectives and time long- and short-term and mental and psylidentified in the con assessment. The compust include the increquired by Minnes subdivision 14, para	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 560			9/10/18
	by: Based on observati review, the facility facomprehensive car R38,R11, R24, R36 lacked updated car Findings include: R25's Diagnoses R identified diagnoses respiratory failure, o status, and also ind impairment. The M admission date as 8 R25's Care Area As dated 5/21/18, iden include and address problems in the cor direct R25's needs	on interview and document ailed to develop a e for 5 of 5 residents (R25, 5 and R44) reviewed who e plans. eport printed 7/26/18, s which included chronic dysphasia and tracheotomy icated severe, cognitive IDS also identified R25's		Corrected.		

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B WINC			
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER I	TH DAVIS AV LD, MN 553			
(X4) I D PREF I X TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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
2 560	urinary continence; dehydration/fluid m psychotropic drug und R25's physician's or Order Summary Reston document in progrespiratory rate, 02 amount, color and appearance of ston frequency of tracher change; and Tracher During observation tracheotomy (tracher receiving oxygen vipresented with audiamount of clear see bubble-like. Licensentered the room a intervene to clear h subsequently provint trach. R25's Initial/Compressed goal dated of computer-generate numerous care and each care area lists scripted intervention checked to include also included spacelisted on the pre-princluded resident-stracheostomy care.	falls; feeding tube; aintenance; pressure ulcer; use; and pain. Inders, as identified on the eport, dated 7/11/18, directed: gress noted after suctioning SATS (oxygen saturation), consistency of secretions, na, frequency of suctioning, (tracheostomy) care and plugging regimen per family. In 7/24/18, at 3:19 p.m. R25 was in place and was at the trach tubing. R25 and ible gurgling, and a small cretion coming from his mouth, sed practical nurse (LP)-A and deteremiend she would his congestion, and ded R25 with suctioning of the rehensive Care Plan with a 5/10/18, was a and document that identified deproblem areas, and under ed various, pre-written, ns, some of which were for R25's care. The document at to detail interventions not inted form. R25's care plan pecific interventions related to a presented in the electronic	2 560			
	heath record, ident or more than two a	ified a target date of 5/10/18, nd one-half months after the fication survey on 7/23/18.				

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 6 of 116

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00775		B. WING		07/2	27/2018
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADD	DRESS, CITY, S	STATE, ZIP CODE	,	
MEEKER	MANOR REHABILITA	ALION CENTER I		H DAVIS AV LD, MN 553:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPR I ATE	(X5) COMPLETE DATE
	target goals and fut areas included in the care plan lacked incomplysician's orders to tracheostomy care. When interviewed or registered nurse (RR25's care plan in the really have a currer "was not right." RN admitted, assessmedone to complete or "we can use that castated she did not promprehensive car acknowledged the or "Initial/comprehension did not have goal do not include the plan, the pertinent labs, the rand "really any infor RN-C stated the connected to be in plan R38's Diagnosis Rediagnoses which infailure, hypertension disease. R38's adright (MDS) indicated R3 was admitted to the Care Area Assessment of the care area area.	ked specific, measurable ure dates for each of the care plan. Further, Reclusion or instruction to hat further directed R25 on 7/26/18 at 10:41 a.m. N)-B stated after review he computer, that R25 of target, and R25's care left and data collection ur initial care plans, and are plan for 92 days." R	e care 25's include 's include 's ing did not e plan ent was was I stated N-C sted as plan lso did ould." RN-C in heets, care." entified i	2 560			

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 7 of 116

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0111	0.10
MEEKEF	R MANOR REHABILIT	ALION CENTER 1	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	plan, related to neemobility, transfers at R38's Treatment Ac 7/26/18 identified at to obtain daily weig (pounds) overnight nephrology. Additional dialysis care includifile for any new ord to remember to ser resident and commobtain vital signs af and snack in the af During interview on stated he gets the facility. R38 stated home, and was in ta heart attack, and following the incide out of the building to During observation exited his room, ho regular wheel chair toward the day roomat a steady pace, mo signs of pain or shortness of breath R38's Initial/comprepresented in the eleidentified a goal damonth following state on 7/23/18, or 20 d CAA. R38's care p	d for supervision with be and toileting. dministration Record printed nursing order dated 6/23/18 ht, and report changes of 3 lbs or 5 lbs in a week to onally, the treatment record direction regarding R38's ing: to check communication ers upon return from dialysis; and a snack or lunch with unication form to dialysis; to the dialysis; and to offer rest ternoons post dialysis. 7/24/18, at 3:00 p.m. R38 help and care he needs at the he was planning to go back he facility for "rehab" following that he felt much better now nt. R38 also stated he went o get dialysis. on 7/24/18, at 3:10 p.m. R38 lding on the handles of a , ambulated down the hallway m area. R38 was able to walk he health a sectronic health record, the of 6/22/18, or more than a lart of the re-certification survey ays following completion of the	2 560			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 8 of 116

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOU	DDRESS, CITY, S TH DAVIS AVE	ENUE		
		LITCHFIL	ELD, MN 5535	55		
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPR I ATE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 8	2 560			
	instruction to includ treatments that furt care.	care plan lacked inclusion or e physician's orders including her directed R38's dialysis				
	stated R38's care p was his original, init	7/26/18, at 10:41 a.m. RN-B lan in the electronic record tial care plan. RN-B stated the s care plan goals was not				
	When interviewed on 7/27/18, at 11:44 a.m., the interim director of nursing (DON) stated there was some misunderstanding as to how long we can use the initial care plan document. The DON stated initial/comprehensive care plans were a good start, but that residents' comprehensive care plans were to be in place by day 21 after a resident admission. The DON stated and recognized some of the residents' care plan were not up to date and had goal target dates that were not in the future.					
	indicated R11 exhib impairment and rec complete her ADL's personal cares. R1 included anemia, cl	ange MDS dated 4/30/18 bited severe cognitive eived extensive assistance to including mobility and 1's medical diagnoses pronic kidney disease, and generalized weakness.				
	experienced alterat wounds on right foo directed staff to imp interventions which watching television family/friends comp directed staff to mo	ised on 7/23/18, identified R11 ion in comfort related to of and coccyx. R11's care plan blement non-pharmacological included: reposition, in her room, warm blanket, pany, music. The care plan nitor R11's level of pain with eet or FLACC (Face, Legs,				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 9 of 116

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	Activity, Cry, Consorpain assessment postated resident was ordered by primary monitor for the efferas well as potential encourage resident encourage resident encourage rest per staff to turn and reptwo and a half hour not slide to decreas directed to encoura while in bed and offor the directed to encoura while in bed and offor the directed to encoura while in bed and offor the directed to encoura while in bed and offor the directed to encoura while in bed and offor the directed to encoura while in bed and offor the directed to encoura while in bed and offor the directed to encoura while in bed and inquire progressed, FM-A was crying because responded "yes". Final received pain roworking. Lets eat query down." R11 was obher wheelchair as F7:29 a.m. R11 was FM-A was dabbing wheeled out of the da.m. On 7/23/18, at 8:35 resting on bed which mat at the bedside. vocalizations, howewhen asked if experience.	plability)/Dementia scale, with a ser protocol. The care plan to receive medications as provider and staff were to ctiveness of the medication, side effects. Staff are to to verbalize discomfort, and iods. The care plan directed position resident every two to s. Staff were directed to lift, see friction. Staff were also ge resident to lie on sides	2 560			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 10 of 116

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		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	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)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	age 10	2 560			
	resting on her bed with eyebrows and was noted in the cowas making rhythm discernible words.	on a.m. R11 was observed and displayed facial grimacing, forehead furrowed, moisture orner of her eyes. Resident nic moaning noises, without				
	assessment was coregistered nurse (Rhad pain in coccyx indicated: "Resider and rated 4/10 at will sleep and daily activated R11 had at 8:00 a.m. and ar assessment identified for Morphine 10 moneded, however, imedications were rassessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed. The assessment period included adminsitration for effect signs are signs and symptom needed. The assessment period included adminsitration for effect signs and symptom needed.	The interventions identified ation of mediations as ordered, ctiveness, monitor resident for as of pain and intervene as esment also indicated that staff are provider as needed. These not added to the care plan.				
	wheelchair with her R11's eyes were claresident was moan pattern. Hospice nuthis time. Nursing a to provide cares, ar pillow to provide ful to cry out with moar oom to provide as to place the mecha	I p.m. R11 was observed in her legs elevated on foot rests. osed, brows furrowed, and ing in a constant, rhythmic urse (HN) present in room at assistant (NA)-G entered room and placed R11's right leg on a ll leg support. R11 continued ning sound. RN-B entered sist. NA-G and RN-B assisted unical lift sling, while R11 y a constant moan which				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 11 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00775	B. WING		07/2	7/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ALION CENTER I	TH DAVIS AV LD, MN 553			
(X4) ID PREF I X 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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	transferred to the b was removed. R11 open area present noted to be in place ceased moaning with any increased positioned, RN-B awas. R11 continued but did not identify offered to remove pintensified with this pillow down and as blanket was placed support/pressure thevel. R11 stated pacrying out/moaning pain, however, R11 with moaning. HN arms, offering word of RN-B of recent pRN-B stated she we room. During interview fol 7/25/18, at 2:46 p.m observed to be understand the word of this was not comfort. NA-G was interventions to be comfort for R11. During continued o p.m. R11 began to	sical movement. R11 was ed and mechanical lift sling was observed to have an on her coccyx with no dressing e. R11 was noted to have hile lying still, however, vocalizations which intensified movement. Once R11 was sked resident where the pain with moaning vocalizations where pain was located. RN-B oillows and vocalizations. HN provided prompts to shift sure heel was floating. A	2 560			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 12 of 116

Minneso	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/27/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MEEKER	R MANOR REHABILITA	ALION CENTER 1	TH DAVIS AVI 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 560	Continued From pa	ge 12	2 560			
	(LPN)-A entered roo liquid and stated R? PRN (as needed) r 2:49 p.m. R11 contiquivering and tears offered to provide F member (FM)-A. R responding "mmmh and tears were prest. LPN-A placed a cal held the phone to Robserved to have lipforehead furrowed. closed and R11 was vocalizations and teme, help me, help r At this time, the hear R11 was lying on he her right leg, and H shoulder and arm in p.m. R11 continued commented with paconsistently take he management. At 2: by staff, R11 spoke LPN-A checked to sphone and identified phone. R11 continuatione, of pain, and c stated R11 also had when asked what in effective. LPN-A was interventions to be medication adminis a family friend (FF)-indicated FF-A may	sent in corners of both eyes. Ito FM-A at 2:51 p.m. LPN-A at 11's left ear and R11 was os pursed, brows and R11's eyes were squinted actively crying with ears present. R11 stated "Helpine" crying out into the phone. It do f the bed was elevated, er back, pillows were under N and LPN-A were rubbing her no comforting motion. At 2:55 to call out. LPN-A in management R11 did not er methadone for pain 58 a.m. while being comforted in to telephone "It hurts." see if FM-A remained on the ed FM-A was no longer on the ed to call out, in an amplified ontinued to moan. LPN-A did Ativan for symptom control aterventions have been				

put on as a distraction, however, was not helpful.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/	27/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	·	
MEEKER	R MANOR REHABILIT	ATION CENTER I	JTH DAVIS AVI ELD, MN 553			
(X4) I D PREF I X 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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 560	LPN-A went on to smorning dose of manifer supply available. Let dose was given and with previous shift to given. On 7/25/18, at 3:26 massage hands an vocalizations decrease frequency. R11 resishe was sad or in page 12.	state R11 had not received her orphine because there was no PN-A was unsure when last d stated she would follow up to check when last dose was p.m. HN continued to ad lower arms and resident eased in intensity and sponded "Both" when asked if pain. HN continued to massage.				
	the Hail Mary and of with facial expressing decreased furrowing tears. On 7/25/18, at 3:30 room and informed methadone was given the morning dose for given. LPN-A stated contacted regarding awaiting a script. It monitored by the far pharmacy.	to pray with R11. R11 started continued to repeat this prayer on becoming more relaxed, ag of brows, and absence of p.m. LPN-A returned to the HN the last dosing of the previous evening and or methadone had not been dight pharmacy had been gineed for refill and was LPN-A stated the supply is acility staff and also by the				
	in correspondence R11 had last receiv 4:48 p.m The doc refusal of methador 7/24/18. The medic indicated a refusal however, the individed indicated a count of on 7/24/18 at 4:45	dication administration sheet, with the Narcotic count book, wed methadone on 7/24/18 at umentation also reflected ne dosing the morning of cation record for 7/25/18 of morning dose of morphine, dual narcotic record for R11 f zero after dosing was given p.m. R11 was noted to received, 0.5 ml (10 mg) at 3:00 p.m.				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 14 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ALION CENTER I	H DAVIS AV			
	T	LITCHFIE	LD, MN 553		ON.	
(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
2 560	Continued From page 14		2 560			
	and again at 4:50 p	.m. for pain management.				
	bedside and stated early morning. FF-A comfortably at this R11 since early mo resting more comformance into room in the low position, head of her bed rai surveyor and stated On 7/26/18, at 10:4 bed, under covers a R11's facial express furrowed brows, squared lips. Trained was in with residen routinely scheduled dose of morphine for the R11 work was in with residen routinely scheduled dose of morphine for the R11 work was in with residen routinely scheduled dose of morphine for the R11 work was in with residen routinely scheduled dose of morphine for the R11 work work work work work work work work	D a.m. FF-A was a resident's she had been with R11 since A stated R11 was resting more time. stated she had been with rning and stated R11 was ortably at this timeupon resident was observed in bed resting on her back with the sed, and R11 looked to d'Good morning". FF-A 5 a.m. R11 was observed in and was noted to be awake. sion was noted to be free from uinted/tearful eyes, and d'medical assistant (TMA)-A t and stated R11 had received methadone and an additional or pain management and was ponded she was "Pretty good."				
	conversation FM-A 7/19/18 and again of R11's pain on 7/22/FM-A reported R11 was having pain in back. R11 stated it stated R11 was obsein a half hours, starting contacted staff and FM-A stated staff stadded "Sometimes us be." FM-A stated stated R11 had refu and they had discussion of R1/2/FM-A stated R11 had refu and they had discussion of R1/2/FM-A stated R11 had refused R1/2/FM-A stated Stated Stated R1/2/FM-A stated Stated R1/2/FM-A stated Stated R1/2/FM-A stated	24 a.m. during telephone stated she been with R11 on on 7/22/18. FM-A described 18 as "really bad". On 7/22/18 was crying, and stated she her buttocks, her legs, and her was from laying all day. FM-A served to cry for about two and ag at lunch. FM-A stated she requested transfer into bed. topped by a few times, but when I am there they just let if the nurse on Sunday had used medications on occasion seed alternate routes, but was anges made in plan. FM-A				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 15 of 116

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	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	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 APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 560	stated she was at the a.m. and R11 was table. FM-A describe. "Kind of moaning" a wrong R11 stated he R11 was experience received meds. FM inquired of her regassoothing. FM-A state watched old time testow. Stated R11 and has been out to aware of music in hot aware R11 had on 7/25/18. FM-A seet yeffective for R like to use morphin the way it made he contacted the admit third week in June to the fact R11 would. A review of the treat for pain management R11 was recorded at 55th to the 25th of p.m. shift. R11's pain management R11 was recorded at zero with which time the pain The information recorded at zero with which time the pain The information processing the state of the same to and information processing the state of the same to and information processing the same to and information processing the same to and information processing the same to a same the same to a same the same the same to a same the same t	ge 15 ne facility on 7/23/18 at 7:00 was crying at the breakfast led R11 to be sitting there and when asked was was her "Butt hurt". FM-A stated if hing pain, she should have M-A stated staff have not harding things R11 would find hed R11 previously had helevision like the Andy Griffith henjoyed country western music ho music activites, but is not her room. FM-A stated she was not received her methadone has been had historically, R11 did not he as needed as she didn't like her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she had histrator approximately the her feel. FM-A stated she was her "Butth to be served she was her "Butth to be serv	2 560			
	experience pain wit	to the difference of the country of				

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 16 of 116

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	7/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER 1 600 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	review of the pain a on 7/23/18, the DO expectation Hospic R11's increased precurrent intervention indicated. On 7/27/18, at 3:35 she had spoke to FThe administrator of FM-A's concerns recomfort for R11. The it was difficult to devocalizations as R1 vocalizations in a path turning and reposition R24's annual MDS identified R24 had it to communicate he noted to have a caturinary functions ar R24 received extended aily living (ADL's turning and reposition R24's diagnoses in neurological disording generalized muscle obesity. The Care A worksheet complete was at risk for preserisk factors, including neurological diseases spasms. The CAA is assist to turn and reservent in the care of t	p.m. the adminstrator stated M-A regarding R11's status. tated she had discussed garding management of e administrator stated at times termine underlying cause for 1 has made moaning ositive manner with pet visits. tated FM-A did express fort interventions and with oning of resident. completed on 4/21/18 ntact cognition and was able r needs and wishes. R24 was heter in place to manage and was incontinent of bowel. sive assist to complete tasks so which included transfers, oning, and personal cares. Cluded diabetes, arthritis, a per which affected mobility, a weakness, and morbid area Assessment (CAA) and on 5/4/18 indicated resident sure ulcers related to multiple and obesity, diabetes, es, chronic pain, and muscle andicated R24 would receive eposition every two hours, in ressure relieving mattress,	2 560			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 17 of 116

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/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOUT	DRESS, CITY, S TH DAVIS AVI 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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 560	R24's plan of care in R24 received assist related to R24's lev indicated R24 requit two staff to assist to every two hours and to provide. The care provide with assistat hygiene, including sincontinence cares plan identified R24 Ostomy, Continence Hospital for wound plan was revised or alteration in skin into on her right buttock staff were to monito with documentation identify weekly wou Integrated Wound On 7/23/18 at 8:44 generally in bed by to turn and reposition light on. R24 stated it was painful to lay extended period of The nursing assistative heading Offload The care sheet did indicator of every to although other residinclude the recommendation was months of June and Months of Jun	revised on 7/6/18 identified tance to complete her ADL's el of strength. The care plan ired extensive assistance of turn and reposition in bed d as necessary, in additional e plan also directed staff to ence to complete personal skin cleansing, and completion every two hours. The care went to the WOC (Wound, e) nurse at Meeker Memorial follow up and PRN. The care in 7/10/18 to identify an egrity related to an abrasion is. The care plan identified or skin integrity during cares, if weekly. The care plan did not not care services provided by Care. a.m. R24 stated she is 9:30 p.m. but is not assisted and until she puts her call a she had skin breakdown and in the same position for an time. ant care sheet identified under a Reposition "Assist of two." not provide a frequency we hours repositioning, dents care directions did nended time frame.	2 560			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 18 of 116

	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		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	0112	772010
MEEKER	R MANOR REHABILITA	ALION CENTER I	H DAVIS AV			
	Г	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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 560	Continued From page 18		2 560			
	be greater than four hours between checks or "repo" (repositioning).					
	plan instructed the least every two hourequested. RN-B st had not been turner frequency as "R24 however, stated the During interview on director of nursing soutlined turning and hours. The DON we preferred not to be was the facility respregarding benefits of	a.m. RN-B stated the care staff to turn and reposition at rs and more often as ated she was unaware R24 d and repositioned at this has never come to me", a care plan should be followed. 7/27/18, at 1:18 p.m. the stated the plan of care for R24 d repositioning every two ent on to state if a resident turned or repositioned then it consibility to educate the client of repositiong and to review its. This discussion should be e plan.				
		eport printed 7/26/18, indicated and chronic kidney disease.				
	decisions and was	/13/18, indicated he can make able to communicate his further indicated he had no				
	6/06/18, indicated has pleasant and coope					
	R44's Minimum Da indicated she was o	ta Set (MDS) dated 4/27/18, cognitively intact				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 19 of 116

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOUT	DRESS, CITY, S 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 APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	A facility investigation Office Of Facility He 7/14/18, at 23:29:00 nurse on duty anoth into her (R44) room money to allow him did. Victim (R44) a did, then he left the indicated R44 does breast. An Internal Facility Investigation 7/23/18, at 18:19:00 was reviewed and a discuss the incident originally indicated and did not want him conversation, R44 if fact accept the \$10 and the alleged per room, closing the dialocated (R44) said someon asked them to keep perpetrator (R36) this room. Victim (R44) want another encoustay away. The fact victim (R44) was put the perpetrator (R36) (R44) wishes to not agreed. During interview 7/2 stated R36's care pubehaviors and should another encoustage.	on report submitted to the ealth Complaints (OHFC) on indicated R44 reported to her resident (R36) had gone her couch her breast, which he sked him to stop, which he room. The report further not want him to touch her investigation was initiated. An five day report dated indicated R44's care plan administrator met with R44 to the investigation report R44 did not accept the cash into touch her. After a informed the facility she did in 100 in cash. R44 stated she petrator (R36) went into her cor behind them. The victim experted the suggested they go down to report the allowed him to touch her her suggested they go down to report the allowed him to touch her him to touch her him to touch her him to touch her him to state that she did not unter and wished for him to him to illity indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to sility indicated on the report the latt on 15 minute checks and him to touch her him to him	2 560			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00775	B. WING	<u> </u>	07/2	27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	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 CORRE (EACH CORRECTIVE ACTION SH- CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 560	Continued From pa	age 20	2 560			
		oited behaviors of sexual acilities care plan lacked to				
	indicated she had r	ecord printed 7/26/18, major depression, muscle I cognitive impairment.				
	R44's CAA dated 5/05/18, indicated she triggered in ADL's due to needing extensive assist in dressing, bathing, grooming and transfers. In addition the CAA indicated she triggered in urinary incontinence due to having occasional incontinence of urine.					
		ressive Care Plan dated she needed assist in ADL's and				
		re care plan dated 5/02/18, ner assistance needed in ncontinence.				
	stated she was awa not completed. RN the care plan must then she was told s	25/18, at 7:08 p.m. RN-A are that R44's care plan was I-A stated she was initially told be completed in 21 days and she had 90 days. RN-A stated a CAA should be included on				
	completion of resid	the development and ent comprehensive care plans none was provided.				
	The director of nurs review policies and regarding the timely	THOD OF CORRECTION: sing (DON) or designee could procedures with staff y development of resident care DON or designee could				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 21 of 116

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ALION CENTER I	TH DAVIS AV LD, MN 553			
(X4) I D PREF I X 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 page 21		2 560			
	perform audits to e	nsure on-going compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 575	MN Rule 4658.0430 Subp. 1 Health Information Management Service		2 575			9/10/18
	Subpart 1. Health information management. A nursing home must maintain health information management services, including clinical records, in accordance with accepted professional standards and practices, federal regulations, and state statutes pertaining to the content of the clinical record, health care data, computerization, confidentiality, retention, and retrieval. For purposes of this part, "health information management" means the collection, analysis, and dissemination of data to support decisions related to: disease prevention and resident care; effectiveness of care; reimbursement and payment; planning, research, and policy analysis; and regulations.					
	by: Based on interview facility failed to com within 48 hours of a	and document review, the aplete a baseline care plan admission for 1 of 1 residents and was admissions and had		Corrected.		
	Findings include:					
	R250 was admitted R250's admission of identified orders for	mission Record identified to the facility on 7/12/18. orders signed 7/12/18, tramadol (narcotic for pain hilligrams (mg) every 6 hours				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 22 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	MANOR REHABILITA	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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 575	Continued From page 22		2 575			
		or severe pain and Tylenol 325 RN for mild pain or fever.				
	Care Plan section for	HM Initial/ Comprehensive or pain and comfort was blank R280's risk for pain, a goal or nage pain.				
	R250's MHM Pain Evaluation dated 7/21/18, identified R250 had frequent lower back pain and rated her pain a 3 out of 10 and had been taking tramadol 50 mg as needed for pain. The pain did not interfere with her sleep but did interfere with her activities of daily living.					
	registered nurse (R back pain and was manage her pain. S completing the base	7/25/18, at 6:50 p.m. N)-A stated R280 had chronic admitted with tramadol to the was responsible for eline care plan, and it was not uld have included a care plan				
	A facility policy on b requested and was	aseline care plans was not received.				
	The director of nurs review/revise police care plans are deve educate all appropri develop a monitorir compliance and repassurance committe recommendations.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 23 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00775		B. WING		07/27/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MEEKEE	MANOR REHABILITA	ATION CENTER 600 SOUT	H DAVIS AV	ENUE		
MICENER	WANOR REHABILITA	LITCHFIE	LD, MN 553	55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF I X TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
2 625	Continued From pa	ge 23	2 625			
2 625			2 625			9/10/18
	MN Rule 4658.0450 Subp. 1 A-P Clinical Record					

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 24 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00775		B. WING		07/27/2	.018
MEEKER MANOR REHABILITATION CENTER 1 600 SOUTH			ET ADDRESS, CITY, SOUTH DAVIS AV HFIELD, MN 55	/ENUE		
(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 C	(X5) OMPLETE DATE
2 625	N. any change habits or appetite; O. pertinent factoresident's general content of the resident assessment.	in the resident's sleeping ctors regarding changes in				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure verification the consulting pharmacist reviewed resident medications and medical record on a monthly basis was readily accessible for 4 of 5 residents (R21, R37, R29, R7) reviewed for medication management.		ing d	Corrected.		
	5/22/18, identified F antidepressant and Diagnoses included anxiety disorder and record lacked evided had reviewed R21's record on a monthly R37's quarterly MD R37 was taking ant and anticoagulant r	imum Data Set (MDS) data R21 was taking antianxiety diuretic medications. I anemia, high blood pressed depression. R21's medicance the consulting pharm a medications and medically basis. S dated 6/28/18, identified ipsychotic, antidepressant nedications. The MDS of anemia, high blood	sure, cal acist			
	pressure and high or record lacked evide	cholesterol. R37's medical ence the consulting pharm a medications and medical				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		00775	B. WING		07/	27/2018
MEEKER MANOR REHABILITATION CENTER 1 600 SOUT			DRESS, CITY, S 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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 62	R29's quarterly MER29 was taking ant medications. The Manxiety disorder an record lacked evide had reviewed R29's record on a monthly. R7's quarterly MDS was taking insulin, diuretic and opioid included diagnoses diabetes, anxiety di R7's medical record consulting pharmac medications and m basis. During interview on interim director of n would need to contato receive the verificand record review of the interim DON state interim DON state consulting pharmac documentation that and record was review of low up and to medication review of the administrator areview policies and of the medical record as needed. The DO and to medical record as needed. The DO and the medical record as needed. The DO and the medical record as needed. The DO and the medical record as needed.	OS dated 5/25/18, identified ianxiety and antidepressant IDS identified diagnoses of didepression. R29's medical ence the consulting pharmacist is medications and medically basis. Is dated 4/20/18, identified R7 antidepressant, anticoagulant, medications. The MDS of high blood pressure, sorder and depression. Identified R7's edical record on a monthly 7/26/18, at 4:01 p.m. the fursing (DON) stated she fact the consulting pharmacist cation the monthly medication were completed. At 4:46 p.m. ated it was important to have macists monthly each resident medications iewed to ensure adequate	2 625			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 26 of 116

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILITA	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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 625	Continued From pa	ge 26	2 625			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			9/10/18
	receive nursing care 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 the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility for medications to allow administered as orc pain and discomfor R250) reviewed for resulted in actual ha	re physical symptoms of pain		Corrected.		
	Findings include:					
	(MDS) dated 4/30/1	ange Minimum Data Set 8, identified diagnoses that nronic kidney disease,				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 27 of 116

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	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKEF	R MANOR REHABILIT	ALION CENTER 1	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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	diabetes, dementia The MDS also indic assistance to comp (ADLs) and was se R11 was identified effective 4/25/18. A Assessment (CAA) identified R11's level limited her day to d severe, and was no assessment indicat pain in her right leg was also noted to h CAA identified pain enrolled in Hospice care was palliative R11's care plan rev experienced alterat pressure ulcers on R11's care plan ind non-pharmacologic repositioning, televi blanket, family/frier addition, the care p R11's level of pain FLACC (Face, Leg Consolability)/Dem assessment per pre R11 received medic primary provider (p monitor for the effe as well as potential encourage R11 to v rest periods. The ca and reposition R11 hours, and to lift, no	and generalized weakness. cated R11 required extensive plete activities of daily living verely cognitively impaired. as enrolled in Hospice a corresponding Care Area completed on 5/14/18, cel of pain impacted her sleep, ay activities, was rated as sted to occur frequently. The red R11 experienced vascular, and pain in her buttocks. The had improved since R11 had and the tright foot and coccyx. icated staff were to implement real interventions including sion in R11's room, warm and scompany, and music. In lan directed staff to monitor with the use of a flow sheet or so, Activity, Cry, centia scale, with a pain obtained as ordered by the hysician), and staff were to ctiveness of the medications side effects. Staff were also to verbalize discomfort, and use are plan directed staff to turn every two to two and a half of slide her to decrease ourage R11 to lie on her sides	2 830			

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018
NAME OF	PROV I DER OR SUPPL I ER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MEEKEI	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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	R11's pain evaluation identified R11 had cover the last five dathe pain had impact to day activities, and At the time of the affective indicated staff were and symptoms of portion of the end of the	on completed on 4/30/18, experienced pain frequently ays. The evaluation indicated ted her sleep, limited her day d was rated by R11 as severe. seessment, R11 was using on (narcotic pain medications) to the assessment indicated staff medications as ordered and to eness. The assessment also exto monitor for increased signs ain and intervene as needed. If a.m. R11 was observed in the sing moaning sounds. Family sponded to R11 and inquired was hurting. As the meal sked R11 at 7:23 a.m. if she are she hurt." R11 continued to FM-A was heard again asking any because she hurt, to which eas." FM-A was heard telling and because she hurt, to which eas." FM-A was heard telling and because she hurt and own." R11 was reclined back in FM-A assisted her to eat. At heard moaning out loud, and R11's eyes with a tissue. R11 and the dining room by FM-A at the dini	2 830			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 29 of 116

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00775		B. WING		07/2	7/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	MANOR REHABILIT	ALION CENTER I	H DAVIS AV			
LITCHFII			LD, MN 553			
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CO		(X5) COMPLETE DATE
2 830	Continued From pa	ge 29	2 830			
	R11 was making rhythmic moaning noises, without discernible words.					
	assessment was coregistered nurse (Rindicated R11 experand right foot. The states pain is occass [10 being the worst and daily activities.' indicated R11 recei (pain medication) 1 a.m., and 5 mg at 4 for morphine (narcomg as needed. How indicated the medicated the medicated the assessmit dentified for use of administration of monitoring for effect signs and symptom needed. The assessment did not Hospice regarding completion, or of ceffectiveness of the	ctronic records indicated a pain ompleted on 7/23/18, by N)-B. The pain assessment rienced pain on her coccyx document indicated, "Resident sional, and rated 4/10 at worst I, and does interfere with sleep The assessment further ved scheduled Methadone 0 milligrams (mg) at 8:00 at 00 p.m. in addition to orders of the pain medications included the pain medications included edications as ordered, at ordered, and intervene as sment also indicated staff care provider as needed. The trindicate notification of the pain assessment oncerns regarding a current pain regime.				
	contact regarding p Hospice director (H received any calls in been no notification increased pain leven nurse (HRN)-A who was currently out of she would advise h	ain management for R11. The D) stated she had not n follow up, and there had nor contact regarding R11's st. The hospice registered was R11's case manager of the office, but the HD stated er of the call and follow up.				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 30 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			, 50,25,110.			
		00775	B. WING		07/2	7/2018
NAME OF I	PROV I DER OR SUPPL I ER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ALION CENTER I	TH DAVIS AV			
		LITCHFIE	LD, MN 553	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 30	2 830			
	expectation of Hos contact the 24-hour of the pain, so eval current intervention subsequent develo of care for R11.	creased pain, it was the pice for the nursing facility to nurse call line to advise them uation and coordination of s could be done, with pment of an appropriate plan p.m. R11 was observed in her bed lying on her back. R11				
	was resting quietly with relaxed facial expressions. On 7/25/18, at 2:14 p.m. R11 was observed in her					
	rests. R11's eyes w furrowed, and R11 rhythmic pattern. H Nursing assistant (I provide cares, and pillow to provide ful to cry out with a monurse (RN)-B enter assistance. NA-G a a mechanical lift sli continued to constawith physical move her bed, and the m removed. An acidic room and HRN-A w related to R11's foo incontinence, so Hi her incontinence br provided by NA-G a incontinence of bow her coccyx with no stated this area wallast seen R11 for every service of the	RN-A requested staff check rief. Incontinence care was and RN-B with no noted wel. R11 had an open area on dressing in place. HRN-A is not present when she had waluation. RN-B stated their				
		ultant (WCC) had instructed rea open without placement of				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOUT	DRESS, CITY, S TH DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	a dressing. HRN-A Dressing (foam mo breathes) to the affr R11 had ceased mo were obtained, but vocalizations which movement. R11 wa body in a semi-fetal repositioned, RN-B was located. R11 co vocalizations and d was located. RN-B R11's vocalizations suggestions to shift R11's heel was float provide less support attempt to improve vocalized crying out leg was moved. RN however, R11 only moaning. HRN-A ru offering words of re RN-B about R11's r RN-B stated she wo room. During interview wit cares on 7/25/18, a R11 was observed evidenced by verba moving in chair, and stated she would as offer to lay R11 dow if those measures w comfort. During the began to cry out lou facial grimaces of h	ge 31 placed an Allevyn Sacral isture absorbing dressing that ected areas on the coccyx. Daning while measurements resumed moaning and intensified with any increased is observed to hold her upper position. Once R11 was asked R11 where the pain continued with moaning id not identify where her pain removed the pillows, and intensified. HRN-A offered in the pillow down to assure ting. A blanket was placed to the pillow down to assure ting. A blanket was placed to the pillow down to assure the pillow in an R11's comfort level. R11 the and moaning when her entire placed by the pillow of th	2 830			

Minnesota Department of Health

Minneso	<u>ita Department of He</u>	alth	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCT I ON	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00775	B. WING		07/2	7/2018
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NAME OF I	PROV I DER OR SUPPL I ER			STATE, ZIP CODE		
MEEKER	MEEKER MANOR REHABILITATION CENTER, I 600 SOU LITCHFI					
(X4) I D PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 830	Continued From pa	ge 32	2 830			
	•					
		p.m. licensed practical nurse				
		I1's room to administer				
		nen asked when the resident				
		eived dosing of morphine,				
		nad not received the morphine				
		lys. At 2:49 p.m., R11 t with her lips quivering and				
		th of her eyes. LPN-A offered				
		stance to contact FM-A. R11				
	•	sponding, "Mmmmmm." R11's				
		iver, and tears were observed				
		th eyes. LPN-A placed a call				
		n. LPN-A held the phone to				
		R11 was observed to purse her				
		ner brows and forehead. R11's				
	eyes were squinted	closed, and R11 was actively				
	crying with vocaliza	tions and tears present. R11				
	cried into the phone	e, "Help me, help me, help				
		e head of the bed was				
		lying on her back, pillows were				
		and HRN-A and LPN-A were				
		1's shoulder and arm in a				
		At 2:55 p.m. R11 continued to				
		ed R11 did not consistently				
		e (pain medication) for pain				
		HRN-A stated she had not				
		11's increased pain and added				
		ing had been increased two Hospice agency had not been				
		efusals to take her medication.				
		peing comforted by staff, R11				
		phone to FM-A, "It hurts." R11				
		t in an amplified tone of pain,				
		oan. During this interaction,				
		nad Ativan (anti-anxiety) for				
		hen asked what interventions				
		e. LPN-A stated R11 had a				
		who visited frequently, and				
	• , ,	who visited frequently, and what				

provided R11 comfort. LPN-A stated the television

STATE FORM 6899 Q3PC11 If continuation sheet 33 of 116

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0112	772010
MEEKER	R MANOR REHABILIT	ALION CENTER I	H DAVIS AV			
		LITCHFIE	LD, MN 553	55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		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	was put on as a dis LPN-A was not awa non-pharmacologic to provide R11 commot received her mobecause there had LPN-A was unsure morphine had been would follow up with During a visit with FHRN-A stated this wobserved R11 expends been notified by observed. HRN-A s FM-A, R11's primar facility on R11's pair R11's methadone hago, and stated she the hospice pharmaneed to increase R However, HRN-A sinformed R11 had retained to advise take the medication exhibiting increased supply of methador had increased the coverified with FM-A to was available. HRN director could have medications if needs stated the facility no for administration with the same could have medications if needs stated the facility no for administration with the same could have medications if needs stated the facility no for administration with the same could have medications if needs stated the facility no for administration with the same could have medications if needs stated the facility no for administration with the same could have medications if needs stated the facility no for administration with the same could have medications if needs stated the facility no for administration with the same could have medications if needs stated the facility no for administration with the same could have medications if needs stated the facility no for administration with the same could have medications if needs stated the facility no for administration with the same could have medications in the same could have medication with the same could have medication with the same could have medications in the same could have medications in the same could have medications and the same c	straction, but was not helpful. are of other cal interventions implemented afort. LPN-A stated R11 had corning dose of morphine been no supply available. When the last dose of administered, and stated she in the previous shift to check. R11 on 7/25/18, at 3:04 p.m. was the worse pain she had erience. HRN-A stated she had a staff of the increased pain stated they had worked with any medical provider, and the in management. HRN-A said and been increased two weeks a had intended to consult with accy and evaluate for a possible 11's methadone dosing. Stated Hospice had not been refused her medications, or out of R11's methadone ed she would have expected as the would have expected as the hospice of R11's refusal to in, of any symptoms of R11 dipain, and of any lack of the HRN-A stated when she dosing two weeks ago she had to assure an adequate supply I-A stated the hospice medical facilitated a refill of led, and if alerted. HRN-A ot having methadone available	2 830			
	massage R11's har	nds and lower arms, and R11 ecrease both the intensity and				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 34 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING			
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ALION CENTER 1	'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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	frequency of her vous "Both" when asked HRN-A continued to offered to pray with prayer out loud and prayer, with her fact relaxed as evidence her brows, and absolute of the brows of the prescript methadone supply and also by the pharmedical doctor (ME that day conducting obtained a written prefill during rounds. On 7/25/18, at 3:38 was responsible for HRN-A said the lact was of concern to her irresponsible" of the A review of the meding correspondence R11 had last receive 4:48 p.m. The docurefusal of methador 7/24/18. A review of the media of the prefile of the media of the brows of the media of the prefile of the pre	icalizations. R11 responded, if she was sad or in pain. It is massage R11's hands and R11. R11 started verbalizing a licontinued to repeat this ial expression becoming more ed by decreased furrowing of ence of tears. In p.m. LPN-A returned to the HRN-A the last dose of en given the previous evening, rning dose of methadone had stated the pharmacy had been he medication and was stion. LPN-A stated the was monitored by facility staff farmacy, and stated R11's D)-A had been in the facility grounds, but staff had not prescription for the methadone. In p.m. HRN-A stated the facility ordering the methadone. It p.m. HRN-A stated the facility ordering the methadone. It p.m. attended to do methadone for dosing her, and stated it was	2 830			
	however, the individ	of morning dose of morphine, dual narcotic record for R11 f zero following the 4:45 p.m.				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 35 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
	00775	B. WING		07/	27/2018	
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILIT	ATION CENTER 1 600 SOUT	DRESS, CITY, S TH DAVIS AVE LD, MN 5535				
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
for 7/25/18, identific mg/ml, 0.5 ml (10 ml) 4:50 p.m. for pain moderated a second management. LPN should be delivered. On 7/26/18, at 7:00 resident's bedside. resting on her back raised. R11 stated, she had been with stated R11 was restime. On 7/26/18, at 10:4 bed, and was noted expression was not brows, squinted/teat Trained medication R11, and stated R1 scheduled methade morphine for pain morphine for	dication Administration Record ed R11 received morphine 100 ng) at 3:00 p.m. and again at	2 830				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 36 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.	A. Bolebino.		
		00775	B. WING		07/2	27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER I	TH DAVIS AV			
		LITCHFIE	LD, MN 553	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 36	2 830			
2 830	shallow breathing in dosing of morphine R11 had taken only needed throughout stated R11 being or difference for her for doses of morphine HRN-A stated she with FLACC and wo score of eight to nir indicating severe particles on 7/26/18, at 11:2 from FM-A. FM-A s 7/19/18, and again R11's pain on 7/22/18 had stated she was legs and back, and stated R11 had been for about two and a contacted staff and into bed. FM-A state times, but added, "stated R11 had been for about two and a contacted staff and into bed. FM-A state T/23/18, at 7:00 a.m. Sunday told me [R1] on occasion and the routes." FM-A state T/23/18, at 7:00 a.m. breakfast table. FM sitting there "kind on R11 was asked what "butt hurt" and was was experiencing pain medication, ar her what types of the state	nay have been related to the e. HRN-A stated historically, one dose of morphine as the course of a day. HRN-A ut of methadone made a huge or pain, and receiving two impacted her response. used a dementia scale for pain ould have classified R11 as a ne on a scale of one to ten,				
	R11 enjoyed countr	ndy Griffith show, and stated by western music. Although been out to music activities,				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 37 of 116

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/	27/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER 1 600 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	FM-A was unaware provided in her roor aware R11 had not 7/25/18, and stated effective for R11 his R11 did not like to ubecause she did not made her feel. FM-the administrator apune regarding transwould call out in pathey had since been keep her comfortable. A review of the treasfor pain management R11 was recorded a 15th to the 25th of 2:30 p.m. shift. R11 2:30-10:00 p.m. for with zero to one. R1 the 11:00 p.m. to 6: pain levels were all exception of 7/26/19 was recorded at on On 7/27/18, at 1:37 (DON) stated if a reexperience pain with medicate before as reposition. When the 7/23/18, was review stated she would exception granding R11's increview current interiof care as necessal with the level of pain	of whether R11 had music m. FM-A stated she was not received her methadone on the methadone had been very storically. FM-A further stated use morphine as needed at like the way the medication A stated she had contacted approximately the third week in asferring R11, because R11 in with moment. FM-A stated in much better about trying to all better about trying to a exhibiting no pain from the July during the 6:00 a.m. to 's pain levels from the the same period was rated and in the same period	2 830			
	review current inter of care as necessal with the level of pai administration reconarrative notes and	ventions and modify her plan ry. A review was completed n recorded on the treatment				

Minnesota Department of Health

STATE FORM 6899 Q3PC11 If continuation sheet 38 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00775	B. WING		07/	27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MEEKER	R MANOR REHABILITA	ATION CENTER I	TH DAVIS AVE			
	T	TEMENT OF DEFICIENCIES	LD, MN 5535		OBBECTION	0/5)
(X4) ID PREF I X TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPR I ATE	(X5) COMPLETE DATE
2 830	correspond with the DON stated she was received her morning she was informed as the afternoon. The substances are ord through a routine restaff note the supply they were supposed to advise them of the time they were out was to be called an The DON further continued the need for a presche had left the facility. On 7/27/18, at 3:35 she had spoken to The administrator as FM-A's concerns recomfort for R11. The it was difficult to defor vocalizations in a purche administrator as expressed concerninterventions, especially as a substantial control of the reconstitution of	e interventions in place. The is unaware R11 had not ing dose of methadone until she was out of methadone in DON stated controlled ered from the pharmacy efill process. The DON stated if y is down to a one day supply, d to fax and call the pharmacy is. The DON stated at the of medication, the pharmacy d a plan of action coordinated. Onfirmed she was unaware of cription form from MD-A until ity following rounds. p.m. the administrator stated FM-A regarding R11's status. Itated she had discussed egarding management of the administrator stated at times termine the underlying causes R11 had made moaning ositive manner with pet visits. Its ostated FM-A had s with R11's comfort cially when turning and	2 830			
	severe pain, and Ty PRN, for mild pain R250's undated, Ini Plan section for pai	ng every 6 hours PRN for vended 325 mg every 6 hours or fever. tial/ Comprehensive Care n and comfort was blank and 0's risk for pain, any goals, or				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 39 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	I \ /	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOUT	DRESS, CITY, S T H DAVIS AV L D, 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	interventions to mark R250's Pain Evalua R250 had frequent pain a 3 out of 10. Thad been taking Tra pain, and indicated her sleep but did int daily living. On 7/23/18, at 11:2 lying in her bed. At had chronic lower be 6 out of 10. R250 de throbbing, and state Tramadol and it hel stated it had been a any Tramadol beca facility staff she was stated other medica stopped asking for On 7/25/18, at 2:28 bed. She sat up to the placed her right har grimaced. Once see she removed her ha longer grimacing. So what was going on was now rating her stated her pain was lying in bed most of her pain. R250's MAR for Jul received 15 doses of 7/12/18, until 7/17/1 Tramadol 50 mg we	nage pain. Ition dated 7/21/18, indicated lower back pain, and rated her The evaluation indicated R250 amadol 50 mg as needed for the pain did not interfere with terfere with her activities of 1 a.m. R250 was observed that time, R250 stated she tack pain, and rated her pain a escribed the pain as ed she had been prescribed ped relieve her pain, but 1-5 days since she received use she had been told by so out of the medication. R250 ations did not help, so she had medication. p.m. R250 was lying in her the edge of her bed and and on her lower back and atted at the edge of her bed, and from her back and was not he stated she had not heard with her pain medication and pain at a 7 out of 10. She better with movement, and the day did not help relieve by 2018, identified R250 of Tramadol 50 mg from 18. No further doses of the eadministered.	2 830			
	During interview on	7/25/18 at 2:36 p m NA-B				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 40 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	I \ /	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOUT	DRESS, CITY, S' TH DAVIS AVE ELD, MN 5535	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 40	2 830			
	interaction with her	ery independent and had little , but if she was having pain ained medication aid or nurse				
	During interview on 7/25/18, at 2:42 p.m. TMA-A stated R250 had not complained of any pain. On 7/25/18, at 5:16 p.m. the medication cart was reviewed with LPN-A. LPN-A stated R250 did not have any Tramadol on the medication cart, and no longer had an order for Tramadol. LPN-A stated R250 had chronic lower back pain. LPN-A was unaware of what non-pharmacological interventions were supposed to be attempted with R250. LP:N-A stated R250 had not been asking for pain medications for about the last week, and added staff should be asking R250 to rate her pain when they gave her pain medications.					
	stated R250 had chadmitted with Tram RN-A stated she was the baseline care prompleted. RN-As should have been dinterventions for paraware until that after complaining of backmedications, or tha RN-A stated she less physician and calle medication. RN-As cart should have remedication when the stated if there were additional pain medicational pain medicational pain medicational should have responsible.	7/25/18, at 6:50 p.m. RN-A pronic back pain, and had been adol to manage her pain. The arresponsible for completing lan, and verified it was not said a baseline care plan developed to include in control. RN-A was not ernoon that R250 had been at pain, had requested pain at R250 was out of Tramadol. The pharmacy to get her pain that the TMA or nurse on the ordered R250's pain here were 5 doses left. RN-A only 2 doses left and lis had not been received, the ave been called. RN-A stated we definitely done more to				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 41 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
MEEKER	R MANOR REHABILITA	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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 41	2 830			
	manage R250's pai	n.				
	A facility policy for prequested, but was	pain management was not received.				
	The director of nurs all residents at risk receiving the neces prevent pain. The of designee, could con delivery of care; to of	THOD OF CORRECTION: sing or designee, could review for pain to assure they are ssary treatment/services to director of nursing or nduct random audits of the ensure appropriate care and nented; to better ensure in.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 890	MN Rule 4658.0525 Motion	5 Subp. 2 A Rehab - Range of	2 890			9/10/18
	that is directed towa through positioning implemented and m comprehensive res of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without a limited rar experience reduction	ho enters the nursing home nge of motion does not on in range of motion unless al condition demonstrates range of motion is				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 42 of 116

	ETED.
00775 B. WING 07/27	7/2018
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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
This MN Requirement is not met as evidenced by: Based on observation, interview and document the facility failed to ensure a range of motion program for upper and lower extremities was implemented for 1 of 2 residents (R35) who had limited range of motion. Findings include: R35's face sheet, undated, identified diagnoses of dementia, muscle weakness and muscle wasting. R35's annual Minimum Data Set (MDS) on 6/18/18 identified R35 had moderate cognitive impairment, limited range of motion of her upper extremities on one side, and no nursing rehabilitation program. R35's rehabilitation Care Area Assessment (CAA), 6/13/18, identified R35 had a daily range of motion program. R35 was observed on 07/23/18 at 11:39 a.m. with her right hand curled around and under the arm of her wheelchair. Her right hand was closed and her wrist was bent and pulled inward towards the resident. On 07/25/18 at 5:58 p.m. R35 was in her wheelchair at the dining room table with her right hand closed and her wrist bent inward. There was no splints or supports on her right hand. She used her left hand to eat her evening meal, while her right hand laid on her lap. R35 was observed during evening cares on 07/25/18 at 7:04 p.m. with nursing assistant (NA)-J. NA-J placed a sling under R35's arms and hooked it to a mechanical lift (EZ stand), NA-J instructed R35 to grasp the handles of the EZ stand so he could hold herself while being	

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 43 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER 1 600 SOUT	DRESS, CITY, S FH 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 890	NA-J my right hand she was unable to g stand, but was able onto the stand. NA-bathroom for evening NA-J washes R35 to perineal care. After gown on R35 and to with the EZ stand. In attempts to prove R35's upper extremadated R35 had no personal cares, and stands for a few mistrengthening. NA-complete range of therapy provided the	does not do too much and grasp the handle of the EZ to use her left hand to hold. If then transfers R35 to the ng cares using the EZ stand. Under R35's arms, back and washing NA-J placed a clean ransferred R35 back to bed During this time NA-J made ide any range of motion to nities. 7/25/18 07:33 p.m. NA-J behaviors and they provide all d use the EZ stand so she nutes during cares for J stated she does not motion for R35 and thought	2 890			
	identified R35 had a (AROM), lower extr (UE), with participal 7 days in assessme minutes documente identified R35 atten offered. Exercise with movement and precontinue with plan. assessments identified R35's care plan, 6/2 with limited physica and osteoarthritis. Simplement active raind upper extremitito attend exercise in	assisted range of motion emities (LE)/upper extremities tion in AROM documented 4 of ent period with 3-5 reps for 10 ed each shift. The review ds exercises in activities when was effective in maintaining went further decline, will There were no other				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00775	B. WING		07/2	27/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER 1 600 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 44	2 890			
	identified AROM UE	y Follow Up Question Report E/LE daily up to 8 minutes. The reports identified the				
	30 times out of 62 of 1-15 minutes of times	entified R35 received AROM opportunities, and ranged from e for AROM. R35 refused ad not applicable 10 times.				
	23 times out of 60 of 2-20 minutes of times	entified R35 received AROM opportunities, and ranged from e for AROM. R35 refused ad was not applicable 12				
	received AROM 30 and ranged from 2-	7/26/18) identified R35 times out of 52 opportunities, 15 minutes for AROM. R35 imes, and was not applicable				
	therapist (PT)-A sta their case load, and	7/26/18 09:00 a.m. physical ted they don't have R35 on any functional maintenance completed by nursing.				
	registered (OTR)-A the exercise group	a.m. occupational therapist stated some residents go to but this would not work for an not follow the program and ve.				
	who provided morn completed AROM v and ready for the da each arm and leg, of	7/26/18 10:47 a.m. NA-D, ing cares for R35, stated she while she gets R35 dressed ay. She stretches and extends doing 10 repetitions on each snothing with her hands or				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 45 of 116

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER 1 600 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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 890	wrists, she only doe legs. On 07/26/18 11:14 get R35 dressed the AROM, for R35's up along with doing AF hand. They should repetitions of each was unaware the NAROM to R35's har should be doing this On 7/26/18 11:25 a therapy assistant (Chand which was clocurled in towards the R35's hand and wabut it "was tight." Ropen her right hand herself. COTA-A statherapy and do som splint to keep it straare tight along with unable to determine had not evaluated FThe occupational thassessment of R35 decreased right wrighter decline. Pla appropriate splint to positioning and estated SUGGESTED MET The facility could we and therapy departing programming for remotion services or motion services or motion services or motion services.	es AROM with her arms and a.m RN-A stated when NA's ey are expected to provide oper and lower extremities ROM of her elbow, wrist and be completing at least 5-10 movement everyday. RN-A A's were not completing nd or wrists and stated they s. m. certified occupational COTA)-A evaluated R35 right used with her wrist bent, and he residents. COTA-A opened a able to straighten her hand 35 stated she was unable to l or move her right wrist hated we need to pick her up for ne strengthening, and maybe a hight. Her upper extremities her shoulders, she was he if this is worse because they R35. herapist completed an h on 7/26/18, which identified het ROM and was at risk for	2 890			

Minnesota Department of Health

STATE FORM 6899 Q3PC11 If continuation sheet 46 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00775	B. WING		07/2	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOUT	H DAVIS AV			
WILLIALI	WANOK KENABILITA	LITCHFIE	LD, MN 553	55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 46	2 890			
	motion services for QA Committee.	completion and report to the				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			9/10/18
	comprehensive resion of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores treatment and services to event infection, and prevent eloping.				
	by: Based on observati review, the facility fa comprehensive ass related to pressure pressure ulcer inter development of mu residents (R24, R11 pressure ulcers. Th R24 and R11 who de-	ent is not met as evidenced on, interview, and document ailed to conduct a essment/reassessment ulcers and implement ventions to reduce the risk of ltiple pressure ulcers for 2 of 2) who were reviewed for is resulted in actual harm for leveloped multiple pressure friction and shear without		Corrected.		

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 47 of 116

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	27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 47	2 900			
	adequate interventi	ons.				
	Findings include:					
		ges defined by the National risory Panel (NPUAP):				
	erythema of intact s Intact skin with a lo erythema, which m pigmented skin. Pro erythema or change or firmness may pro changes do not inc	njury: Non-blanchable skin calized area of non-blanchable ay appear differently in darkly esence of blanchable es in sensation, temperature, ecede visual changes. Color lude purple or maroon e may indicate deep tissue				
	loss with exposed of Partial-thickness lo dermis. The wound moist, and may also ruptured serum-fille visible and deeper Granulation tissue, present. These inju	ss of skin with exposed bed is viable, pink or red, o present as an intact or ed blister. Adipose (fat) is not tissues are not visible. slough and eschar are not ries commonly result from ate and shear in the skin over				
	Full-thickness loss is visible in the ulce epibole (rolled wour Slough and/or eschof tissue damage vareas of significant wounds. Undermir Fascia, muscle, ter	njury: Full-thickness skin loss of skin, in which adipose (fat) or and granulation tissue and and edges) are often present. Her may be visible. The depth aries by anatomical location; adiposity can develop deep ning and tunneling may occur. Indon, ligament, cartilage texposed. If slough or eschar				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 48 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		R WING			
	00775	B. WING		07/2	27/2018
NAME OF PROVIDER OR SUPPL			STATE, ZIP CODE		
MEEKER MANOR REHAB	LITATION CENTER I	ITH DAVIS AV ELD, MN 553			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
Unstageable Prifull-thickness skewill-thickness sextent of tissue be confirmed be eschar. If sloug 3 or Stage 4 prestable eschar (if erythema or fluction should not R24's annual M4/21/18, identific was able to contain The MDS identification indwelling urinations. The MDS indicates assistance to contain the MDS indicates as in	tent of tissue loss this is an				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 49 of 116

				(X3) DATE SURVEY COMPLETED	
	00775	B. WING		07/2	27/2018
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION	N CENTER I 600 SOUT	DRESS, CITY, S H DAVIS AVI LD, MN 553			
PREFIX (EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	ULD BE	(X5) COMPLETE DATE
wheelchair. R24's care plan revised received assistance to complete personal dress R24. NA-K completed pto provide classistant to care seed that the dealing of the care should be as necessary. The care provide R24 with assistant hygiene including skin closed incontinence cares even plan identified R24 went Continence (WOC) nurs wound follow up, and as plan was revised on 7/10 abrasion on R24's right be identified staff were to meduring cares, and to condocumentation. The care identification of weekly we provided by Integrated V consultant). The nursing assistant cathe heading Offload Rep The care sheet lacked the hours repositioning as displayed as a sistent (NA)-K complete personal dress R24. NA-K completed pto provide cleansing to a sistence of the care sheet provide cleansing to a sistence of the care sheet personal dress R24. NA-K completed pto provide cleansing to a sistence of the care sheet personal dress R24. NA-K completed pto provide cleansing to a sistence of the care sheet personal dress R24. NA-K completed pto provide cleansing to a sistence of the care plan revised to the care plan revise	on 7/6/18, identified R24 complete her ADLs related The care plan indicated assistance of two staff to ed every two hours, and plan also directed staff to ence to complete personal leansing, and completion every two hours. The care to the Wound, Ostomy, se at the hospital for enceded (PRN). The care of 18, to identify an buttocks. The care plan honitor skin integrity mplete weekly be plan lacked wound care services wound care (wound care eare sheet identified under cosition "Assist of two." The frequency of every two directed by the care plan. (2/23/18, at 9:02 a.m.) K provided assistance to sing and grooming for peri cares, and proceeded abdominal folds. Upon to complete cares, R24's ia, rectal area, and skin	2 900			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 50 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		SURVEY PLETED	
			, w Bolesine.	·		
		00775	B. WING		07/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY,			
MEEKER	R MANOR REHABILIT	ATION CENTER I	UTH DAVIS AV FIELD, 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 900	'	age 50 ine. NA-K stated the nurses	2 900			
	will come in to asse concerns. NA-K sta	ess areas if there are ated at times the area is "So adding the areas were				
	at 9:14 a.m. R24 righthigh had an area appearance and m	of personal care on 7/23/18, ght gluteal cleft and upper macerated with a slough-like easured approximately 18 by 23 cms in a triangular				
	shape. R24's left by measuring approximal R24 also had an ar registered nurse (R	uttocks had a smaller area mately 13 cms by 13 cms. rea on her labia, which RN)-B described as, "Scabs."				
	light yellow (serous areas were conside	oximately a 5 cm area with b) drainage. RN-B stated thes bered friction or sheering, area would not be blanchable				
	personal cares wer and RN-B. Upon re product, RN-B state of tissue or scabs. commented the are	on 7/26/18, at 7:21 a.m. re provided with NA-F, NA-L, emoving the incontinence ed R24's areas had a build upouring provision of care, R2 ea was "Sore" and "It burns." heasurement of the areas as				
	Left buttocks area was described by F The alteration in sk perirectal area was by 2.4 cm.	was 17 cm by 11.6 cm and RN-B as oval in shape. in integrity on the labia and measured by RN-B at 3.7 cm a measured at 9.9 cm by 9.5	n			
	cares) RN-B stated (shifting and remove	th RN-B (during provision of I R24 should be off loaded ving pressure from affected oned every two to two and a				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 51 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOU	DDRESS, CITY, S Th Davis Ave Eld, Mn 5535	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 900	half hours. R24 co 7/25/18, she was as approximately 9:10 reposition until she a.m. to request repubetween being turn. Immediately following skin measurements RN-B reviewed the directed staff to turnevery two hours and RN-B stated the presonant would cause increat heat, which would letting it dry out," into pressure. RN-B stated the pressure. RN-B stated thicknessure. RN-B stated thicknessure. RN-B stated thickness following findings: 6/5/18: R24 was identified thickness buttock with the season the seaso	mmented aloud that on ssisted to bed at p.m. and was not assisted to put her call light on after 5:00 ositioning (over seven hours ed and repositioned). In the provision of cares and son 7/26/18, at 7:21 a.m. plan of care for R24 which and reposition R24 at least down more often as requested. Esence of an incontinence pad sed moisture sweat/body keep the wound moist, not creasing effects of friction and ted she was unaware of R24 and, adding R24 had not a concern. In grated Wound Care (Wound MCC) progress note was	2 900			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 52 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00775	B. WING		07/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION 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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 52	2 900			
	skin being normal.					
	listed with measure length X 0.5 cm wid cm. Again, scant se and the surrounding	kness buttock wound was ements recorded of 0.5 cm of th; with an area of 0.25 sq erous drainage was observed g skin was normal. The "The wound is improving."				
	listed with measure length X 0.5 cm wid cm. Again, scant se and the surrounding	kness buttock wound was ements recorded of 0.5 cm of th; with an area of 0.25 sq erous drainage was observed g skin was normal. The "The wound is improving."				
	wounds. Right buttocks: Par with a status of not in length by 3 cm in Left buttocks: Mixe	d pressure/ friction area, not ents of 1 cm in length by 5 cm				
	A wound care visit I the week of 7/10/18	by WCC was not completed on B.				
	status denoted as i Left buttocks: Mixed Deteriorating. A me	asured 14 cm by 14 cm. Skin mproving. d pressure and friction. asurement of the area was the wound care nurse.				
	7/24/18: Right buttocks: Par	tial thickness mixed disease.				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 53 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOL	DDRESS, CITY, ST JTH DAVIS AVE ELD, MN 5535	NUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Not healed. Measured Left buttocks: Mixed Deteriorating. Measured After this review on deterioration in skir should have been of causes of the deterioration in skir should have been of causes of the deterioration in skir should have been of causes of the deterioration in skir should have been of causes of the deterioration in skir should have been of causes of the facil Pressure Wound E 5/29/18, to 7/26/18, to 7/26/18, Coccyx: (site unsperecorded measurer completed of the wind is looking less red at the resident." 6/12/18: Coccyx (site unsperecorded measurer completed of the wind has decreased in scenter coccyx and in 6/19/18: Coccyx (site unsperecorded measurer completed of the wind secreased in scenter coccyx and in 6/19/18: Coccyx (site unsperecorded measurer completed of the wind secreased in scenter coccyx and in 6/19/18:	rement: 14 cm x 16 cm. d pressure/friction. surement: 14 cm by 16 cm. 7/26/18, RN-B stated with a condition, an assessment done to address the potential cioration. lity documents titled, Weekly valuation, were reviewed from which identified the following ecified): Shearing with no ments. No staging was ound. A "Date wound orded of 5/22/18. Further, has improved and not as red				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 54 of 116

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND LEAN	S. SOMESHOW		A. BUILDING:			1 0
		00775	B. WING		07/2	7/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	MANOR REHABILITA	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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 54	2 900			
	"Sheering [sic] is or slightly pink. Almos	nly around the coccyx area and thealed."				
	cm. Stage 2 Coccyx (Site unspectm. Stage 2 Coccyx (Site unspermeasurement) Stage Narrative note indiction being healed, with the areas on her left control of the stage of the	cified): Sheering: 1 cm x 3 cified); Sheering: 1 cm x 5 cified): Sheering: (no ge 1 cates that coccyx is close to the exception of two open ccyx. to reflect areas on coccyx.				
	14 cm Narrative note ident two to transfer with identify frequency of offloading.	cified): Sheering: 14 cm by tified R24 received assist of a mechanical lift but did not if turning, repositioning, or ecified): Type: Pressure. No				
	7/24/18:	gh: Pressure: Size 14 cm by 16				
	Right buttocks: Pre-identified).	ssure (No staging or size sure: (No staging or size				

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 55 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00775	B. WING		07/	27/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	MANOR REHABILITA	ATION CENTER I 600 SOUT	TH DAVIS AV	ENUE		
WILLIALIA	WANTON NETIABLE II	LITCHFIE	LD, MN 553	55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 55	2 900			
	Narrative note indic	cated R24 was educated as to nd reviewed with the director of ch included decreased healing				
	months of June and documentation was during this period o occasions it was no hours between che	s completed for R24 for the d July, 2018, and sunavailable for 14 days f 56 days possible. On 12 oted to be greater than four cks or "repo" (repositioning).				
	open areas were not 7/26/18, by RN-B a stated she was unaturned and reposition however, stated should be reflected DON stated when a assessment for pocompleted, and state consistent reposition had reviewed the ris 7/26/18, which incluskin condition, delacomfort if not routing of routine reposition further deterioration have not have specific documentation of Freposition, and state documented if this	p.m. the DON indicated R24's beted in the documentation on a pressure ulcer. The DON aware R24 was not being oned every two hours, as was aware R24 would refuse the DON stated refusals in staff's documentation. The askin area is not improving, tential cause should be ff should monitor for ming. The DON stated staff sks and benefits with R24 on uded potential worsening of the y in healing, and alteration in all repositioned. The benefits hing would be prevention of a of skin breakdown, improved rt. The DON stated she did cific information or 824's refusal to turn or ed this should have been had occurred. The DON stated benefits of routine turning and				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 56 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00775	B. WING		07/0	7/0040
NAME OF I		00775		274TE 7ID 00DE	07/2	7/2018
	PROVIDER OR SUPPLIER	600 SQU	DRESS, CITY, S T H DAVIS AV	STATE, ZIP CODE ENUE		
MEEKER	R MANOR REHABILIT	ATION CENTER I	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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 56	2 900			
	provide any docum	, however, she was unable to entation to reflect this had or was it included on R24's /26/18.				
	regarding R24's sk returned the phone The WCC stated sl care, and received 6/5/18. The WCC scaused by a mix of shearing. The WCC had deteriorated as notes, and there we involved for R24. T frequency of repositioning R24, and the second repositi	ed on 7/27/18, at 2:46 p.m. in condition. The WCC call on 8/1/18, at 4:45 p.m. he does consultation for R24 on stated R24's skin condition was things: pressure, friction, and C stated the pressure ulcer identified in the progress ere multiple areas that were his was related to lack of itioning R24, the process of and items underneath R24 bed or up in her wheelchair.				
	indicated R11 exhibitimpairment and recomplete her ADLs personal cares. R1 anemia, chronic kiddementia, and geneidentified R11 was pressure ulcer or g development of adR11 had an unhealR11's most severe noted to be eschardidentified as having and bed, and receivant and receivant and receivant identified as having and bed, and receivant and receivant identified as having and bed, and receivant identified as having and bed, and receivant identified as having and receiv	lange MDS dated 4/30/18, bited severe cognitive beived extensive assistance to sincluding mobility and 1's diagnoses included dney disease, diabetes, eralized weakness. The MDS identified as having a Stage 1 reater, was at risk for ditional pressure ulcers, and ed Stage 1 pressure ulcer. stage of pressure ulcer was /unstageable. R11 was g a pressure reduction chair wed pressure ulcer care.				
		oice Interdisciplinary note on a wound on R11's buttocks had				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 57 of 116

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018	
	PROVIDER OR SUPPLIER	STREET ADI	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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 900	R11's care plan rev was at risk for alter immobility, incontindiagnosis of hyperts staff to turn and rep and a half hours. Sislide to decrease from to encourage R11 to offload the press plan identified that regarding the press 7/23/18, and turning changed on 7/24/18 hours to every 2 1/2 During observation was resting on her the right side of the position. Review of the facility indicated R11 received and had, "Pressure coccyx. Resident her coccyx is smaller a was being reposition as needed (PRN). Incontinent of bowe incontinence pad to the documentation treatment for the coccyt in her back, with two pillows support her foot off	ised on 7/24/18, identified R11 ation in skin integrity related to ence, weight loss, and ension. The care plan directed position R11 every two to two taff were directed to lift, not iction. Staff were also directed to lie on her side while in bed ture on her bottom. The care the care plan was updated ture ulcer on the coccyx on and repositioning was a (during survey) from every 2 hours. On 7/23/18, at 8:33 a.m. R11 bed on her back with a mat on bed, with the bed in the low and is light red in color." R11 ned every 2- 21/2 hours and the note indicated R11 was all and bladder, and wore an aide in keeping the skin dry. In did not reflect a plan of occyx pressure ulcer. On 7/24/18, at 2:28 p.m. R11 or room resting on her her we under her right leg to of the bed. There were no place to attempt to alleviate	2 900				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 58 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	\ /	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOUT	DRESS, CITY, ST FH DAVIS AVE LD, MN 5535	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	A review of the WC indicated R11 had a 1 cm x 1 cm as WC assessment by the however, the WCC visit. The narrative Mepilex (soft silicor trauma to the press R11's coccyx, and Additional intervent included for staff to two and a half hour pressure reduction hospice recommen cares, and weekly s The WCC document to lay down in bed. During observation was seated in her velevated on foot reseyes closed, brows constant, rhythmic was present in roor in response to R11 reposition R11's rig continued to cry outhen entered the roassistance to transcontinued with a coassisted to transfer mechanical lift. An room and hospice reservant.	C wound note of 7/24/18, a reddened area on her coccyx C had noted per the narrative nurse manager on 7/17/18, did measure the wound at the note directed staff to apply a ne foam dressing minimizes sure ulcer) dressing border to change every three days. Sions outlined by the WCC reposition R11 every two to s, air mattress to bed, cushion in wheelchair per dations, daily skin checks with skin assessments by nurse. Intation indicated R11 preferred on 7/25/18, at 2:14 p.m. R11 wheelchair with her legs sts. R11 was sitting with her furrowed, and moaning in a pattern. The hospice nurse m. NA-G entered R11's room crying out. NA-G proceeded to the leg, however, R11 to with a moaning noise. RN-B om to provide NA-G fer R11 into bed. R11 nstant moan while being to the bed with the use of acidic odor was noted in the registered nurse (HRN)-A was	2 900	DEFICIENCY)		
	bowel incontinence incontinence brief to incontinent of bower area present on he place. HRN-A state	elated to the pressure ulcer or and requested R11's be checked. R11 had not been I, however, R11 had an open recoccyx with no dressing in this area was not present R11. The coccyx had drainage				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 59 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
			A. BOILDING.			
		00775	B. WING		07/2	27/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKE	R MANOR REHABILIT	ALION CENTER 1	TH DAVIS AV ELD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	on the incontinence HRN-A as circular, measured 2.5 cm b two areas on the let HRN-A stated it app. The area on the lef and the second meright side of the coc 2.5 cm by 1.7 cm w present measuring length. RN-B state them to leave the a a dressing. The HR dressing (dressing areas on the coccy RN-B asked R11 w offered to remove s R11's vocalizations offered suggestions assure R11's heel of 7/25/18, at 2:46 p.r uncomfortable as everbalizations/voca and facial expressions assist to reposition, would advise the niproviding comfort. It positioning for area but did not indicate alleviate pressure of Cn 7/25/18, at 3:36 and requested order coccyx. RN-B state resident for skin ca	e brief which was described by blood tinged drainage and by 2 cm. The coccyx also had ft side which were moist and peared, "as if it could slough." It measured 2.5 cm by 1 cm, easured 1.8 by 0.6 cm. On the ccyx there was an open area with a center bridge of slough 0.3 cm in width and 1.0 cm in d the WCC had instructed area open without placement of RN-A placed an Allevyn sacral that removes fluid) to the open x. Once R11 was positioned, where her pain was. RN-B some of R11's pillows and of pain intensified. HRN-A is to shift the pillow down and was floating. Illowing provision of cares at m. NA-G stated R11 was evidenced by dizations, moving in the chair, ons. NA-G stated she would and offer to lay down, and then curse if this was not beneficial in NA-G stated the importance of any specific interventions to on R11's coccyx. NA-G stated specific interventions for this. In p.m. HRN-A met with RN-B ers for wound care to R11's ed the WCC followed the re needs. HRN-A stated the eyx had been healed with most				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 60 of 116

	(X3) DATE SURVEY COMPLETED	
00775 B. WING 07/27/20	7/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MEEKER MANOR REHABILITATION CENTER, I 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	(X5) COMPLETE DATE	
2 900 Continued From page 60 Interdisciplinary Team (IDT) note identified on 7/20/18, indicated a wound on R11's buttocks was healed at that time. On 7/26/18, at 11:24 a.m. family member (FM)-A stated R11's pain level on 7/22/18, was "really bad." On that day, FM-A stated R11 was observed crying out, stating her back and coccyx hurt once she had been gotten up for lunch. FM-A stated R11 cried continuously for about two and a half hours on 7/22/18, and attempts at diversion by propelling her in the wheelchair and reclining the wheelchair were of little benefit. FM-A stated R11 ceased crying once assisted into bed per family request. This was a period of greater than three hours between repositioning. FM-A stated staff will usually not intervene or provide care to R11 when family is visiting. FM-A stated on 7/23/18, at 7:00 a.m. R11 was noted to be crying and moaning while up in her wheelchair, and she expressed pain in her coccyx. FM-A stated she had spoken to the facility about the frequency of repositioning for R11 towards the end of June, and had agreed upon a plan to turn and reposition her every one and a half hours. FM-A stated earlier in July, FM-A stated there was a period of one week between visits and upon her return visit, she observed R11 had developed a "bedsore." On 7/27/18, at 1:37 p.m. the DON stated she was aware R11 had a reddened coccyx, but was unaware of any open areas on R11's coccyx. The DON stated with observation of the reddened open area of the coccyx. The medical provider should be contacted. The DON stated staff should re-evaluate the turning and repositioning program to assure completion, and determine if		

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 61 of 116

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	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	the length of time parea of the body) as R11. The DON state tolerance assessment completed with the area, a significant of into Hospice. The Didentified triggers for she was unaware of R11's family. On 7/27/18, at 3:35 she had spoken to concerns about R1 and R11's pain mar stated she had follow the concerns relate. The administrator sidetermine the undervocalizations at time vocalizations at time vocalization in a positive of the work of the wor	ge 61 ressure can be tolerated to an assessment was completed for ed a subsequent tissue ent should have been development of a pressure change, and with enrollment DON state R11 met all three or evaluation. The DON stated f any concerns addressed by p.m. the administrator stated FM-A regarding the family's 1 not being positioned timely, hagement. The administrator owed up with staff regarding d to turning and repositioning. Itated it was difficult to orlying cause of R11's es, because R11 made similar sitive response to pet visits. p.m. The WCC was called to conditions, and plan of A phone call was returned w1/1/18, at 4:45 p.m. The WCC atted wound care consultation 12/18. Initial measurements of sure ulcer on the coccyx were The narrative note of 7/24/18, ased on the nurse manager's 17/18, which indicated wound 1 cm x 1 cm reddened area areview of measurements. A on 7/25/18, at 2:14 p.m. observed to have had ontinence brief which was A as circular, blood tinged sured 2.5 cm by 2 cm. The pareas on the left side which care as on the left side which	2 900			

Minnesota Department of Health

STATE FORM 6899 Q3PC11 If continuation sheet 62 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF C	CORRECTION	IDENTIFICATION NUMBER.	A. Bu i ld in g:		COMP	LETED
		00775	B. WING		07/2	7/2018
NAME OF PRO\	VIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MEEKER MA	ANOR REHABILITA	ALION 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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
we con cm op of 1.0 car and every we in I import the control of 1.0 car and every we in I import the car and every we in I import th	and slough." The and by 1 cm, and the new area was 2.5 lestough present more of the pressure o	N-A stated it appeared, "as if it area on the left measured 2.5 e second measured 1.8 by 0.6 le of the coccyx there was an by 1.7 cm with a center bridge neasuring 0.3 cm in width and ne WCC stated the underlying are ulcers was from pressure, apportant to reposition R11 ne WCC stated these areas sitting in wheelchair, and laying The WCC stated it was ion R11 every two hours, reduction mattress on the are reduction cushion in her are reduction cushion in her are reduction was noted to be skin condition was noted to be skin condition was noted to be skin condition and the policy cific interventions to be skin condition was noted to be a feet of pressure ulcers to assure the necessary to prevent pressure ulcers do promote healing of the director of nursing or anduct random audits of the ensure appropriate care and nented; to reduce the risk for	2 900			

6899

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00775	B. WING		07/2	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 915	Subp. 6. Activities comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's condipart, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of tion. For purposes of this ily living includes the as, and groom; d ambulate;	2 915			9/10/18
	by: Based on observati the facility failed to recommended walk implemented consis (R23) who needed Findings include: R23's significant ch (MDS) dated 4/17/1 moderate cognitive functional limitation lower extremity. R2 assistance with mo	ent is not met as evidenced on, interview and document implement a therapy sing program was not stently for 1 of 1 residents staff assistance with walking. ange Minimum Data Set 8, identified R23 had impairment, and had a in range of motion to one 3 needed extensive bility. The MDS identified a s. R23's activities of daily living		Corrected.		

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILITA	ALION 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 64	2 915			
	4/30/18, identified F 4/9/18, and was sur receiving physical a a goal to utilize her On 7/23/18, at 8:10 wheelchair in her rowheeled walker in t stated she had brok ago and was suppo	essessment (CAA) dated R23 fractured her right hip on regically repaired. R23 was and occupational therapy with walker again. a.m. R23 was seated in a fractional seated four her corner of her room. R23 was her right hip a few months used to be walked twice a day aff were not walking her as				
	R23's Therapy Recinstructed staff to w	ommendations dated 5/9/18, ralk R23 with her four wheeled one staff member twice daily.				
	needed an assistan nursing rehabilitation staff to walk R23 tw	ised on 7/21/18, identified R23 ace of one to walk. R23 has a on program, which directed vice a day to promote daily naintain and improve her				
	to walk were docum - June 2018, identif to walk were docum - July 2018, identifie					
	assistant (PTA)-A s recommendations v	7/26/18, physical therapy tated the physical therapy were given in writing to nursing g staff were to follow through commendations.				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER I	TH DAVIS AV LD, MN 553			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	On 7/26/18, at 10:4 (NA)-A stated the n supposed to walk F day shift and once stated R23 "probab day. The staff were only occasionally didocumented reside charge nurse know During interview on stated if the nursing applicable in the nursing applicable in the nursing applicable in the nursing assistants were not able to wanursing assistants were not able to wanursing note could RN-A was not awar recommended. Not was not completed. METHOD OF COF nursing and/or desiresponsible staff to dependant on facilii comprehensively as designee could cor resident cares to enneeds are met considerations.	26 a.m. nursing assistant pursing assistants were R23 twice a day, once on the conthe evening shift. NA-A only did not get walked every to offer walking to her and id she refuse. The aids then ent refusal and were to let the control of the second and the second and the second are second as a second and the second are second and the second and t	2 915			
21375		0 Subp. 1 Infection Control;	21375			9/10/18

Minnesota Department of Health

STATE FORM 6899 Q3PC11 If continuation sheet 66 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· '	(X2) MULTIPLE CONSTRUCTION (X			
			R WING	B. WING		
		00775	b. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER		TADDRESS, CITY,			
MEEKER	R MANOR REHABILIT	ATION CENTER I	OUTH DAVIS A\ FIELD, MN 55:			
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	nge 66	21375			
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow contact and enteric precautions for 2 of 2 residents (R100 and R3) who were place on transmission based precautions.			Corrected.		
	Findings include:					
	admitted to the age	undated, identified he was ency on 7/18/18, with urinary dwelling urinary catheter.				
	identified, he was a acute kidney injury, Methicillin-resistant (MRSA) organism i infection caused by become resistant to	narge summary on 7/18/18 admitted to the hospital for and urinary tract infection was Staphylococcus aureus in his urine. MRSA is an a type of staph bacteria that many of the antibiotics used the infections, and is classification stant organism.	t's			
	identified infection. of MRSA, with inter medication per phy	prehensive Careplan, 7/18/1 R100 had a current infection eventions of antibiotic sician order, all staff to follows, isolation precautions per n resident's door.	n			
		i 7/23/18 08:37 a.m. registei d R100 had MRSA in his uri				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 67 of 116

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/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOUT	DRESS, CITY, S FH 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21375	and has an indwelli retention. During observation R100's room had a contained gloves, g bleach. There was Contact Precaution Precautions. Every entering and leaving Must: gown and glodedicated or disposins disinfect shared equidentified contact proconditions of MDRC Equipment and supdisposable equipmed disinfect reusable ecell pone or pages, and equipment prior room. Transport, a clothes, clean and compared to the back of his whe stated staff come in usually a gown and them they need to cabout it. During observation physical therapist (I with no gloves or gourinary catheter back of his watubing and bag. PT of R100's walker ar	on 7/22/18 at 8:40 a.m. In isolation bag on his door that lowns and sani cloths with sign on the door that read, s, in addition to Standard rone must, clean hands when groom. Doctors and Staff ove at the door, use patient sable equipment. Clean and uipment. The back of the sign recautions and listed common D's, which included MRSA. In it is possible, use dedicated or lent when available. Clean and requipment including IV pumps, and other electronic, supplies in to removing from residents source resident is in clean elisinfect assistive devices. If on 07/23/18 01:06 p.m. R100 that a vinyl bag that covered his bag which was hanging from the lechair under his seat. R100 in his room, with "stuff on" gloves. If they don't I tell do this and they are good on 07/25/18 02:27 p.m. PT)-A entered R100's room own on. He unhooked R100's grom the wheelchair and alker handling the catheter for the touches the handles and places a transfer belts to without first washing his	21375			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 68 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00775	B. WING		07/2	7/2018
	NAME OF PROVIDER OR SUPPLIER 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	and places his clip wheelchair cushion sitting. PT-A then a walker while holding transfer belt. PT-A his transfer belt. PT-A his transfer belt, an PT-A does not was catheter tubing and the room, PT-A piclit while walking with down the hallway. At 07/25/18 03:20 pthe physical therapy clip board which was an overbed table in p.m. PT-A leaves R rolled up and under while he cleansed here. PT-A stated the gai R100. He was told assistant (PTA)-A the dedicated equipme what to do with R10 since he was on coreviewed the instruction identified using ded He stated there was room, and he shoul sanitize the gait/traner. A also stated he therapy room. He was check in the future precautions are improved.	A assists R100 to stand up, board on the residents, where the resident was assisted R100 to stand with his g onto the back of R100's walks with R100 holding onto d ambulate with resident. In his hands after touching the catheter bag. Before leaving as up his clip board, and holds a R100 to the therapy room. I.M. PT-A and R100 were in a room exercising. The soiled as in R100 room, was lying on therapy department. At 3:22 at 100's room and has a gait belt in his arm touching his clothing his hands with a gel sanitizer. It belt, under his arm, was from yesterday by physical therapy hat he did not need to use int for R100. PT-A was unsure 20's equipment or other items intact precautions. PT-A actions on R100's door, that dicated patient care equipment. It is a transfer belt in R100's in the will clean the clipboard and that it was sitting on in the will ask the nurses and double what he needs to do when	21375			
	stated all staff need	I to wear glove and gown, R100 R100 has been				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 69 of 116

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/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOUT	DRESS, CITY, S FH 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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21375	emptying his own in are unsure of his te wear gloves, gown is using a gait/trans each time, or use the is on contact preduction. During interview on observation was disall staff need to folk door and use the defendance of the de	indwelling catheter bag, and we chniques so it is important to and wash hands. If someone if belt they need a clean one in e one in R100's room since ecautions. 7/26/18 at 2:00 p.m. the PT-A scussed with RN-A who stated by the precautions on R100's edicated equipment. Contact Precautions, use gown and gloves when it contact with body fluids. mum data set (MDS) dated liagnoses including anxiety, Inutrition. d 7/23/18, indicated she was for c-Diff (Clostridium difficile The care plan further ere to follow contact om indicated she was on ecautions". The note also st wear gloves and gown while nove them before leaving. In the catheter is and goggles." cated that Contact Enteric meant it "will be used in the sknown or suspected to be sms that are transmitted by the contact in the contact i	21375			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 70 of 116

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/27/2018	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	MEEKER MANOR REHABILITATION CENTER, I 600 SOU LITCHFIE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From page 70		21375			
	The Policy further indicated "Residents whom contact enteric precautions are clinically indicated to include some of the following common conditions."					
	 Residents who have acute diarrhea of unknown etiology. Residents who have Clostridium difficile (is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). Residents with Norovirus or Rotavirus (stomach flu). 					
	During observation on 7/23/18, at 9:38 a.m. maintenance assistant (MA)-A entered R3's room and stated he was going to put a new footboard on R3's room. MA-A did not put on a gown or gloves and proceeded to touch R3's bed, bed linen while mounting the footboard on the frame of R3's bed. MA-A was in R3's room for approximately 10 minutes, and left the room without first washing his hands.					
	interim director of n who go into R3's ro	7/24/18, at 3:00 p.m. the ursing (DON) stated all staff om "should gown and glove" d maintenance staff.				
	review facility polici isolation precaution education regarding DON or designee c	sing (DON) or designee could es/procedures regarding s for resident and provide staff the policies. Additionally, the ould perform audits to ensure ollowed to ensure on-going				
1	Time Period for Cor	rrection 21 (twenty-one) days.				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 71 of 116

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	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOUT	DRESS, CITY, S 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 71	21530			
	A. The drug regim reviewed at least mourrently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of I Health Care Finance This standard is incavailable through the system. It is not sure B. The pharma irregularities to the and the attending processing must be acted upor physician visit, or so pharmacist. For purpon' means the act report and the significant of nursing services C. If the attend with the pharmacist not provide adequate.	ge 71 O A.B.C Drug Regimen Review en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ing-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is ing Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports in by the time of the next coner, if indicated by the rposes of this part, "acted exceptance or rejection of the ing or initialing by the director and the attending physician. ing physician does not concur 's recommendation, or does the justification, and the sterile the resident's quality of life is	21530 21530			9/10/18
	being adversely afforefer the matter to the if the medical direct	ected, the pharmacist must he medical director for review or is not the attending edical director determines that				
	the attending physic justification for the ophysician does not must be referred for assessment and as by part 4658.0070. the medical directors	cian does not have adequate order and if the attending change the order, the matter review to the quality surance committee required If the attending physician is r, the consulting pharmacist er directly to the quality				

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	7/2018
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOUT	DRESS, CITY, S T H DAVIS AV I 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
21530	Continued From pa	ge 72	21530			
	assessment and as	surance committee.				
	by: Based on observati	ent is not met as evidenced on, interview and document		Corrected.		
	recommendations vappropriate rational implementing record	ailed to ensure pharmacist were acted upon timely, and le was recorded for not nmendations for 1 of 5 iewed for unnecessary				
	Findings include:					
	NOT ACTED UPON	N:				
	5/25/18, identified F severe cognitive im Diagnosis Report p had numerous med	imum Data Set (MDS) dated R29 had dementia with a pairment. In addition, R29's rinted 7/27/18, identified R29 lical diagnoses including gh blood pressure, and major r.				
	identified R29 had o	ary Report signed 7/19/18, current physician orders for c medications including:				
	everyday, - Lorazepam (an ar	pressant) 10 milligrams (mg) ntianxiety medication) 0.5 mg d for anxiety give twice daily				
	Review dated 5/14/ pharmacist (CP) did Non-antipsychotic F	harmacist's Medication 18, identified the consulting ctated an irregularity as, " PRN psychotropics such as aml are limited to 14-day				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 73 of 116

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	7/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		0.10
MEEKEI	R MANOR REHABILIT	ATION CENTER I	H DAVIS AV			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	duration, unless the treatment by provide documenting intendent the physician to relorazepam therapy evaluation/rationale was going to be collabeled, "Follow-Upphysician to circle in recommendation were completed in, " Adays." However, not did the report have physician to demonand/or addressed. R29's subsequent like Review dated 6/28/identified the same lorazepam use, and re-evaluate R29's addocument their clinaresident if treatment As prior, a section lacepted or rejected time frame to be collater than 60 days.' were circled nor did from the physician reviewed and/or addressed and/or addre	e prescriber chooses to extend ling clinical rationale and ded duration." CP requested evaluate R29's current and document their clinical of the resident if treatment intinued. A listed section or Action Taken," directed the fithey accepted or rejected the fith a time frame to be SAP but no later than 60 either of these were circled nor any signature from the estrate it had been reviewed. Pharmacist's Medication (18, identified CP again irregularity with R29's direquested the physician current lorazepam therapy and ical evaluation/rationale of the entity was going to be continued. It was going to be continued abeled, "Follow-Up or Action is physician to circle if they are the recommendation with a completed in, " ASAP but no of However, neither of these is the report have any signature to demonstrate it had been	21530			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 74 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 0172	.772010
		600 SOUT	H DAVIS AV			
WEEKER	R MANOR REHABILIT	LITCHFIE	LD, MN 553	55		
(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 SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Continued From pa	age 74	21530			
	accepted or rejected time frame to be consider than 60 days." were circled nor did from the physician reviewed and/or add. When interviewed or registered nurse (R. was originally order continued to use the looking at the Medi (MAR). RN-B states to CP's identified or therapy despite sever recommended. RN following through," sure these identifies	e physician to circle if they ed the recommendation with a ampleted in, " ASAP but no 'However, neither of these dithe report have any signature to demonstrate it had been lidressed. on 7/27/18, at 10:28 a.m. RN)-B stated R29's lorazepam red in April 2018, and she as-needed lorazepam when cation Administration Records ed their had been no follow-up oncerns with R29's lorazepam veral months of it being N-B added, "We're not and it was important to make dirregularities were acted the sure the resident is kept				
	interim director of r been a "lack of folk the pharmacy reco and it was "not app should have occurr the resident."	n 7/27/18, at 2:17 p.m. the nursing (DON) stated there had by through" with making sure mmendations were addressed propriate." DON explained this red as it was "what's best for interview on 7/27/18, at 2:32				
	p.m. CP stated the communicating with identified irregularity expressed some "buneeded, and their sare addressed "needed".	facility should be he the physician to ensure the cies are addressed timely. CP petter communication" was systems to ensure the reports ed to be worked on."				
	LACK OF DOCUM	ENTED RATIONALE:				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOUT	DRESS, CITY, S FH 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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	R29's Order Summidentified R29 had of dual doses of Tylen which can cause live. These orders direct a tablet orally as nead a day," and, 2) "Tylenol Extra St as needed for Paintabs] every 4 - 6 ho Not to exceed a totain 24 hours." R29's Consultant P Review dated 3/16/pharmacist (CP) ide R29's dual Tylenol of "Suggested Course" Please consider dineeded] orders." A Action Taken," instrathey accepted or rethis was circled as physician. This was unit coordinator (HI explanation or dictary this recommentation is R29's medical recommendation is R29's medical recommendation regarding the summer of the	ary Report signed 7/19/18, current physician orders for ol (an anti-inflammatory; er damage in high doses). ted: rength Tablet 500 mg Give reded for pain tid [three times 25 mg Give 325 mg orally (Fever May give 650 mg [2 urs as needed for pain/fever. al daily dose of 4 gm [grams] harmacist's Medication 18, identified the consulting entified an irregularity with	21530			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 76 of 116

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		L' COME		(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILITA	ALION 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 76	21530			
	pharmacist as a po 2018.	tential irregularity in March				
	RN-B stated she re and was unable to demonstrate or sup rejected CP's recor of the as-needed Ty	on 7/27/18, at 10:28 a.m. viewed R29's medical record locate any documentation to oport why the physician mmendation to discontinue one ylenol orders. RN-B stated the owing through" and staff				
	DON stated the lac	7/27/18, at 2:17 p.m. the k of rationale was a result of a igh" and staff should have physician asking for the				
		pharmacy recommendations vever, none was received.				
	The director of nurs education staff rega follow up of pharma recommendations.	THOD OF CORRECTION: sing or designee could arding the monitoring and acist's drug regimen review The DON or designee could part audits to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.1319 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			9/10/18
	monitor each reside	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 77 of 116

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ALION CENTER 1	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
21540	resident's attending physician does not home's recommendadequate justification believes the reside adversely affected, matter to the medical director is the medical director physician does not the order and if the change the order, treview to the Qualit (QAA) committee resident the attending physician does not the order and if the change the order, the change the order, the attending physician directly to the QAA	eport any irregularity to the group physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for the ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter	21540			
	Based on observat review, the facility forders were followed monitor diuretic met (R44) reviewed for Findings include: R44's admission M 4/27/18, included defailure, hypertension MDS also indicated R44's current physwere reviewed and and to notify the do (pounds) in 24 hou two diuretic medical	ion, interview and document failed to ensure a physician's ed and obtain daily weights to edication use for 1 of 1 resident unnecessary medication. inimum Data Set (MDS) dated iagnoses of congestive heart in and renal insufficiency. The IR44 was cognitively intact. ician's orders dated 6/17/18, directed to obtain daily weight octor wight increases 3 lbs included ations for congestive heart od pressure: Bumetanide		Corrected.		

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 78 of 116

	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/	27/2018	
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOUT	DRESS, CITY, S TH DAVIS AV LD, MN 553				
(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 SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
21540	tablet 2 mg (milligra and Spironolactone day. During observation was seated in her was seated in her was no observation on her lower extremathere was no observation including interview on talked about her stamedications, including medications, including medications, and the blood work. R44 staweigh me everyday R44's weights from reviewed. The election in the ele	ams) orally two times a day; tablet 50 mg by mouth once a on 7/25/18, at 3:00 p.m., R44 wheel chair, in her room. R44 emeanor, and exhibited no ess. R44 had two bandages nities, one on each leg, and wed swelling or edema of the st. 7/25/18 at 3:11 p.m., R44 ay in the nursing home and her ing how often she got at she had to frequently get ated they are supposed to , "but they don't." 6/1/18 to 7/26/18 were stronic medical record ghts were not obtained or emborated the mount of the following 8, 6/7/18, 6/8/18, 6/30/18, 18/18, 6/28/18, 6/30/18, 18/17/18, 7/10/18, 7/11/18, and 7/22/18 for a total of 19 ortunities. During July 2018, weights have ranged from 190	21540				
	medication to contribute stated they monitor checking for any switchecking blood presentations, "and will LPN-D stated if R44	N)-D stated R44's received of blood pressure. LPN-D ed R44's blood pressure by velling or edema in her legs, ssures, following the fluid e also do a daily weight." It's weight was 3 pounds or previous weight, the doctor					

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 79 of 116

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	MANOR REHABILITA	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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 79	21540			
	was to be notified. recently had any se	LPN-D stated R44 had not rious weight gains.				
	registered nurse (R diuretic medication, daily weights. RN-A fluid overload and s point in the hospital removed. RN-A stachecking for edema also included daily responsibility for the	7/26/18, at 3:39 p.m. N)-A stated R44 was on a and had current order for stated R44 had symptoms of thortness of breath, and at one had 18 pounds of fluid ated R44's monitoring included a, lungs, respiration rates and weights. RN-A stated it is the effloor nurse and charge to pleted, and "I can't explain e missing.				
	interim director of n	on 7/27/18, at 2:07 p.m. the ursing (DON) stated is a -ordered daily weights, she completed daily."				
		linical monitoring of weights requested, but none was				
	administrator, direct consulting pharmac policies and proced medication usage. with the pharmacist	THOD OF CORRECTION: The tor of nursing (DON) and sist could review and revise ures for proper monitoring of The DON or designee, along could audit medication r basis to ensure compliance.				
	TIMEFRAME FOR (21) days.	CORRECTION: Twenty-one				
21695	MN Rule 4658.1419 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			9/10/18

Minnesota Department of Health

STATE FORM 6899 Q3PC11 If continuation sheet 80 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	age 80	21695			
	provide housekeep necessary to maint comfortable interior	eeping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain carpet in a clean, sanitary manner in 1 of 1 hallways observed to have visibly stained carpeting. This had potential to affect 2 of 2 residents (R36, R24) who voiced concerns with the carpeting and 35 additional residents identified to use the area on a routine basis. In addition, the facility failed to ensure a freezer door in the main kitchen was in working condition to prevent condensation and ice build up in the freezer to safely store food for 1 of 1 walk-in freezers reviewed. This had the potential to affect all 56 residents, visitors and staff who consumed food stored and subsequently served from this freezer.			Corrected.		
	Findings include:					
	DIRTY CARPET:					
	6/20/18, identified If When interviewed of stated he would like in the building replacexpressed it made furnishing and carp	num Data Set (MDS) dated R36 had intact cognition. on 7/24/18, at 2:27 p.m. R36 to see some of the carpeting aced as it was unsightly. R36 someone feel better if the set were nice looking.				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 81 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00775	B. WING		07/2	27/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
MEEKER	R MANOR REHABILITA	ATION CENTER I	TH DAVIS AVI 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21695	Continued From particles had intact cognition at 2:28 p.m. R24 state carpeting as it was added, "Please get on 7/27/18, at 1:19 main dining room a floor was carpeted and dark maroon edging carpet had numerous colored stains which the entire hallway, applied carpet which individual tile(s) had border. Further, se had visibly smashed them which were dawhen touched with A facility provided S7/27/18, identified 3 used the hallway which apel services. On 7/27/18, at 1:22 observed the carpe surveyor and stated condition for approx HK-A added the face	ge 81 During interview on 7/24/18, ated the building needed new so stained and soiled. R24 clean carpet in here." p.m. the hallway outside the nd chapel was observed. The with a light gray center and g. The light gray area of the us, various sized dark brown h were present up and down There were several tiles of the h the perimeter of the d visible edging of a dark black veral areas of the carpeting d substance(s) present on ark black in color and sticky	21695		J. NIATE	
	environmental servi maintenance team repairs since taking months prior. ESD maintenance crews correctly, so moistu	on 7/27/18, at 1:24 p.m. the ices director (ESD) stated the had been working on various over the building a few explained the prior were not cleaning the carpets re wasn't being wicked away sed the edges of the carpet				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 82 of 116

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	E CONSTRUCT I ON	(X3) DATE SURVEY COMPLETED		
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	tiles to discolor and had been discussion the carpet(s) in the been "all talk" so fa place. Further, ESI like one used at so sites, would help in	ge 82 curl. ESD expressed their on on improving or replacing nursing home, however, it had r with no formal plans put into D stated a tasking machine, me of their other managed aprove the carpet appearance.	21695			
		uested, however, none was				
	On 7/23/18, at 7:02 kitchen was comple cooler/freezer comple cooler/freezer comple cooler/freezer complete the cooler doplastic strips (in platemperature) were behind serving cartentry door, inside the freezer door, about 8" (inches) from the cooler, about 7" cooler above the freezer door, about 8" (inches) from the cooler, about 7" cooler above the freezer door, about 7" cooler above the freezer door, about 8" (inches) from the cooler, about 7" cooler above the freezer door, about 8" (inches) from the cooler above the freezer door, about 7" cooler above the f	a.m. a brief tour of the facility eted, and the walk in bination unit was inspected. oor was opened, hanging				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 83 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	R MANOR REHABILITA	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	Expandable foam we frame, some of white and, in one section, approximately 1" awelectrical box inside "caution" and was Various frozen mean packaged on the strate door. On one we chicken dated 7/22 crystals in the bag, pork tenderloin pace 2" by 4" in size) on During interview on assistant (DA)-A strate ice/frost build up in water on the floor at the ceiling. DA-A deen a problem. On 7/25/18, at 6:39 was reviewed with the and culinary services was present and we inside the cooler. To outside of the freez However, the frost/I the door, the door felastic strips. The gone, but the packathe ice chunks were freezer. When interviewed of the frost on the outer moved, as well as CD stated maintenacleaning schedule,	vas in place around the door ch protruded from the frame, forced the door way from the wall. An exthe freezer was labeled encased in frost build up. Its and other foods were nelving to the left and right of upper shelf a bag of cubed v18, had chunks of ice and ice. On another top shelf, two kages had ice chunks (about	21695			

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 84 of 116

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00775	B. WING		07/2	7/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
MEEKER	MANOR REHABILITA	ALION 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	
21695	director (ESD) joine about the interventi freezer door. The E track when they can function and also ca other week "to know stated they updated past three months to down. The ESD state expandable foa seal the door. The I aware of the condit were no formalized During interview on administrator stated and a vendor had be coordinate installatic correct the problem. A facility policy regarefrigerators and fronne was provided. SUGGESTED MET The director of main repair and/or replace and update carpet of they are maintained.	n. the environmental service of the conversation and talked ons in place to deal with the ESD stated he created a log to me in to check the freezer ame into the cooler every ok the ice down." The ESD If the exhaust system in the cohelp keep the moisture ated he was unaware when me had been placed to try and ESD stated although he was son of the freezer door, there plans to correct it. 7/27/18, at 3:31 p.m. the if the freezer had a faulty seal, een contacted who would on of a new freezer door to arding maintenance of eezers was requested, but	21695				
21730	(21) days. MN Rule 4658.1418 Housekeeping, Ope	5 Subp. 11 Plant eration, & Maintenance	21730			9/10/18	
	Subp. 11. Insect ar	nd rodent control. Any					

Minnesota Department of Health

STATE FORM 6899 Q3PC11 If continuation sheet 85 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOU	DDRESS, CITY, S TH DAVIS AV ELD, 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
21730	condition on the site conducive to the har insects, rodents, or eliminated immedia control program mupersonnel. This MN Requirements by: Based on observation review, the facility from timely pest con and/or eliminate flie potential to affect all facility. Findings include: During observation during breakfast R1 his plate while eating had four flies on his offered to replace he done. R13 stated it and night." DA-B sign the dining room of and added staff were flyswatters in the difference of	e or in the nursing home properties or breeding of other vermin must be stely. A continuous pest lest be maintained by qualified ent is not met as evidenced on, interview and document earlied to implement effective trol measures to reduce is in the facility. This had lest of the facility in the series of the facility in the series and form on 7/23/18, at 7:48 a.m. If a was shooing flies away from the series of the facility is meal, but R6 stated he was was like this "morning, noon, that there were flies present during the summer months, are told they can't use	21730	Corrected.		
	head, then rested o	ed on her. The flies circled her n her nose, forehead and in s, which triggered R33 to				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 86 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/2	27/2018
NAME OF PROVI	DER OR SUPPL I ER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
MEEKER MAI	NOR REHABILIT	ALION CENTER I	TH DAVIS AV ELD, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
On bed flies land fore lips as f at 1 roor R111 On her As: Wh p.m. sum sho wisl exp som aide has On with he I Dur env que see the fly s wer	7/23/18, at 8:18 I with her eyes of were circling reding on her face chead, corner of the R11 furrowed here. R11 furrowed here and continued its forehead and r126 a.m., flies on and continued its forehead and r123/18, at 11:1 room, R8 stated she watched a file in the dining to R 20 stated the mer". As a fly lood it away, R2 in they could get we seed she wish neone in to man the sand nurses we changed. 7/24/18, at 2:36 in a purple fly swell as been using the rest control consituation and the resprayed today in the sprayed today.	more moaning noises. a.m. R11 was lying on her closed, glasses on, and two esident's upper body and . Flies were on R11's her lips, and crease between her brow and pursed her lips ring a subsequent observation continued to be present in the d to fly about and land on				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 87 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOU	DDRESS, CITY, S Th Davis Ave Eld, Mn 5535	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPR I ATE	(X5) COMPLETE DATE
21730	been a fly light instarmonths ago. The cawas installed 24 hor room was reviewed size flies and sever cardboard was also stated there were a ESD stated he was entryways, but was dining or resident rowas no formalized scontrol and insect in he placed 10-12 fly help with fly manag was observed buzz computer. During interview on nursing assistant (Nother flies and everyon NA-G stated flies habut had become incompated the placed the past coup residents had compated the placed maintenance them "as far as I know was being done. Note that mainly the flies in the was being done. Note that was really hot. LPN swatters to use.	alled in the dish room several ardboard collector strip that urs 24 hours ago in the dining I, and the ESD counted six-full all gnats. The fly light collector of checked in the dish room and t least 15 flies counted. The aware only of flies near the not aware of any flies in the coms. The ESD stated there system in place for pest nanagement. The ESD stated swatters out in the building to ement. During interview a fly ing around surveyor's 7/26/18, at 10:32 a.m. NA)-G stated she was aware of the was provided a fly swatter, and been present all summer, creasingly "persistent" and ble of weeks. NA-G said blained and stated she even esidents to kill them. NA-G was aware of the problem now" but was unsure of what A-G stated big problem was ne residents' rooms. On 7/26/18, at 11:30 p.m. urse (LPN)-C stated the flies eral" but became worse when it N-C stated the staff had fly				
	administrator stated problems with flies	7/27/18, at 3:31 p.m. the d they have been having in the building and had st control agency out to treat.				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 88 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00775		B. WING		07/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0772	772010
MEEKER	R MANOR REHABILITA	ALION 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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21730	Continued From pa	ge 88	21730			
	A facility policy regarequested, but none	arding pest control was e was provided.				
	director of nursing (educate staff regard maintaining an effect The DON or design maintenance and hoperiodic audits of an ensure pests is confunctional and home maintained to the educate staff.	·				
	(21) days.	R CORRECTION: Twenty-one				
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			9/10/18
	residents shall, at a are legal rights for stay at the facility of treatment and main that these are described written statement or responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and organizations.	tion about rights. Patients and admission, be told that there their protection during their r throughout their course of atenance in the community and wribed in an accompanying of the applicable rights and forth in this section. In the mitted to residential programs on 253C.01, the written of describe the right of a dor older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in as. Reasonable				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 89 of 116

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILITA	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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21800	accommodations sl communication imp speak a language of facility policies, insp local health authorit the written statement to patients, resident chosen representate to the administrator person, consistent of Practices Act, and se vulnerable adults.	ge 89 nall be made for those with eairments and those who other than English. Current section findings of state and cies, and further explanation of nt of rights shall be available to, their guardians or their ives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to	21800			
	facility failed to time and appeal rights no Medicare A services	and document review, the ely provide the required liability otices prior to discharge from s for 2 of 3 residents (R39, beneficiary protection		Corrected.		
	Services was 6/20/ CMS-20052 (SNF [Beneficiary Protecti R39's Notice of Me CMS-10123) was s representative on 6	overed Medicare Part A Skilled 18, as identified on the form skilled nursing facility] on Notification Review). dicare Non-Coverage (form igned by the authorized /20/18, with a notation the ntative was called on 6/19/18.				
	R39's Skilled Nursin Beneficiary Notice (ng Facility Advance SNFABN, form CMS-10055) and date from the resident or				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 90 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILITA	ATION CENTER 1	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 90	21800			
	R39's census recor resided in the facilit	d identified R39 currently y.				
		overed Medicare Part A Skilled B, as identified on the form				
	R42's census recordischarged from the	d identified R42 was e facility on 7/6/18.				
	family representativ	rd lacked evidence R42 or a re was provided the Notice of erage (form CMS-10123) prior				
	regional director of R39's authorized rebeen contacted on skilled coverage on CMS-100055 shoul authorized represer R42's CMS- 10123 should have been s 7/3/18, at the latest previously responsi	7/24/18, at 10:49 a.m. the operations (RDO) stated presentative should have 6/18/18, regarding the end of 6/20/18. Further the d have been signed by the ntative. The RDO stated could not be located, and signed by the resident on . A former staff person was ble for providing resident the notices and the facility was rocedure.				
		peneficiary protection notices none was provided.				
	The director of nurs inservice staff regardiability notice(s) are	HOD OF CORRECTION: sing (DON) or designee could rding ensuring Medicare e provided timely and in plicable rules and regulations; e compliance.				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 91 of 116

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEEKER	MANOR REHABILITA	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
21800	Continued From pa	ge 91	21800			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144. Residents of HC Fa	651 Subd. 5 Patients & c.Bill of Rights	21805			9/10/18
	residents have the courtesy and respec	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review, the facility fa maintained when ba dated in large font f	ent is not met as evidenced on, interview and document ailed to ensure dignity was andages were conspicuously or 2 of 2 residents (R47and ace and leg dressings.		Corrected.		
	Findings include:					
		nimum Data Set (MDS) dated he was cognitively intact.				
	assisted into the dir had a skin colored be 4 inches on her right date of 7/21/18 write which covered appreand was easily read	a.m. R47 was observed being ning room for breakfast. R47 bandage about 4" (inches) by at cheek, which had a large ten in thick black marker eximately 50% of the dressing lable across the width of the r than 20 feet in distance).				
	was seated in her re	on 7/25/18 at 8:00 p.m. R47 ecliner in her room. R47 had was in place on her right				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 92 of 116

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER	ATION CENTER I 600 SOUT	DRESS, CITY, S FH 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21805	cheek, dated, A skii (inches) by 4" was i dated "7/25/18" in bhalf the dressing. L (LPN)-A entered R4 medications. During interview on stated she thought bandage "should be date could be writte of the dressing. LP attracted more attered to chright cheek every 2-During interview on interim director of nheard about "the daface. The DON statissue." R44's admission Mid/27/18, indicated F During observation was seated in her won both R44's right tan-colored bandag (inches) by 4". The large, black font on was easily visible at R44's treatment add 2018, directed to apabrasions to shins a seated in shins a seated in seated in the	ge 92 n-colored bandage, about 4" ntact on R47's face and was black ink which covered about licensed practical nurse 17's room with evening 7/25/18, at 8:00 p.m. LPN-A the writing on R47's face less in size" and that the en small and on the lower edge N-A stated the size of the date intion to the dressing. ministration record dated July hange foam border dressing to 3 days and as needed. 7/27/18, at 2:02 p.m. the lursing (DON) stated she late" on R47's dressing on her ted "that would be a dignity finimum Data Set (MDS) dated R44 was cognitively intact. on 7/25/18, at 5:04 p.m. R44 wheel chair, dressed in shorts. It and left shins was a le, each approximately 4" It date "7/24" was written in a leach of the bandages, which and seen by anyone nearby. ministration record for July happly border foam dressings to land cleanse with wound land new dressing every 3 days.	21805			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, \$ F H DAVIS AV	STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER I	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
21805	ра	ge 93 7/25/18, at 5:04 p.m. R44	21805			
	stated the bandage	s would come off when she				
		t and added "I don't like the ges." R44 stated she did not				
	know why they had	to do that and her knees without the dates on them."				
	R44 stated staff pu	t the dates on them the day				
		ndages and added "they could dates in my chart instead. In a				
	subsequent intervie	ew on 7/26/18, at 10:39 a.m. ot the fact the date was written				
	on the bandage, bu	it that it was written "so big"				
	that was upsetting. R44 stated she'd be "ok" with the dates on her bandages if the date was written					
	smaller.	-				
		7/26/18, at 12:22 p.m. the				
	written on the band	(DON) stated the date was ages so we know when it was				
		DON then stated she did not es were writing the date so big				
	and if it's that big, "t	that concerns me for dignity" Id be written smaller.				
	A policy regarding on none was provide.	dignity was requested, but				
		HOD OF CORRECTION: sing (DON) could review and				
	update polices pert	aining to medical bandaging, on applying and labeling				
	dressings and band	dages in a manner to maintain				
	the dignity of the re audit to ensure con	sident. The DON could then pliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00775	B. WING		07/2	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 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 CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 94	21830			
	MN St. Statute 144. Residents of HC Farsidents of HC Farsidents of HC Farsidents of HC Farsidents and in the planning of the includes the opportunity to request care conferences, a family member or oboth. In the event the present, a family member or oboth. In the event the present, a family member or oboth. In the event the present, a family member or occommunicate, the freefforts as required the either a family member writing by the reside an emergency that admitted to the facilifamily member to personal planning, unless the tobelieve the resided directive to the conference of the	651 Subd. 10 Patients & ac.Bill of Rights pation in planning treatment;	21830 21830			9/10/18
	executed an advance esident's health car	ne if the resident has ce directive relative to the e decisions. For purposes of asonable efforts" include:				

NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, I (X4) ID PROVIDER (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 95 (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident makes a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patients privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility is fidal attempt to identify family	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
MEEKER MANOR REHABILITATION CENTER, I (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Continued From page 95 (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or designated emergency contact or designated emergency contact or directive. If a facility notifies a family member or designated emergency contact or the promote of the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member or emergency contact or of the gamily member or designated emergency contact or allows a family member or emergency contact or the participation of the family member or of the family member or or colated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact.	00775	B. WING	07/27/2018
MEEKER MANOR REHABILITATION CENTER, I (X4) ID PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 95 (1) examining the personal effects of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact emergency contact,	NAME OF DROVIDED OR SUDDIJED STREET AD	DRESS CITY STATE ZID CODE	1 000-000
(24) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY MISS BE PRECEDED BY PULL REQUIDED FICIENCY MISS BE PRECEDED BY PULL REQUIDED FICIENCY MISS BE PRECEDED BY PULL REQUIDED FICENCY MISS BE PRECEDED BY PULL REQUIDED FIGURATION OF LORD FOR ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE 21830 Continued From page 95 (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has a vecuted an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact,			
CX4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	MEEKER MANOR REHABII ITATION CENTER I		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21830 Continued From page 95 (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact.			OF CORRECTION (Y5)
(1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact,	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE) TAG CROSS-REFERENCED	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE
resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact,	21830 Continued From page 95	21830	
members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in	(1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law	21830	

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21830	designated emerge service agency or lo that assists a facility subdivision is not lia damages on the gro the family member	ncy contact. A county social ocal law enforcement agency in implementing this able to the resident for bunds that the notification of or emergency contact or the family member was improper	21830			
	by: Based on observati review the facilty fa given a choice of th resident (R9) who s language. Additiona residents were allow	on, interview and document iled to ensure residents were eir meal preference for 1 of 1 spoke Spanish as her primary ally, the facility failed to ensure wed the choice of bathing (R24) reviewed for choices.		Corrected.		
	7/26/18, identified F and depression with During interview on dietary aide (DA)-C each noon meal rest the next day's meal either choose the modified or mark what they are unable to assistants (NA) help They have a few stathat speak Spanish item on the menu anot working, they possion with the speak Spanish item on the menu anot working, they possion with the speak Spanish item on the menu anot working, they possion with the speak Spanish item on the menu anot working, they possion with the speak Spanish item on the menu anot working, they possion with the speak Spanish item on the menu anot working, they possion with the speak Spanish item on the menu anot working, they possion with the speak Spanish item on the spanish item on the spanish item on the speak Spanish item on the spanish item	num Data Set (MDS) dated R9 had diagnosis of dementia in severe cognitive impairment. 07/25/18 5:44 p.m. with and DA-D; DA-C stated at sidents are given a ticket for to choose from. They can nain entree or alternate and they want for these meals. If the this, then we or the nursing to the resident complete this. aff in the dietary department and they help R9 choose food is well. If these dietary staff are bint to the food item word, and a Spanish or "no" and she tells				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
,	o. co20.1c		A. BUILDING:			
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ALION CENTER I	H 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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	us, even though RS stated nothing during R9 was observed of table, and had just meal. She ate 1/2 and sips of her sour out menu choices, highlighted with a ghelped R9 fill the matranslator on an iPaproceeded to show with R9. DA-B place translator, and show stated "papas". R9 started to laugh lood DA-B repeated the seemed puzzled, a menu had potatoes choice. In an interview on 7 who was R9's table table mate of R9's never seen the faci whatever that thing or only a few bites, plate. They don't as next day, if they gar probably would eat On 7/26/18 11:55 and (RN)-A stated she if use the Google Translating Preference R24's annual MDS	is unable to read. DA-D ing this conversation. In 07/25/18 06:01 p.m. at the finished with her evening of sandwich, 100% pear sauce p. There was a pile of filled and R9 menu preference was reen marker. DA-B stated she included and show she used Google and DA-B found the iPad and show she used the translator ced the word potato in the wed it to R9, and the translator pilet looked at DA-B, and sking puzzled and confused. Word "papas", and R9 again and said "No." The 7/26/18 is highlighted as R9's menu In a the stated, I have been a for two years now. I have lity use that computer or was. R9 never eats her bread she always leaves it on her isk her what she wants for the we her a choice of food, she more but they don't. I.m. a.m. registered nurse has never seen dietary staff inslator app on the iPad for R9.	21830			
		intact cognition and was able r needs and wishes. R24 was				

Minnesota Department of Health

STATE FORM 6899 Q3PC11 If continuation sheet 98 of 116

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		07/	27/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER 1 600 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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21830	noted to have a cat urinary functions ar R24 received exten of daily living (ADL's grooming and mobidiabetes, arthritis, a affected mobility, go and morbid obesity. R24's plan of care in R24 received assist related to R24's levindicated R24 requiturn and reposition necessary. The car provide with assistat hygiene, including sincontinence cares plan was revised or alteration in skin into on her right buttock staff were to monito with documentation. On 7/23/18, at 8:46 like to receive a bat weekly for both constated she requested on the floor, though and was told they were receiving meds, againd they stated the however, did not rethe most correct per During observation.	heter in place to manage and was incontinent of bowel. sive assist to complete tasks by which included personal lity. R24's diagnoses included a neurological disorder which eneralized muscle weakness, are vised on 7/6/18, identified tance to complete her ADL's el of strength. The care plan red extensive assistance of in bed every two hours and as e plan also directed staff to ince to complete personal skin cleansing, and completion every two hours. The care in 7/10/18, to identify an egrity related to an abrasion s. The care plan identified or skin integrity during cares, weekly. a.m. R24 stated she would the more frequently than a infort and health concerns. R24 and a second bath from the staff was unable to recall whom, were unable to do anything. The care had asked a nurse when an was unable to recall whom, by didn't schedule baths, lay the request or direct her to	21830			
	nurse (RN)-B and calmoseptine (a zir	viewed cleansing of nc based barrier cream) off of				

Minnesota Department of Health

STATE FORM 99 G3PC11 If continuation sheet 99 of 116

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, S	STATE, ZIP CODE		
MEEKE	R MANOR REHABILITA	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	removed with gentle most effective removed stated she only received she would benefit for baths for comfort and buring interview on 7:30 a.m. RN-B stated she request for an follow up with this. I relayed any request the floor nurse or to would add a second On 7/27/18, at 11:4 was unaware of any and to her knowled Tuesdays. R24 had assistance to bathe On 7/27/18, at 1:18 (DON) stated, upon that had been upda and R24 had been and would have received and train staff on the assessment and assessment	I-B stated the cream was e cleansing, however, was oved with a whirlpool bath. R24 eived one bath weekly but felt from more frequent whirlpool and cleanliness. 7/26/18, at approximately ated she was unaware of diditional baths and would RN-B stated staff should have ts for additional baths to either a RN-B. RN-B stated she di bath for R24. 9, R24 stated at this time she of change in her bath schedule ge was scheduled on anot received any additional at this week. p.m. the director of nursing a review of the bath schedule ted on 7/27/18 at 5:42 a.m. scheduled for a second bath seived a whirlpool this morning.	21830			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00775	B. WING		07/2	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	'	ge 100 R CORRECTION: Twenty (21)	21830			
21850	Residents of HC Fassubd. 14. Freedor Residents shall be defined in the Vulne "Maltreatment" measection 626.5572, sintentional and non-physical pain or injuconduct intended to distress. Every resident in fully docu authorized in writing resident's physician period of time, and protect the resident others. This MN Requirement by: Based on observation review, the facility fast abuse were identified appropriate action of the provide resident protect the resident provide resident p	ac.Bill of Rights om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the etherapeutic infliction of ary, or any persistent course of a produce mental or emotional ident shall also be free from emical and physical restraints, mented emergencies, or as a after examination by a for a specified and limited only when necessary to from self-injury or injury to ent is not met as evidenced on, interview, and document ailed to ensure allegations of ed timely; failed to ensure was taken to immediately of the allegations for 1 of 1 of felt shamed and was unable in incident with R36 who and touched her breasts when in to. In addition, the facility or knew why R44 was placed as, and there were subsequent in R44 and the perpetrator of there was conflicting	21850	Corrected.		9/10/18

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 101 of 116

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2040
NAME OF I				STATE ZID CODE	0772	7/2018
	PROVIDER OR SUPPLIER	600 SQUI	TH DAVIS AV	STATE, ZIP CODE ENUE		
MEEKER	R MANOR REHABILIT	ALION CENTER I	LD, MN 553			
(X4) I D PREF I X 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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21850	Continued From pa	ge 101	21850			
	of abuse, and lack protections resulted situation for R44. The IJ began on 7/	nvestigation. These allegations of facility investigation and in an immediate jeopardy (IJ)				
	facility staff that on money in exchange she did not want his identify potential se protect R44, or thos circumstances to doccurred. The facilinursing (DON) were	hed and self-reported to the that day R36 offered her for touching her breasts, and m to. The facility failed to xual abuse and immediately roughly investigate the etermine if actual abuse ty administrator and director of e notified on 7/26/18, at 5:00				
	3:50 p.m. however, the lower scope an	IJ was removed 7/27/18, at non-compliance remained at d severity of a D which is ial for more than minimal				
	Findings include:					
	into taking money in resident) to touch a the incident occurre R44's room, without R44 to become fear resulting in making Although R44 told told not want R36 in	bused when she was coerced in exchange for R36 (male and fondle her breasts. Once ed, R36 continued to enter ther consent which caused arful, scared and afraid, it difficult for her to sleep. The facility multiple times she her room, the facility did not protection for R44, after the arred.				
	(MDS) dated 4/27/2 cognitively intact, re of one staff with act	ssion Minimum Data Set 18, indicated she was equired extensive assistance tivities of daily living (ADLs), hair for mobility. R44's care				

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 102 of 116

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.			
		00775		B. WING		07/2	27/2018
NAME OF I	PROVIDER OR SUPPLIER	STR	REET ADD	RESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ATION CENTER I		H DAVIS AV			
	CLIMMA DV CTA		CHFIEL	_D, MN 553		OTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21850	Continued From pa	age 102		21850			
	depression, adjustr mild cognitive impa Assessment (CAA) required assistance	, indicated diagnoses incl ment disorder, dementia, irment. R44's Care Area dated 4/27/18, indicated with ADLs, was alert and ts in judgement, and was	and she				
	indicated he was concextensive assistant R36's Initial Comprise 6/6/18, indicated he had weakness. The R36 had no behavioridicted he was ale therapy due to a fall	ssion MDS dated 6/13/18, ognitively intact, and require of two staff with ADLs. when sive Care Plan dated was alert and orientated ors. R36's CAA dated 6/1 and orientated, and red at his previous living a indicated R36 planned to	d d, and ted 13/18, ceived				
	Office Of Facility H-7/14/18, at 11:29 p. the nurse on duty tl gone into her (R44' offered her money breast, which he divictim (R44) asked then he left the roo R44 did not want R Internal investigation Five E6:19 p.m. indicated reviewed, and the adiscuss the inciden originally indicated she did not want R: conversation, R44 fact accept the \$10	tion Report submitted to the ealth Complaints (OHFC) m. indicated R44 reported hat another resident (R36 s) room, closed the door, to allow him to touch hered. The report indicated the him to stop, which he did m. The report further indicased to touch here breast. A son was initiated. A Facility Day Report dated 7/23/18 R44's care plan was administrator met with R4 t. The investigation report R44 did not accept the case to touch her. After a informed the facility she can in cash. R44 stated she ator (R36) went into her resident in the state of the cash. R44 stated she ator (R36) went into her resident in cash.	on ed to s) had had he d, he dated he he d, he dated he				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 103 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION (X3) DATE COMP		SURVEY LETED	
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER 1 600 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21850	and closed the door someone knocked to keep the door op go down to his room. R36 to his room, the allowed him to touch did not want another wished for him to stindicated on the reminute checks, R36 wishes to not meet agreed. During interview on administrator stated between R44 and F7/14/18, and she wooccurred. The adminiformed by the direct the incident, then restate Agency (SA) administrator stated investigation, and Formed her \$10 in Further, the adminison 15 minute check also place R36 on administrator stated did admit to offering touch her breasts. Informed R36 that F happen again. Although the incide occurred on 7/14/18 incident in the medianorm.	ge 103 In behind them. R44 said on the door, and asked them en. R36 then suggested they in. R44 stated she followed ey closed the door, and she in her breast. R44 stated she in encounter with R36, and any away from her. The facility bort R44 was placed on 15 is was informed of R44's with him again, and R36 In the encounter with R36, and any away from her. The facility bort R44 was placed on 15 is was informed of R44's with him again, and R36 In the encounter with R36 is unsure what time it instrator stated she was ector of nursing (DON) about exported the incident to the attention to the attention of the completed the exchange to touch her breasts. Strator stated R44 was placed is, then the facility decided to 15 minute checks. The in the talked with R36, and he is the talked with R36 an	21850			

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:			
		00775	B. WING		07/2	7/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ALION CENTER 1	H 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)	LD BE	(X5) COMPLETE DATE
21850	On 7/16/18, at 10:4 R44's room, and th outside shortly afte stated, "I'm going of door." Staff redirect courtyard near the stated to be supervised would knock on the On 7/25/18, at 12:3 morning, R36 was coming out of R44's busy." Staff asked her room, and R44 her case worker and her room. R44 also or do anything else As a result of the 7/1 initiated monitoring residents had a Re staff were directed R44's and R36's wifer their safety. R44's 15 minute met 10:30 a.m. (four da Review of R44's 15 that R36 was in R4 a.m. but identified F that time. R36's RCL indicate 7/18/18, at 10:00 a. 7/23/18, at 11:15 a. implemented RCL filling residented RCL filling residen	40 a.m. R36 was observed in en left her room. R36 went r R44 went outside, and outside but I'm using a different oted R44 to go outside in the south nursing station, so she d by staff. R44 stated she door if R36 came around her. 30 p.m. at 11:00 a.m. that observed by a staff member is room. R36 stated, "[R44's] R44 about R36 coming into stated she was going to see and was leaving, and so R36 left to stated R36 did not touch her,	21850			
	During an initial inte	erview on 7/23/18, at 8:45 a.m.				

Minnesota Department of Health

STATE FORM 9899 Q3PC11 If continuation sheet 105 of 116

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2018
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER I	MANOR REHABILITA	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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	wheelchair when Figave her \$10. R44 for, I don't want you wanted her to show wanted to touch her giving R36 his \$10 fouch her breasts. Finim to do this. R44 for a nurse who was becurred. R44 also administrator were and they were both stay away from her fouring an additional region of the stay way from her foom, gave her foom again after the ust comes into my door." R44 further come into her room. During a subsequent to play with her breast a fown and rubbed of feel "awful". She id foom again after the ust comes into my door." R44 further come into her room. During a subsequent for awhile, go to tow after it happened. I knew I should, so shut the door when made her feel "dirty and abused." R44 my room the last tire.	s in her room in her electric R36 came into her room and stated she asked R36, "What ir money." R36 told R44 he him her breasts, and he reasts. R44 stated she tried back, but he continued to R44 stated she did not want stated she had reported this working the night the incident o stated the DON and the both aware of the incident, aware she wanted R36 to all interview with R44 on n. R44 stated R36 came into \$10.00, and stated he wanted asts and she told him "no." If pulled on her shirt and and continued to pull her shirt in her breast which made her lentified R36 came into her e incident. R44 state, "[R36] room without knocking on my stated she did not want R36 to	21850			

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 106 of 116

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLET	URVEY ETED
	-120
00775 B. WING 07/27/2	/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MEEKER MANOR REHABILITATION CENTER, I 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850 Continued From page 106 which he did, and backed his wheel chair out of the room, and I closed the door in my room." R44 further indicated it made her feel humiliated and upset. While R44 was describing the incident her eyes became watery, and teary. R44 stated she was worried the incident would happen again, adding she had not been sleeping, and she was afraid. R44 reiterated she did not want R36 in her room. During interview 7/26/18, at 10:53 a.m. R36 stated he had been at the facility for several months, and the administrator talked with him shortly after the incident occurred on 7/14/18. R36 stated the administrator told him that R44 did not want him to come around her. After the administrator, "OK." R36 did not disclose he went back into R44's room on 7/16/18, and 7/25/18, after he was told by the administrator not to go into her room, and he had agreed to say out of her room. Review of the facility 15 minute monitoring for R44 and R36 identified the following: During interview on 7/25/18, at 7:00 p.m. nursing assistant (NA)-H stated she worked with R44, and was not aware of any incident between R44 and another resident. NA-H further stated she was not aware R44 was on 15 minute checks or monitoring. In addition, NA-H checked her nursing assistant care sheet, and verified there was no direction for monitoring for R44. During interview on 7/25/18, at 7:21 p.m. NA-I stated she has worked with R44, and R44 had no behaviors. NA-I stated she was supposed to keep an eye on R44 every 15 or 30 minutes. NA-I	

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 107 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	L COM		SURVEY PLETED	
		00775	B. WING		07/2	27/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 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 CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPIDEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21850	between R44 and a was not certain of w During interview on companion (RC)-A any behaviors with special monitoring f During interview on stated she was not R44, and she was restricted by the read that is a checks on a sheet a C	nother resident last week, but what happened. 7/25/18, at 7:27 p.m. resident stated she was not aware of R36, or if there was any for R44 or R36. 7/25/18, at 7:51 p.m. NA-J aware of any monitoring for not aware of any incidents	21850			
	the administrator ar was informed of the	and DON, the DON stated she incident on 7/14/18, around -D informed her what				

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 108 of 116

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00775	B. WING		07/2	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILIT	ALION CENTER I	H DAVIS AV LD, MN 553			
(X4) I D	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
21850	Continued From pa	ge 108	21850			
	administrator of the administrator filed a was informed of the placed R44 on 15 r later decided R36 a minute checks. The told about the incide who were working to nurse (LPN)-D, and residents. The DON nurse who was carried because incident confidential administrator stated minute checks, and also placed on 15 r	I stated she informed the incident, and the a report to the SA. After she incident, the DON stated she minute checks, and a few days also needed to be placed on 15 a DON stated when she was ent she told the two nurses that day, licensed practical I RN-B to keep an eye on both I stated she did not tell the ing for R36 what actually she wanted to keep R44's al. In addition, although the I R44 was placed on 15 a few days later R36 was minute checks, the reports a placed on 15 minute checks				
	stated they were do to monitor her local found out about the	7/26/18, at 2:20 p.m. LPN-B bing 15 minute checks on R44 tion. LPN-B further stated she incident through a nursing ad R44 had issues with another ot sure why.				
	stated the incident gave her the mone: "What is this for?" If touch her breasts, a your money" but he back. R44 indicated through her shirt, a strap, put his hand her breast. R44 st felt R36 tried to brik the first incident occ	7/26/18, at 2:35 p.m. R44 happened so fast he (R36) y and she took it and said, R36 told her he wanted to and she told him, "I don't want would not take the money d he touched her breasts nd then removed her shirt down her shirt and touched tated she felt assaulted, and be her with the money. After curred, R44 stated R36 told rould give her another \$10 to				

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 109 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LTIPLE CONSTRUCTION (X3) DATE OING: COM		SURVEY PLETED	
		00775	B. WING		07/2	27/2018
	PROVIDER OR SUPPLIER R MANOR REHABILITA	ATION CENTER 1 600 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21850	touch her breasts. It don't want you to do go to his room, and occurred in her room. During interview on stated the facility st checks after their moreology of the content of the conten	R44 stated she told R36, "I obtais!" R44 stated she did not confirmed the incident m. 7/26/18, at 4:36 p.m. RN-B opped R36's 15 minute norning meeting on Monday, and no additional incidents was directed by the p the 15 minute checks, even R44's room after the 15	21850			
	7/27/18, at 3:50 p.n	n 7/14/18, was removed on n. when the facility conducted the incident, and additional and to the DON and				

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 110 of 116

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING077		07/2	7/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MEEKER	R MANOR REHABILITA	ALION 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 APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	administrator, R44 checks, R36 was plead monitoring to ensure from abuse, all verto to ensure they were mistreatment and ensure they were mistreatment and ensure they were ensured all staff were educated on the read and the administrational the Abuse Prevention abuse. On 7/27/18, front line staff and restated they were ensured to potential for more they were ensured they were ensured to resident could educate all and designee could devensure ongoing corresults to the quality	had been placed on 15 minute laced on 1:1 for close re other residents were free pal residents were interviewed at free from abuse, neglect, exploitation, the facility Abuse ble Adult Plan was reviewed, ated on the Abuse ble Adult Plan, staff were ason for resident monitoring, for and DON were educated on con/Vulnerable Adult Plan gresident abuse and sexual from 3:15 p.m. to 3:45 p.m. nurses were interviewed, and ducated on the Abuse ble Adult policy, and the diagram at the lower scope of D which is isolated with	21850			
21980	MN St. Statute 626. Maltreatment of Vul	.557 Subd. 3 Reporting - Inerable Adults	21980			9/10/18

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00775	B. WING		07/2	7/2018
	PROVIDER OR SUPPLIER	ATION CENTER 1 600 SOUT	DRESS, CITY, S FH DAVIS AV ELD, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	Subd. 3. Timing of reporter who has revulnerable adult is lor who has knowled has sustained a phyreasonably explained information to the condividual is a vulnerable the individual is addividual is another facility and believe the vulnerable previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this sas described above (c) Nothing in this known or suspected knows or has reason been made to the condition of the condition	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the ommon entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected endividual that occurred prior is: as admitted to the facility from the reporter has reason to be adult was maltreated in the enows or has reason to believe a vulnerable adult as defined endividual that occurred prior is a vulnerable adult as defined endividual that occurred prior is a vulnerable adult as defined endividual that occurred in the ection may voluntarily report is section requires a report of dimaltreatment, if the reporter on to know that a report has	21980			

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 112 of 116

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		00775	B. WING		07/	27/2018
NAME OF PR	OVIDER OR SUPPLIER		T ADDRESS, CITY,			
MEEKER I	MANOR REHABILITA	ATION CENTER I	IFIELD, MN 553			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F	racility may provided directly to the lead at a now the event meet 526.5572, subdivising 55. The lead agent of the report under sulfate and under the report under sulfate and under the report under sulfate and under the report under sulfate and under the report under the report under the report under the report under sulfate and under the report under the	clause (5), the reporter or to the common entry point agency information explain its the criteria under section on 17, paragraph (c), claus acy shall consider this making an initial disposition belowing an initial disposition belowing an initial disposition belowing an initial disposition belowing and interview and documentalled to ensure allegations of dimmediately, no later that gency (SA) for 1 of 1 resides sexual abuse. Innimum Data Set (MDS) stated she was cognitively ensive assist of one with the plan dated 5/02/18, coses including depression, r, dementia and mild cognitive to Care Area Assessment 8, indicated she required vities of daily living (ADLs), the dwith deficits in judgementated and needed extensive one of the common	ing e of d t of n 2 nts or	Corrected.		

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 113 of 116

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. Building:		COIVIE	LLILD						
		00775	B. WING		07/2	7/2018						
NAME OF I	PROV I DER OR SUPPL I ER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE								
MEEKER MANOR RELIABILITATION CENTER 1 600 SOUTH DAVIS AVENUE												
MEEKER MANOR REHABILITATION CENTER, I LITCHFIELD, MN 55355												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE							
21980	Continued From page 113		21980									
21000	and orientated and at his previous living R36 planned to retune the During interview 7/2 administrator stated	received therapy due to a fall g situation. The CAA indicated	21888									
	not sure what time then stated she was she reported the ind that night due to an	it occurred. The administrator is informed by the DON and cident to the state agency later allegation of sexual abuse.										
	Health Complaints (11:29 p.m.)indicate duty another reside closed the door, an touch her breast, whim to stop, which I further indicated restouch her breast. A initiated. A Facility	mitted to the Office Of Facility (OHFC) 7/14/18, at 23:29 and R44 reported to nurse on the nurse of the nurse										
	was reviewed and a discuss the inciden originally indicated accept the cash and her. After a conver facility she did in farthe victim said she went into her room,	7 indicated R44's care plan administrator met with victim to t. The investigation report resident stated she did not did not want him to touch sation, she informed the ct accept the \$10.00 in cash. and the alleged perpetrator closing the door behind them.										
	and asked them to perpetrator then su room. Victim stated perpetrator down to door and she allow Victim did state tha encounter and wish	neone knocked on the door keep it open. The alleged ggested they go down to his d that she followed the his room, they closed the ed him to touch her breast. It she did not want another hed for him to stay away. The the report the victim was put										

Minnesota Department of Health

STATE FORM Q3PC11 If continuation sheet 114 of 116

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	27/2018		
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, I STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE COMPLETE			
21980	on 15 minute check informed of the victi and he agreed. During interview on the DON and admir stated she was info 7/14/18, around 9:00 the DON returned to parade. The DON it incident and stareport. Although the facility incident that occurre time. The facility be at 9:00 p.m. and the state agency unlater. The facility Abuse F Plan dated 7/18, incinfliction of injury, unintimidation, or puniphysical harm, pain defined sexual abuse contact of any type directed: Suspected OHFC (state agency later than 2 hours a abuse. SUGGESTED MET The administrator of abuse or maltreatments.	ge 114 as and the perpetrator was im's wishes to not meet again 7/26/18, at 11:54 a.m. with estrator present, the DON rmed of the incident on 10 p.m. by a floor nurse, after to the facility from the town informed the administrator of the administrator filed the 12 was made aware of the ed on 7/14/18, at unknown are aware of the allegation of incident was not reported to 11:29 p.m., two half hours Prevention/Vulnerable Adult dicated Abuse is the willfully increasonable confinement, ishment with resulting in or mental aguish. The policy se at non-consensual sexual with a resident. The policy sed Abuse shall be reported to be by online reporting process not after forming the suspicion of the thought of the suspicion of allegations, timely reporting of allegations, timely reporting of allegations,	21980					
	TIME PERIOD FOR	R CORRECTION: Twenty-one						

6899

Minnesota Department of Health STATE FORM

PRINTED: 09/04/2018 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING_ 00775 07/27/2018 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 (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

Minnesota Department of Health