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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: S9MS
Facility ID: 00775

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/14/2016**

6. DATE OF SURVEY **10/18/2017** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

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

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 10/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS
Posted 11/08/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **10/04/2017** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245361 October 27, 2017

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

Dear Mr. Rehkamp:

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 October 3, 2017 the above facility is certified for or recommended for:

90 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

An equal opportunity employer.

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered October 27, 2017

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

RE: Project Number S5361026

Dear Mr. Rehkamp:

On September 14, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 24, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 2, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 24, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 24, 2017, effective October 3, 2017 and therefore remedies outlined in our letter to you dated September 14, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: S9MS
Facility ID: 00775

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/14/2016**

6. DATE OF SURVEY **08/24/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

X 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Tim Rhonemus, HFE NE II 09/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/03/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

Posted 10/04/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 14, 2017

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

RE: Project Number S5361026

Dear Mr. Rehkamp:

On August 24, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> <u>Opportunity to Correct</u> - **the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> <u>Electronic Plan of Correction</u> - **when a plan of correction will be due and the information to be contained in that document;**
>
> <u>Remedies</u> - **the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> <u>Potential Consequences</u> - **the consequences of not attaining substantial compliance 3 and 6**

months after the survey date; and
<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Brenda Fisher, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fisher@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 3, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 3, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been

affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 24, 2017 (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 February 24, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/21/17 to 8/24/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Meeker Manor Rehab Center LLC was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=E	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to determine if the practice of self administration of medications (SAM) was safe for 2 residents (R115 and R72) in the sample who were observed self administering their nebulizer treatments. This had the potential to affect all 9 residents who are prescribed	F 176	R 115 and R 72 were assessed for self administration and found to not be appropriate for self administration of nebulizers. They will be supervised for their nebulizer treatments. All current residents receiving nebulizers have been assessed for self	9/29/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 09/23/2017

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 1 nebulizer treatments and had not been assessed for SAM. Findings include: R115's Order Summary Report (print date of 8/24/17) indicated that R115 was receiving DuoNeb Solution 0.5-2.5 milligrams (mg) in 3 cubic centimeters (cc) (Ipratropium-Albuterol) 1 application inhale orally three times a day for pneumonia, with a start date of 5/12/17. The August 2017 Medication Administration Record, identified R115 received scheduled nebulizer treatments at 8:00 a.m., 2:00 p.m., and 8:00 p.m.. R72's Order Summary Report (print date of 8/24/17) indicated that R72 was receiving DuoNeb Solution 0.5-2.5 mg in 3 cc (Ipratropium-Albuterol) 1 vial inhale orally three times a day for COPD (Chronic Obstructive Pulmonary Disease), with a start date of 6/30/17. The August 2017 Medication Administration Record, identified R72 received scheduled nebulizer treatments at 8:00 a.m., 2:00 p.m., and 8:00 p.m.. During observations on 8/21/17 1:46 p.m., licensed practical nurse (LPN)-B was observed to have left both R115 and R72 sitting in their rooms (across the hall from each other) sitting in their wheelchairs (WC), with their nebulizer masks strapped over their faces with the nebulizer treatments running. Both R115 and R72 were both asleep during these treatments and there were no staff in the room or near the room while they received these treatments. During this time there was no nurse checking to make sure the R115 and F72 received the entire dose of inhalant and did not remove their mask during the	F 176	administration and care planned appropriately. All residents will be assessed for self administration appropriateness on admission and PRN. Nursing staff education regarding set-up, administration, self administration and requirements for self administration at inservice. Nurse Managers will audit 4 nebulizer administrations weekly x4 then monthly x3 to ensure compliance. Nurse Managers will review all residents quarterly at care conference for appropriateness of self administration. DON provided education. Nurse managers will be responsible for the self administration assessments and reviews. Audits results will be reviewed by DON. DON will present to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 2 treatment. During an observation, the following day (on 8/22/17 at 1:35 p.m.), trained medication assistant (TMA)-A was observed to have left both R115 and R72 in their rooms, with nebulizer treatments running, alone. TMA-A did not check on these residents while the nebulizer was being administered. In an interview on 8/23/17 1:00 p.m., LPN-B stated she was not aware residents could not be left alone with their nebulizer (neb) treatments. She placed the neb solution in the aerosol container, and placed the masks on the resident and left the room. She then checked back on the residents in 5-7 minutes, when the treatment has completed. During interview on 8/23/17 1:14 p.m., case manger (CM)-A , stated they have not assessed resident who receive nebulizer treatment, for their self administration abilities, because the nurse places the treatment in the neb machine, not the resident, so she did not consider this SAM. During an interview on 8/23/17 at 2:16 p.m., the director of nursing (DON) stated the facility did not have a policy for assessing resident for self administration of medications. The DON further stated the expectations would be that the facility would assess a resident's ability to self administer any medication and have a physicians order allowing the resident to do so.	F 176		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each	F 241		9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 3 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 1 residents (R54) with severe cognitive impairment observed not served her meal in a timely manner. Findings include: R54's quarterly Minimum Data Set (MDS) dated 8/5/17, identified R54 had severe cognitive impairment and required extensive assistance with eating. R54's care plan printed 8/24/17, identified R54 had an activities of daily living (ADL) self care deficit and required, "setup / supervision / cues with [as needed] assist of 1 to eat." During observation on 8/23/17, at 8:33 a.m. R54 was seated in her wheelchair in the commons area watching television. Dietary aide (DA)-A approached R54 and assisted her in to the dining room and seated her at a table with several other unidentified residents. At 8:43 a.m. (10 minutes later) R54 remained seated in her wheelchair at the table in the dining room. Her eyes would be closed for short periods, then open and she would look around the dining room at other residents eating their meals. At 8:49 a.m. R54's eyes were open and she had a furrowed brow while her left hand was under her chin, watching her table mate, who was seated across from her	F 241	R 54 is no longer a resident at facility. All staff re-education on dignified dining experience, expectations in the dining room and flow of service. Designated nursing staff will be present in the dining room during breakfast to ensure timely assistance provided for those needing assistance. Specific duties reviewed with dietary staff. Dietician, CDM or designee will audit the dining room for continued dignity and timely service weekly x4 then monthly until QA determines compliance. CDM will report audit results to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 4	F 241		

at the table, eat her served meal. At 8:55 a.m. DA-D pushed a mobile cart over to R54's table and cleared off the soiled plates and glasses which were next to R54. R54 still had not been served her breakfast meal, and watched DA-D clear the table away of soiled dishes. At 9:07 a.m. (34 minutes later) R54 was served her breakfast meal by DA-E which consisted of a single egg with toast and hot cereal. R54 consumed the entire meal without any staff assistance. At 9:27 a.m. the surveyor attempted to interview R54 about her breakfast meal, however, R54 did not verbally respond to questions.

When interviewed on 8/23/17, at 9:29 a.m. DA-E stated resident orders were taken by dietary staff when they come into the dining room. DA-E stated staff just, "kinda watch," for new residents who enter, however, added some are, "overlooked," at times as DA staff aren't sure when they were brought in. Further, DA-E stated R54 was waiting for over thirty minutes to be served her meal was, "very inappropriate," as R54 was, "watching her [table mate] eat," and did not have a meal herself.

During interview on 8/24/17, at 9:15 a.m. assistant dietary director (ADD)-A stated the facility used an open dining model for the breakfast meal adding she felt, "it goes relatively well," but it, "really depends on the day," and if nursing is fully staffed or not. ADD-A stated residents should be served their meals within three minutes of being seated in the dining room, and R54 having to wait for over 30 minutes before getting her meal was, "a long period of time," and staff, "should have checked on her earlier," for her, "dignity."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5 When interviewed on 8/24/17, at 12:14 p.m. registered nurse (RN)-B stated she was unaware of any concerns with lack of timely meal service during the breakfast time, and felt maybe the dietary staff thought R54 had already been served and, "think she'd eaten already." Further, RN-B stated a residents dining experiences should be, "pleasant, just like home," as, "this is their home." A facility policy on dignity was requested, but none was provided.	F 241		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting as directed by the care plan for 1 of 1 residents (R54) reviewed for urinary incontinence. Findings include: R54's quarterly Minimum Data Set (MDS) dated 8/5/17, identified R54 had severe cognitive impairment, required extensive assistance with activities of daily living (ADLs) and was frequently	F 282	R 54 is no longer a resident in facility. Reviewed all residents with current scheduled toileting and/or requiring assistance to ensure care plans are current. Staff re-educated on following each residents plan of care and toileting program. Audits will be conducted to ensure compliance with care planned toileting schedules for residents. Nurse Managers will audit 10 residents	9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 incontinent of urine. Further, the MDS identified R54 was currently on a toileting program to manage her incontinence. R54's care plan printed 8/24/17, identified R54 had, "urge and functional bladder incontinence," and listed several interventions for staff to implement including, "Toilet on or about every 2 hours." During continuous observation on 8/23/17, at 6:49 a.m. R54 was seated in a high-back wheelchair being assisted out of her room into the commons area. R54 remained seated in her wheelchair in the commons area watching television until 8:33 a.m. when dietary aide (DA)-C approached her and brought her to the main dining room, seating her at a table with several other unidentified residents. R54 was served her breakfast meal at 9:07 a.m. and remained in the dining room until 9:46 a.m. when nursing assistant (NA)-D approached her and brought her out to the commons area. Shortly after, NA-G approached R54 and started to bring her down the hallway towards her room, however, stopped in the hallway to answer a different residents call light. R54 began to self propel herself down the hallway using the hand rail while repeating nonsensical speech to herself. At 9:59 a.m. (3 hours and 10 minutes later) NA-H approached R54 in the hallway and brought her to her room. NA-H assisted R54 to stand up using a mechanical lift and removed her pants exposing a visibly soiled incontinence product which had a strong urine odor present. NA-H removed the soiled incontinence product and disposed of it in the trash after seating R54 on the toilet. R54 did void a small amount while seated on the toilet.	F 282	per week until 3 consecutive weeks at 100% compliance, then 5 residents per week until 3 consecutive weeks at 100% compliance, then 5 residents monthly until compliance determined by QA, with ongoing random audits. Nurse Managers will report audit data to DON. DON will review and report to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 When interviewed on 8/23/17, at 10:11 a.m. NA-H stated R54 was last toileted, "when she got up," which was at 6:45 a.m. according to the flowsheet staff used to track cares. NA-H stated R54 had been incontinent of urine when assisted to the bathroom (at 9:58 a.m.), "between [a] medium and large," amount. Further, NA-H stated R54 should be assisted with toileting every two hours, however, the facility was short staffed and, "We [NA staff] get behind." An undated facility Toileting / Repositioning / Rehab Checklist flowsheet identified R54's name along with various times she had been assisted with care(s) on 8/23/17. The flowsheet identified R54 had been incontinent of urine when assisted at 6:45 a.m., and had been incontinent with a continent void at 10:10 a.m. (with the surveyor present). There were no other written times on the flowsheet when R54 had been assisted with toileting. When interviewed on 8/23/17, at 1:05 p.m. registered nurse (RN)-B stated care plans were used, "to allow staff to see the care of the resident," and staff should have assisted R54 with toileting, "about every two hours," as directed by the care plan. A facility policy on implementing the care plan was requested, but none was provided.	F 282		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily	F 311		9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 8 living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement a communication system to ensure resident needs were met for 1 of 1 resident (R36) who's primary language was not English, and was unable to read. Findings include: R36's quarterly Minimum Data Set (MDS) of 7/22/17 identified R36 had cognitive impairment and required supervision to minimal assist of one to complete activities of daily living, including dressing, grooming and bathing. The MDS identified R36 would need or want an interpreter to communicate with doctor or health care staff and preferred language was Spanish. During observation on 8/21/17, at 2:01 p.m. R36 was seated in the day room area when initial contact was made by the surveyor for an interview. The licensed practical nurse (LPN)-A informed the surveyor R36 only spoke a few words of English, although did understand some words spoken to her. LPN-A stated housekeeping staff, (HK)-A, was able to assist to "interpret information" at times. R36 responded to the surveyor when greeted with a smile and nod, but not verbal interaction. R36's care plan, initiated on 11/12/14, identified the potential for altered communication as resident speaks Spanish as primary language. The care plan also identified R36 had impaired cognitive function related to diagnosis of	F 311	New communication cards were made for staff to utilize with R 36, who does not speak English nor can she read. The new cards have pictures, words in Spanish and words in English as well as some having frequently used phrases to allow staff to communicate effectively to R 36 in her primary language and any other Spanish speaking residents. All residents with language barriers were reassessed and care planned for appropriate communication methods. Communication is assessed on all residents on admission, quarterly and with significant change in condition and care planned accordingly. There are 4 copies of the cards for staff to utilize for any resident who may need them. Staff educated on the use of the cards, locations of the cards and following each residents individualized interventions for maximum communication. Staff fluent in Spanish will interview resident weekly x4 then monthly x3 to assess improvement in communication between resident and staff. Nurse manager will audit communication with the cards to ensure compliance weekly x4, then monthly x3. DON will review audit and interview results and report to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 9 dementia. Interventions identified in the care plan included the following: *Resident requires cue cards, interpreter service, family or Spanish speaking staff at Meeker Manor. Resident has cue cards in her room, Spanish dictionary available for staff. Ensure availability and function of adaptive communication equipment. *Use gestures for communication. *Ask yes/no questions in order to determine the resident's needs. *Communicate with resident/family/caregivers regarding residents capabilities and needs *Use resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions-turn off TV, radio, close door, etc. The resident understands consistent, simple, directive statements. Provide the resident necessary cues-use cue cards in room. On 8/22/17, at approximately 7:00 p.m., R36 was observed seated in a chair, gathered in a circle for a group activity, with other unidentified residents. R36 was introduced to another Spanish speaking resident by the activities director (AD) by having stated their names and resident were then directed to participate in activity "Yard Yahtzee" as assisted by nursing assistant (NA)-L. Each resident was handed six large dice (approximately six inches square) in a basket and NA-L demonstrated to throw dice into the center of circle. NA-L then collected the dice and went on to the next resident. R36 responded by throwing dice when handed but otherwise sat with little facial expression, sitting back in chair between turns to throw "dice". On 8/23/17, at 7:13 a.m. R36 was guided to the	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 10 tub room for a bath with gestures by nursing assistant (NA)-D and brief explanation in English to "come" to the tub room to "take a bath". R36 followed NA-D with no verbal exchange. After R36 was assisted into the tub, nursing assistant (NA)-D began to fill the tub with water. R36 stated, "Caliente [hot]", and attempted to lift her feet out of the water. NA-D stated, I do not speak Spanish, however, did adjust water temperature once resident's discomfort was noted by R36 lifting her feet out of the water. R36 stated "Bien [alright]" after the water temperature was adjusted. During the bath, at 7:24 a.m., R36 placed her arm across her chest and said nothing. When asked by surveyor if she was cold using the Spanish word "frio". R36 stated "si' [yes] " NA-D stated she primarily uses gestures, but does know the words "Por Favor [please]", "De Nada [you're welcome]" and "El Bano [bathroom]". NA-D also referenced using HK-A and some TMA's who work on the evening shift to help with communication. NA-D stated the facility had some iPad's available to use, and the resident had signs in her room. NA-D identified a sign on R36's dresser drawer which stated "Cajon [drawer]", and a sign in the bathroom, written in Spanish but NA-D was unsure of what was written. NA-D stated R36 has picked up a lot of English. Upon completion of her bath, NA-D gestured to R36 to walk with her out to the dayroom area. R36 followed NA-D out to the dayroom, where NA-D gestured to the chairs across from the nurses station and R36 sat down in a chair across the nurses station. Throughout the interaction with R36, NA-D used gestures and short cues in English but did not use either the communication board referenced or the iPad to communicate tasks to be completed or to interact with R36.	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 11 On 8/23/17, at 9:16 a.m. R36 was observed walking in the hallway and was approached by beautician (B)-A. R36 was heard to say "No entiendo [I do not understand]" and shook her head from side to side. B-A then gestured to resident her intent by reaching out with both hands and fluffing the ends of R36's hair and gesturing for her to go with to get her hair fixed. R36 followed B-A to have her hair set. At this time, B-A did not utilize additional communication aides such as an iPad or cue card to indicate what she was going to do. At approximately 9:30 a.m., surveyor noted R36 in the beauty shop having hair set and commented "Bonita [pretty]", R36 smiled and nodded head up and down in response. During interview on 8/24/17, at 9:30 a.m., NA-E stated R36 understands some English and staff also had a communication board which was used, with pictures identifying some words. NA-E provided the communication board used, which displayed pictures with English subtitles (including picture of lips with a large X through it labeled as "Non-speaking", a picture of a face with a large X through it with a subtitle of "You've misunderstood", a face, with hand held to the forehead, and lightning type lines going to scalp, labeled "Headache", a face smiling, frowning, and tearful with the subtitles of happy, angry, and sad. NA-E stated this board was kept in the storage room because the resident historically has tucked the communication board away in her room and it had been difficult to find. NA-E stated the communication board is available for use, however stated they "thinks she [R36] understands some English.".	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 12 On 8/24/17, at 9:41 a.m. R36 was observed sitting in a chair positioned against the wall across from the nurses station. R36 had her arms crossed against her chest, observing other residents participating in a dice game at the round table. At 9:58 a.m. R36 remained sitting alone, reposition herself, and had her chin resting in her hand, looking down, as she was seated across from the nurses station. R36 remained seated in chair with no staff interaction noted by others when passing R36. During interview on 8/24/17, at 10:20 a.m. social services (SS)-A stated she had utilized a variety of services when communicating with R36. SS-A stated she had used the Certified Language International service via the telephone,with completion of assessments, however with R36's diagnosis of dementia, it was difficult for her to understand the communication process with the use of the phone. SS-A stated R36's community pastor was fluent in Spanish and he has assisted in translation for R36, and they use a communication board which is beneficial. SS-A stated R36 was unable to understand any written materiel in either English or Spanish, she is unable to read. SS-A identified staff members who spoke Spanish (including HK-A, one staff member in Dietary, a therapy staff member, and an employee who works in activities). SS-A stated R36 can speak very basic words in English and a lot of staff can speak basic Spanish. During observation on 8/24/17 at approximately 10:40 a.m., R36 was sitting in devotions with her eyes closed and arms crossed against her chest, no bobbing of head noted to indicate she was sleeping, and appeared to be resting, but not engaged. The devotion service were presented	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 13	F 311		

in English.

On 8/24/17, at 10:54 a.m. activities assistant (AA)-A stated he used Google translator to communicate with R36. AA-A opened Google translator to demonstrate system used. The audible translation did not play when activated. AA-A stated R36 was also able to read the translation when provided, stating R36 will look at the iPad translation, smiles and said "Si'". indicating she understood the information. AA-A stated this was gratifying as R36 understood the attempts to "Bridge the language barrier."

On 8/24/17, at 10:57 a.m., NA-F stated communication with R36 was difficult but did the best she could with the use of gestures. She was unaware of anything else to be used for communication with R36. NA-F expressed desire to learn Spanish so she could communicate with R36, and "No one can really understand her [R36]." NA-F stated she was aware of two other staff members who spoke Spanish that worked in other departments

On 8/24/17, at 1:53 p.m. AD identified R36 had a basic understanding of English and staff used Google translator to communicate. AD-A identified staff members who worked in housekeeping, dietary, and activities who were able to speak Spanish and communicate information to R36 as needed. AD-A stated R36 would read information on the Google Translator and nod her head in confirmation, responding in Spanish. AD-A was unaware R36 could not read Spanish or English. AD-A stated R36 was invited to participate in activities by stating "Come" and gesturing to join. AD-A did state evening games were confusing for R36 and often times she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 14	F 311		

would sit back, with her arms across her chest and observe. The resident's minister was fluent in Spanish and has been used to communicate with R36 when her roommate had passed to assist with grieving. AD-A stated she was unaware of any staff training to aide in communication, aside from use of the iPad's. AD-A stated attempts to recruit Spanish speaking volunteer through the residents church has been unsuccessful. AD-A had not attempted to outreach to other Spanish speaking groups in the area and the resident goes out with her family weekly.

During interview on 8/24/17, at 2:20 p.m., clinical manager (CM)-B stated she identified her self as "Enfermera [nurse] " and her name to R36. CM-B stated she holds her hand in a curved fashion in front of her mouth and makes chomping motion to communicate with R36 to come and eat for meals. CM-B stated R36 often laughs in response. CM-B stated R36 has cue cards to help communicate and the cards are kept in her room. CM-B stated the translator line is also used when completing assessments or preparing for physician rounds. They had a listing of key phrases pinned to the bulletin board in her office, including "You want something to eat?", "Are you hungry", "Do you need something?", "Call me if you need me." At 8/24/17, at 2:31 p.m., CM-B returned to the surveyor and was unable to locate the cards R36 was given, however stated the words on the cards were in both Spanish and English and was unaware of when they were last used. CM-B stated staff will bring the iPad into the room for translation as needed, and to her knowledge, they have not provided staff with training with commonly used phrases in Spanish. CM-B stated they do have Spanish channels on the television which the resident enjoys. CM-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 15 stated family members have also been used as interpreters. A policy was requested for use of interpreter with language barriers. A policy, titled Interpreter Policy was provided, dated 7/2017 which identified: Residents with limited English proficiency (LEP) are provided the opportunity to participate in the plan of care. The policy goes on to identify that authorization from the Administrator to use the services listed were needed. The policies identified contracted interpreter services for both the metro and Mankato area.	F 311		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely	F 314	R 54 is no longer a resident at facility. Reviewed residents with scheduled	9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16 repositioning to prevent skin breakdown and pressure ulcer development for 1 of 1 residents (R54) reviewed for pressure ulcer care. Findings include: R54's quarterly Minimum Data Set (MDS) dated 8/5/17, identified R54 had severe cognitive impairment, required extensive assistance with activities of daily living (ADLs) and had no current pressure ulcers, however, was at risk for pressure ulcer development. R54's MHM (Monarch Health Management) Tissue Tolerance Evaluation and Skin Risk Factors assessment dated 2/6/17, identified R54 to be at, "mild risk," of pressure ulcer development related to pain, incontinence and cognitive impairment. Further, the assessment listed interventions to reduce R54's risk of pressure ulcer development which included, "Turning and Repositioning Schedule," further adding, " [R54] is able to tolerate 2 [hour] repositioning." R54's Pressure Ulcer Care Area Assessment (CAA) dated 2/7/17, identified R54 to be at risk of pressure ulcer development related to needing extensive assistance with mobility and impaired cognition. The CAA identified an objective to, "minimize risks," for pressure ulcer development for R54 noting, "... is able to manage around 2 hrs [hours] repositioning plan." R54's care plan printed 8/24/17, identified R54 had an ADL self-care deficit along with a, "potential impairment to skin integrity," and listed several interventions for staff to implement which included, "The resident requires weight bearing	F 314	repositioning and those requiring assistance with repositioning to ensure care plans are current. Staff re-education on following plan of care and repositioning schedules, and the risks associated with failing to do so. Audits will be conducted to ensure compliance with care planned repositioning schedules for residents. Nurse Managers will audit 10 residents per week until 3 consecutive weeks at 100% compliance, then 5 residents per week until 3 consecutive weeks at 100% compliance, then 5 residents monthly until compliance determined by QA, with ongoing random audits. Nurse Managers will report audit data to DON. DON will review and report to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17 assist of 2 to turn and reposition in bed [every] 2 hours and as necessary." The care plan lacked any direction for staff on how often to reposition R54 when in her wheelchair. During continuous observation on 6:49 a.m. R54 was seated in a high-back wheelchair being assisted out of her room into the commons area. R54 remained seated in her wheelchair in the commons area watching television until 8:33 a.m. when dietary aide (DA)-C approached her and brought her to the main dining room, seating her at a table with several other residents. R54 was served her breakfast meal at 9:07 a.m. and remained in the dining room until 9:46 a.m. when nursing assistant (NA)-D approached her and brought her out to the commons area. Shortly after, NA-G approached R54 and started to bring her down the hallway towards her room, however, stopped in the hallway to answer a different residents call light. R54 began to self propel herself down the hallway using the hand rail while repeating nonsensical speech to herself. At 9:59 a.m. (3 hours and 10 minutes later) NA-H approached R54 in the hallway and brought her to her room. NA-H assisted R54 to stand up using a mechanical lift, removed her pants and her soiled incontinence product which exposed her coccyx. R54's coccyx had no visible open areas, however, had visible bright pink colored skin on the upper portion of the gluteal crease which blanched when pressed on by NA-H. NA-H stated R54's skin appeared, "a little pink." NA-H then finished assisting R54 with toileting and assisted her back into her wheelchair. When interviewed on 8/23/17, at 10:11 a.m. NA-H stated the NA staff used flowsheets to monitor when residents needed to be repositioned. NA-H	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18 stated the last time someone helped R54 with repositioning was, "probably when she got up," that morning adding the flowsheet identified, "6:45 [a.m.]," to be the last documented time R54 had been assisted with repositioning. Further, NA-H stated R54 should be repositioned, "every two hours," but the facility was short staffed and, "we [NA staff] get behind." An undated facility Toileting / Repositioning / Rehab Checklist flowsheet identified R54's name along with various times she had been assisted with care(s) on 8/23/17. The flowsheet identified R54 had been helped at 6:45 a.m. and at 10:10 a.m. (with the surveyor present). There were no other written times on the flowsheet when R54 had been assisted with repositioning. During interview on 8/23/17, at 1:05 p.m. registered nurse (RN)-B stated R54 had no current skin issues but was, "at risk for pressure ulcers." RN-B stated R54 required staff assistance to make purposeful changes in position and she should have been repositioned, "every two hours," as directed by her tracking flowsheet. A facility policy on pressure ulcer prevention and care was requested, but none was provided.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible	F 315		9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 19 to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting to reduce or prevent incontinence for 1 of 1 residents (R54) reviewed for urinary incontinence. Findings include:	F 315	R 54 is no longer a resident at facility. Reviewed all residents with scheduled toileting and/or requiring assistance with toileting to ensure care plans current. Staff re-education on following each residents plan of care and toileting schedule and risks associated with failure to do so.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 20 R54's quarterly Minimum Data Set (MDS) dated 8/5/17, identified R54 had severe cognitive impairment, required extensive assistance with activities of daily living (ADLs) and was frequently incontinent of urine. Further, the MDS identified R54 was currently on a toileting program to manage her incontinence. R54's MHM (Monarch Health Management) Bladder Evaluation dated 2/3/17, identified R54 to be, "not always aware of the need to urinate," and require assistance with mobility which resulted in R54 having functional urinary incontinence. Further, the evaluation identified a goal, "to maintain some continence weekly," and directed staff to toilet, "about [every] 2 [hours]," during the day and evening hours. R54's care plan printed 8/24/17, identified R54 had, "urge and functional bladder incontinence," and listed several interventions for staff to implement including, "Toilet on or about every 2 hours." On 8/22/17, at 1:36 p.m. R54 was laying in bed in her room with her eyes closed. The room had a strong odor of urine present, and the trash cans in the room were empty. During continuous observation on 8/22/17 at 6:49 a.m. R54 was seated in a high-back wheelchair being assisted out of her room into the commons area. R54 remained seated in her wheelchair in the commons area watching television until 8:33 a.m. when dietary aide (DA)-C approached her and brought her to the main dining room, seating her at a table with several other residents. R54 was served her breakfast meal at 9:07 a.m. and remained in the dining room until 9:46 a.m. when	F 315	Audits will be conducted to ensure compliance with care planned toileting schedules for residents. Nurse Managers will audit 10 residents per week until 3 consecutive weeks at 100% compliance, then 5 residents per week until 3 consecutive weeks at 100% compliance, then 5 residents monthly until compliance determined by QA, with ongoing random audits. Nurse Managers will report audit data to DON. DON will review and report to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 21 nursing assistant (NA)-D approached her and brought her out to the commons area. Shortly after, NA-G approached R54 and started to bring her down the hallway towards her room, however, stopped in the hallway to answer a different residents call light. R54 began to self propel herself down the hallway using the hand rail while repeating nonsensical speech to herself. At 9:59 a.m. (3 hours and 10 minutes later) NA-H approached R54 in the hallway and brought her to her room. NA-H assisted R54 to stand up using a mechanical lift and removed her pants exposing a visibly soiled incontinence product which had a strong urine odor present. NA-H removed the soiled incontinence product and disposed of it in the trash after seating R54 on the toilet. R54 did void a small amount while seated on the toilet. When interviewed on 8/23/17, at 10:11 a.m. NA-H stated R54 was last toileted, "when she got up," which was at 6:45 a.m. according to the flowsheet staff use to track cares on. NA-H stated R54 had been incontinent of urine just prior when assisted to the bathroom, "between [a] medium and large," amount. Further, NA-H stated R54 should be assisted with toileting every two hours, however, the facility was short staffed and, "We [NA staff] get behind." An undated facility Toileting / Repositioning / Rehab Checklist flowsheet identified R54's name along with various times she had been assisted with care(s) on 8/23/17. The flowsheet identified R54 had been incontinent of urine when helped at 6:45 a.m., and had been incontinent with a continent void at 10:10 a.m. (with the surveyor present). There were no other written times on the flowsheet when R54 had been assisted with	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 22 toileting. When interviewed on 8/23/17, at 1:05 p.m. registered nurse (RN)-B stated R54 did have, "some continence weekly," when assisted with toileting. RN-B stated staff should of assisted R54 with toileting, "about every two hours," adding, "that is the expectation." A facility policy on bladder incontinence management was requested, but none was provided.	F 315		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs.	F 329		9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 23 Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and monitor specific target behaviors for 3 of 5 residents (R78, R4, R64) reviewed for unnecessary medication use and was on an antipsychotic medication. Findings include: R78's quarterly Minimum Data Set (MDS) dated 7/11/17, identified R78 had intact cognition, did not display any physical, verbal or other behaviors including rejection of care or wandering, and took antipsychotic and antidepressant medications on a daily basis. R78's signed physician orders dated 8/8/17, identified R78 consumed, Olanzapine (antipsychotic) Tablet 2.5 milligrams (mg), once daily for, "Depression with Psychosis." The order listed a start date of 5/10/16. The physician orders lacked any specific target behaviors to monitor R78 for while consuming the	F 329	R 78, R 4 and R 64 reviewed. Target behaviors were added to tasks for documentation and updated in care plan. All residents receiving antipsychotic medications were reviewed and ensured to have target behaviors in tasks for documentation and current in care plan. Target behaviors will be specifically addressed and summarized on the psychotropic medication review form quarterly and PRN. Staff education on charting of behaviors, observing changes to the behavior documentation to be more individualized for each resident. Nurses educated on necessity to obtain the target behaviors on admission and with new orders for antipsychotic medications. NAR's will document behaviors. Nurse Managers will enter and update target behaviors in tasks and care plan on admission, with new orders, order	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 24	F 329		

antipsychotic medication.

During observation on 8/21/17, at 1:57 p.m. R78 was laying in bed in her room with her eyes closed. R78 appeared comfortable with no obvious physical signs of pain, and was clean and well groomed.

R78's care plan printed 8/24/17, identified R78 consumed psychotropic medication for, "Disease process depression with anxiety and [history] of psychosis," and listed several interventions for staff to follow including administering the medications as ordered by the physician, monitoring for side effects and effectiveness, reviewing the medication with family and consulting with the pharmacist to consider dosage reductions when clinically appropriate. The care plan lacked any identified target behaviors R78 demonstrated which required the prescribed antipsychotic medication.

R78's medical record was reviewed, and lacked any documented target behaviors or subsequent monitoring while consuming the antipsychotic medication, olanzapine.

When interviewed on 8/23/17, at 1:43 p.m. nursing assistant (NA)-D stated R78 could be, "very needy," at times, however, she was not aware of any other behaviors. NA-D stated she was not sure of any specific behaviors being tracked for R78.

R78's physician progress note dated 10/11/16, identified R78 had failed past dose reductions of the olanzapine with, "worsening anxiety, agitation, depression and poor sleep."

changes and PRN as well as complete the psychotropic medication review form per schedule.
DON or designee will audit all residents with antipsychotics to ensure target behavior documentation and care plan is present. Audit will be conducted monthly x4.
DON will report to QA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25	F 329		

A single sheet of paper titled, "[R78] Target Behav [behaviors]," was provided with handwriting from registered nurse (RN)-B which identified R78 had a history of psychosis with depression, however, "[R78] has not had noted psychosis at nursing home. [No] target behaviors [with] this."

During interview on 8/24/17, at 10:29 a.m. RN-B stated resident behaviors were tracked on the computer, however, "[R78] hasn't had behaviors." The tracking is identified as generic questions (i.e. hitting, kicking) and are the same for all residents. Further, RN-B stated there was no other behavior tracking used other than the computerized tracking and no target behaviors for R78 had been documented or monitored in the medical record.

R4's quarterly MDS of 7/29/17, identified R4 displayed a continuous level of inattention, with fluctuating levels of disorganized thinking, and severe cognitive impairment. The assessment identified R4 exhibited symptoms of behavioral symptoms not directed towards others on one to three days during the assessment period.

R4's signed physicians orders, dated 6/19/17, identified that R4 was prescribed "Remeron (Mirtazapine) tablet 30 mg (antidepressant) Give 30 mg by mouth at bedtime related to Bipolar II Disorder " with a start date of 8/27/14. R4 was additionally prescribed "RisperDal Consta Suspension Reconstituted (RisperiDONE Microspheres) 37.5 MG (antipsychotic), with orders to inject 37.5 mg intramuscularly in the afternoon every 14 days" related to unspecified psychosis with a start date of 2/16/17.

During observation on 8/24/17, at 9:02 a.m., R4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 26	F 329		

was observed in the dayroom, seated in a group setting with others performing exercises. R4 was sitting in chair, leaning toward right side, with eyes closed, not participating in any exercises. At 9:10 a.m., NA-B assisted R4 to her room to provide cares. During initial attempt with cares, R4 yelled "Get out" however, with ongoing prompts, including divisional conversation of family events with NA-K, R4 became cooperative with cares, and was assisted to toilet. NA-B stated R4 was on medication for mood and had been combative at times, "hollering" and swinging her arms and this behavior was worse during the evening shift. NA-B and NA-K both identified redirection worked well with R4, so they can provide cares. NAs B and K were unaware of any other behaviors R4 had besides calling out and being resistive with cares and were unaware of R4's history of visual hallucinations.

R4's care plan, revised on 5/1/17, identified an alteration in mood state related to bipolar depression and paranoia with diagnoses listed as paranoia, anxiety and behavior disorder, Alzheimer's dementia, and history of hallucinations involving cats and mice. Additionally, R4 had occasional behaviors due to dementia with delusions of being "gassed" and needing the windows opened, as identified by the care plan revision date of 6/2/16.

On 8/24/17, at 10:29 a.m. social services (SS)-A identified R4 had a history of behaviors but was improved with current medication regime. SS-A stated R4's medications have been adjusted to meet her needs. SS-A stated R4 had the diagnoses of depression and dementia, which were impacted by additional medical diagnoses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 27 On 8/24/17, at 12:24 p.m., a review of the facility narrative notes from 5/24/17 to 8/24/17. The social service (SS)-A note indicated on 7/31/17, at 11:47 am. R4 exhibited both disorganized thinking and inattention at times as evidenced by rambling or irrelevant conversation, easily distracted, difficulty following what was said. SS-A identified R4 has exhibited occasional episodes of weepiness and agitation, called out at times and became tearful, and had a history of significant anxiety. A nursing note on 7/6/17, at 4:22 p.m. from registered nurse (RN)-B identified R4 was very anxious at times, with crying and agitation, which affected her sleep. A subsequent note identified the MD was contacted for review of meds, with subsequent orders received. A nursing note on 7/29/17 at 7:58 p.m. identified R4 had physical aggression and running into others with wheelchair has ceased, but continued with yelling and crying, but was less than before. A review of point of care (POC) nursing assistant documentation from past 30 days. Indicated, R4 on all three shifts had "Behaviors". The specific target behaviors for R4 were not identified, but on all three shifts R4 had been calling out, crying, had expression of sadness, and asked repetitive questions. The documentation identified R4 was given reassurance, and redirection which was effective. The logs did not identify if R4 had hallucinations, delusions, physical aggression, tearful, crying and agitation that affected her sleep. The logs only identified these as "behaviors" even though R4 has Remeron (antidepressant) for Bipolar II Disorder, and RisperDal an antipsychotic medication. During interview on 8/24/17, at 2:49 p.m. RN-B	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 28	F 329		

stated she was unaware that R4 was experiencing hallucinations of cats and mice or being fearful of being "gassed". RN-B stated if this was the concern identified, the nursing staff should be aware of these behavior so they can be monitored. The monitoring should be specific to what "behavior" R4 was exhibiting, so they could effectively track and trend these behaviors.

R64's face sheet, undated, identified medical diagnoses of anxiety disorder, dementia, and major depressive disorder. R64's Quarterly Minimum Data Set (MDS) dated 5/8/17, identified R64 was cognitively intact.

During observation on 8/21/17, at 6:15 p.m. R64 was in her room sitting on wheelchair, watching TV, she was alert and call light was in reach. On 8/23/17, at 7:25 a.m. resident observed in her room lying in her bed, eye was closed, call light in reach and bed left at lower position.

During interview on 8/16/17, at 2:15 p.m. when asked what specific behaviors were being monitored for R64, Nursing Assistant (NA)-A stated "I do not know."

Review of the Meeker Manor Rehabilitation Center Order Summary Report dated 8/24/17, directed staff to administer Mirtazapine (antidepressant) 15 mg, at bedtime for appetite, rest and depression with the order start date 8/20/14 and Zyprexa (antipsychotic) 2.5 mg PO at bedtime for aggressive behavior - delusions verses hallucinations.

R64's care plan, revised on 11/15/16, indicated an alteration in mood state related to depression and motor vehicle accident, at times mood can go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 29 from one extreme to another: R64 also had " ...Hx [history] of scoring higher on depression scale ..." Under the section of intervention identified to monitor R64's behavior as shown in the facility tracking system, however there was no indication resident hallucination and delusional behavior were being monitored. The facility document titled "Follow Up Questions Report", a data collecting system indicated R64 was monitored for refusal of cares, socially inappropriate language, calling out and yelling behaviors, however there was no indication the faciltiy was monitoring delusions and hallucinations, even though R64 was receiving an antipsychotic medication. On 8/16/17, at 2:36 P.M. the Assistant Director of Nursing (ADON) indicated charting should be done on resident behavior every day, but ADON was unsure if R64 required any documentation. At 2:51 p.m. registered nurse (RN)-A stated this was a small facility and the charge nurse would alert the staff for look for specific behaviors. the NA would report to the nurse, and the nurse would chart on the behaviors once a week.	F 329		
F 353 SS=F	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 353		10/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 30	F 353		

resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]

(a) Sufficient Staff.
(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 31 Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed needs for 1 of 3 residents (R54) reviewed for urinary incontinence and pressure ulcer care, and 3 of 3 residents (R17, R5, R126), 1 of 1 family members (FM-A) and 11 of 11 staff members (SM-B, NA-I, NA-H, NA-D, RN-B, NA-G, NA-A, NA-B, NA-C, LPN-B, LPN-D) who expressed concerns with the lack of sufficient nursing staff. This lack of sufficient nursing staff had the potential to affect all 64 residents, visitors and staff in the facility. Findings include: ASSESSED RESIDENT NEEDS NOT MET: The facility did not provide timely assistance with toileting as directed by the care plan for 1 of 1 residents (R54) reviewed for urinary incontinence. R54's care plan printed 8/24/17, identified R54 had, "urge and functional bladder incontinence," and listed several interventions for staff to implement including, "Toilet on or about every 2 hours." During continuous observation on 8/23/17, from 6:49 a.m. to 9:59 a.m. (3 hours and 10 minutes) R54 was not assisted with toileting as directed by the care plan. When assisted at 9:59 a.m. R54 had been incontinent of urine. When interviewed on 8/23/17, at 10:11 a.m. NA-H stated R54 should be assisted with toileting every two hours, however, the facility was short staffed and, "We [NA staff] get behind." See F282 for additional information The facility did not provide timely repositioning to prevent skin breakdown and pressure ulcer development for 1 of 1 residents (R54) reviewed	F 353	R 54, R 17 and R 126 are no longer residents at facility. R 5 was interviewed for her bedtime preferences and care plan updated to reflect. All nursing staff were asked to complete a form laying out what an average shift looks like hour by hour. This will be reviewed by DON and Administrator to determine the times of higher need and allow positions to be scheduled/adjusted to ensure resident needs are met. Item of staffing concerns added to resident council agenda, to hear and address concerns. Item of staffing concerns added to the family council agenda, to hear and address concerns. New daily assignment sheets will replace the current form so as not to give the perception of having open shifts. We have posted for the development of an employee recruitment, retention and burnout prevention committee. This committee will meet monthly and PRN, DON will lead. Staff education provided regarding customer service, time management, prioritization, clinical importance of following care plan/risks associated with failing to and the process of staffing to census and acuity. Call light logs will be run and reviewed daily by DON. Census, acuity and nursing hours PPD will be reviewed daily by DON and Administrator, ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 32 for pressure ulcer care. R54's Pressure Ulcer Care Area Assessment (CAA) dated 2/7/17, identified R54 to be at risk of pressure ulcer development related to needing extensive assistance with mobility and impaired cognition. The CAA identified an objective to "minimize risks" for pressure ulcer development for R54 noting, "... is able to manage around 2 hrs [hours] repositioning plan." During continuous observation on 8/23/17, from 6:49 a.m. to 9:59 a.m. (3 hours and 10 minutes) R54 was not assisted to reposition to reduce the risk of pressure ulcer development. At 9:59 a.m. when R54 was assisted to stand by staff, R54's coccyx had no visible open areas, however, had visible bright pink colored skin on the upper portion of the gluteal crease which blanched when area pressed by NA-H. NA-H stated R54's skin appeared, "a little pink." When interviewed on 8/23/17, at 10:11 a.m. NA-H stated R54 should be repositioned, "every two hours," but the facility was short staffed and, "we [NA staff] get behind." See F314 for additional information. The facility did not provide timely assistance with toileting to reduce or prevent incontinence for 1 of 1 residents (R54) reviewed for urinary incontinence. R54's care plan printed 8/24/17, identified R54 had, "urge and functional bladder incontinence," and listed several interventions for staff to implement including, "Toilet on or about every 2 hours." During continuous observation on 8/23/17, from 6:49 a.m. to 9:59 a.m. (3 hours and 10 minutes) R54 was not assisted with toileting. When assisted at 9:59 a.m. R54 had been incontinent of urine, and further voided when finally assisted to the restroom by staff. When interviewed on 8/23/17, at 10:11 a.m. NA-H state R54 should be assisted with toileting every	F 353	DON will present staffing monitoring, log results, interview concerns and follow up to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 33	F 353		

two hours, however, the facility was short staffed and, "We [NA staff] get behind." See F315 for additional information.

RESIDENT & FAMILY CONCERNS WITH LACK OF STAFFING:

R17's quarterly Minimum Data Set (MDS) dated 7/6/17, identified R17 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs). When interviewed on 8/21/17, at 11:55 a.m. R17 stated there was not enough staff in the facility to meet her needs timely. R17 stated she will, at times, be seated on the toilet for up to one-half hour waiting for assistance which sometimes causes her back to ache. Further, R17 stated she has had urinary incontinence as a result of having to wait for staff to assist her.

R5's quarterly MDS dated 7/22/17, identified R5 had intact cognition and required extensive assistance with ADLs. When interviewed on 8/21/17, at 2:55 p.m. R5 stated the facility did not have enough staff to help residents get their needs and cares met. R5 stated several of the staff had quit and often times there would only be two nursing assistant (NA) staff to help care for everyone on her unit. Further, R5 stated she liked to go to bed around 8:30 p.m., however, sometimes would not be assisted to bed until 10:00 p.m. as there were no staff to help her.

When interviewed on 8/22/17, at 1:17 p.m. R126 stated there was not enough staff in the facility to help with cares. R126 stated if you need help, "you have to wait," and when staff finally respond they have, "about two minutes," to help you, "before they're off to someone else." R126 stated

F 353 Continued From page 34 F 353

she had noticed instances in the dining room where there was only one staff member to help others feed themselves which was, "not fair to her or us [residents]."

During interview on 8/21/17, at 2:32 p.m. family member (FM)-A stated R38 resided at Meeker Manor as a long term resident. FM-A expressed concerns regarding staff turnover and limited number of long term staff. FM-A stated the facility was frequently "short-handed." FM-A stated on at least a weekly basis, the call light had been turned on to summon assistance and the response time had been greater than half an hour. FM-A stated he visited R38 routinely and provided assistance with meeting R38's needs as able, including having had training to provide hands on assist with transfers. FM-A expressed concerns for other residents, "where nobody comes in to see them."

STAFF CONCERNS LACK OF STAFFING:

On 8/22/17, at 7:20 p.m. nursing assistant (NA)-I stated full staffing would be six NA staff for the South Unit and added staffing in the facility was, "not fantastic right now." NA-I stated the staffing had struggled, "since Spring [2017]," and often times the scheduler would only have two NA staff scheduled for the unit until, "last minute." NA-I stated, "a lot of physical therapy," and range of motion (ROM) programs were not being completed as a result of the poor staffing.

During an anonymous interview on 8/22/17, staff member (SM)-B stated the nursing staffing levels at the facility were, "absolutely ridiculous," and, "just not OK in general." SM-B stated residents were often not helped to bed timely, with some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 35	F 353		

being left up in their wheelchair asleep until nearly midnight. SM-B stated the staffing had been poor for, "about seven months," with many shifts having only, "two people [NA staff] period," on the South Unit to help with resident cares. SM-B stated an evening prior, one resident only got a bed bath instead of their scheduled whirlpool bath, "because we're so short staffed," and, "we're out of time." Further, SM-B stated these concerns with insufficient nursing staffing had been reported to administration, however, they "don't do anything about it, [rather] just kind of nod along," to the concerns.

On 8/23/17, at 10:11 a.m. NA-H and NA-I both stated they were often short staffed. NA-I stated there were typically five NA staff for the South Unit which was, "not enough," to get all assigned cares completed as the staff end up, "running," and "get behind." Further, NA-H stated staff had reported these concerns, "all the time," to administration, however, no feedback was ever provided except they were, "looking for staff [and] trying to get employees."

When interviewed on 8/23/17, at 1:43 p.m. NA-D stated the staffing in the facility was, "a huge problem," and had been an issue, "this whole summer [2017]." NA-D stated staff was frequently being asked to work double shifts which was causing them to be, "worn out," and the care provided to residents was, "very rushed sometimes." NA-D stated the NA staff worked, on average, "three plus" days a week being short staffed further adding, "[the] weekends are always short." Further, NA-D stated the administration of the facility had been told and are aware of the insufficient staffing concerns, "They know its an issue."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 36	F 353		

During interview of 8/23/17, at 2:47 p.m. NA-A identified there were times when staffing of nursing assistants was limited to one assistant for each wing on the south unit. NA-A stated this occurred on a routine basis. At times, with limited staffing, the trained medical assistant (TMA) has been shifted from passing medication to working on the floor and assisted with personal cares. When this occurred, the charge nurse was responsible to pass medications. NA-A stated at times, bathing was not completed due to lack of staffing.

During interview on 8/24/17, at 12:14 p.m. registered nurse (RN)-B stated the South Unit (third and fourth street) had 48 total residents when the unit was full. RN-B stated the staffing on the unit should be five NA's, "including a float." RN-B stated she noticed the NA staff picking up, "a lot of hours," adding the NA staff needed more help to complete cares as, "obviously they're being asked everyday," to come in and work additional shifts. Further, RN-B stated she had noticed the ambulation programs and, "the walks," were, "struggling," to be completed on the unit.

When interviewed on 8/24/17, at 2:26 p.m. NA-G stated the facility was, "short of staff," which was, "not fair," to the residents or staff. NA-G stated, "the walking and the therapy," were not consistently being completed, "like it should be," as staff did not have, "enough time to do it in." NA-G stated the staffing levels, "[have] declined more," in recent months and the facility administration was aware of these concerns and they report, "they're working on it." NA-G added, "we hear it all the time," however, the staffing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 37 levels never changed or improved. Staffing "just gets worse and worse." Further, NA-G stated she had even noticed some residents having more urinary incontinence as a result of not being assisted timely with care, adding the current staffing levels in the facility were "unsafe." During interview on 8/24/17, at 9:16 a.m. NA-B acknowledged staffing was "awful." NA-B stated when the facility was short staffed, the TMA would be pulled from the med cart to assist on the floor with personal cares. NA-B stated when charting was not done, they were instructed to stay late to complete it. NA-B stated although incentives are offered to staff when they pick up extra time or shifts, staff found this difficult to do because of hours that had been already worked or scheduled. During interview on 8/23/17, at 12:27 p.m. licensed practical nurse (LPN)-B stated there have been staffing issues on all shifts over the last year, but it was more noticeable the last several months. LPN-B stated there have been weekends where there was only one nursing assistant on each of the 4 wings, on several shifts, and that a lot of good staff have been lost. LPN-B stated the staffing has been better this week, and although considered a casual staff person, has worked 10-12 days in a row. LPN-B stated on weekends when there was a call in, she has been told to place staff names who were currently working "in a hat" and draw to see who would be staying into the next shift. LPN-B stated it was not uncommon for staff to pull double shifts to cover the schedule. LPN-B went on to say that there are times that baths, walking lists, and cares were either missed or passed on to the next shift for completion.	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 38	F 353		

On 8/23/17 at 1:00 p.m., LPN-B stated that she usually works on one end of the building, but will be asked to work the other area when the facility was in need of covering nursing shifts. LPN-B stated she felt the work got done, except when there was a call in, someone was sent to the hospital or if there were multiple resident illnesses. This staff nurse also stated that there have been weekends when there was only one nursing assistant for each of the 4 units, and was concerned about staff burn-out.

An interview on 8/24/17, 9:01 a.m., LPN-D stated that on 100 an 200 units they usually had 2 nurses/TMAs and two NARs, and while currently Unit 100 had lighter care levels that appeared to be enough. This LPN stated there were approximately 3-4 residents on 200 that required the assistance of assistance of two NAs, and between the two units (100 and 200) the NARs floated from unit to unit. LPN-D stated when they can, the nurses also assisted with call lights and cares. LPN-D stated that when there was a call in, things can become more difficult.

During an interview on 8/24/17, 10:02 a.m., NA-C stated the facility was short today with only one nursing assistant for each of the two units on the north end. When asked, NA-C stated they would get everything done for the shift, including breaks, but not at the times that cares and breaks are scheduled. NA-C (who is also a trained medication assistant - TMA) stated that when she was a TMA, they were responsible for range of motion (ROM) activities as well, stating ROM gets done "for the most part" but may miss a day here or there.

In an interview on 8/24/17, 12:25 p.m., the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 39	F 353		

scheduler (SCHED) stated the facility was staffed according to the care level needs of each unit. SCHED stated on the North end, it was the practice to schedule one nurse and one NA on the 100 unit and 1 nurse/TMA and two NAs on the 200 unit, with a floating NA for both units. On the South end, it was the practice to schedule one nurse/TMA and two NAs on both the 200 and 300 units with a floating NA as well. SCHED stated this was the scheduling pattern they planned for both the Day and Evening shifts. On the Night shift, the staffing pattern should be one nurse and two NAs for both the North and South ends. SCHED stated the facility has been offering bonus pay for shift pick ups and allows nurses on the weekends to offer the same for when there are call ins. SCHED stated the bonus program works 50-75% of the time to cover shifts. SCHED stated they have hired a few new staff, continued to advertise, and encourage staff to recruit new employees.

Review of the facility nursing assistant schedule, for the period of July 28 through August 10, 2017, the following was noted:
North Nursing Assistant Schedule -
Day shift:
Saturday July 29, 2017 - 2 of 3 positions filled
Sunday July 30, 2017 - 2 of 3 positions filled
Evening Shift:
Sunday July 30, 2017 - 2 of 3 positions filled
Monday July 31, 2017 - 2 of 3 positions filled
Monday August 7, 2017 - 1 of 3 positions filled
Thursday August 10, 2017 - 2 of 3 positions filled

South Nursing Assistant Schedule -
Day Shift:
Saturday July 29, 2017 - 3 of 5 positions filled
Sunday July 20, 2017 - 2 of 5 positions filled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 40 Evening Shift: Wednesday August 2, 2017 - 3 of 5 positions filled Thursday August 3, 2017 - 3 of 5 positions filled Friday August 4, 2017 - 3 of 5 positions filled Sunday August 6, 2017 - 4 of 5 positions filled Monday August 7, 2017 - 2 of 5 positions filled Further review of the facility nursing assistant schedule, for the period of August 11 through August 24, 2017, the following was noted: North Nursing Assistant Schedule - Day Shift: Saturday August 19, 2017 - 2 of 3 positions filled Sunday August 20, 2017 - 2 of 3 positions filled Tuesday August 22, 2017 - 2 of 3 positions filled Evening Shift: Sunday August 13, 2017 - 1 of 3 positions filled Monday August 14, 2017 - 0 of 3 positions filled Tuesday August 15, 2107 - 2 of 3 positions filled Wednesday August 16, 2017 - 1 of 3 positions filled Thursday August 17, 2017 - 1 of 3 positions filled Friday August 18, 2017 - 2 of 3 positions filled Saturday August 19, 2017 - 2 of 3 positions filled Sunday August 20, 2017 - 2 of 3 positions filled Tuesday August 22, 2017 - 1 of 3 positions filled Wednesday August 23, 2017 - 2 of 3 positions filled South Nursing Assistant Schedule - Day Shift: Saturday August 19, 2017 - 3 of 5 positions filled Sunday August 20, 2017 - 4 of 5 positions filled Monday August 21, 2017 - 4 of 5 positions filled Evening Shift: Friday August 11, 2017 - 4 of 5 positions filled Monday August 14, 2017 - 4 of 5 positions filled Wednesday August 16, 2017 - 3 of 5 positions filled	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 41 Friday August 18, 2017 - 4 of 5 positions filled Saturday August 19, 2017 - 2 of 5 positions filled Sunday August 20, 2017 - 2 of 5 positions filled Monday August 21, 2017 - 4 of 5 positions filled During interview on 8/24/17, at 2:00 p.m., the facility administrator (ADM) and director of nursing (DON), both stated they were aware of the facility staffing concerns. ADM stated a year ago, when ownership changed, they were staffing 1:6 staffing ration (one NA to every 6 residents). However with the change in census (current 64 residents to the 90 certified beds available) they have changed the staffing ratio to 1:8 (one NA to 8 residents) while they were finding it difficult to obtain staff. The DON stated they have extended the TMA hours, so that when medication passes are completed, TMA staff is free to assist the NAs with direct care needs (mornings over lapping by 30 minutes and evenings by 45 minutes). The ADM and DON both stated the prior owners had a PIP Grant (Prevention Innovation Program) which allowed them to staff nursing rehab and bath aid personnel. However, in the months prior to the ownership change, the previous owners discontinued the program. As a facility, they have had to re-incorporate those positions back into the facility schedule. The ADM stated the North end, having their Medicare A / Short Stay residents, the scheduling fluctuates depending on the admission and discharges they experience. The DON stated the facility was looking at potential concerns of "employee burnout", by talking with the employees, looking at offering nursing assistant classes, offering the facility to nursing programs as a clinical location (to encourage those nurses to seek employee there after graduation), and a staff bonus for referring new hires to the facility. The DON stated as of	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 42 this morning, the facility census was 62 with 41 residents on the South end and 21 on the North, with both a discharge and death that morning on the North end. A written policy and or written guidelines for scheduling nursing department personnel was requested, however was not provided.	F 353		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow manufacturer recommendations when administering insulin by a pen for 1 of 1 residents (R84) observed to receive a Novolog 70/30 insulin via insulin pen. Finding include: R84's annual Minimum Data Set (MDS) dated 5/12/17, identified R84 had a diagnosis of diabetes, and required daily insulin injections to manage his blood sugars.	F 425	R 84 was reviewed for any possible negative outcomes from potential of failure to prime insulin, none observed. Nurses meeting held, all nurses re-educated on requirement to prime insulin pens with 2 units prior to dose administration. Policy was reviewed with the nurses. Nurse Managers will directly observe insulin prep 5 times weekly x4, then 5 times monthly until compliance determined by QA. Nurse Managers will report audit results to	9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 43 R84's physician orders of 8/9/17, identified R84 received prescribed Novolog 70/30 flexpen (fast-acting insulin) 35 units every morning and 14 units subcutaneously in the evening for diabetes. R84 had his blood glucose checked on alternating days and times. A review of the medication administration record (MAR) for August 2017 identified blood glucose results at 7:00 a.m. from 124-161, and results at 5:00 p.m. ranging from 97-171. On 8/23/17, at 8:31 a.m. during observation of medication administration licensed practical nurse (LPN)-E was observed to prepare for insulin pen administration of Novolog 70/30 35 units. LPN-E was not observed to prime the insulin pen needle prior to preparing the dose. LPN-E was stopped by the surveyor. Although not observed to do so, LPN-E stated she had pushed one unit through the pen and was unaware of the facility policy for this. LPN-E then primed the pen with the required 2 units before administering the insulin. LPN-E identified the purpose of priming the pen was to get any air bubbles out of the pen and to assure the correct dose was given. The Novolog manufacturer guidelines require a 2 unit "air shot" to be dispensed prior to injecting an insulin dose. This ensures an accurate dose of insulin. The facility policy, Insulin Administration-Pen, revised 4/14, identified the following steps for priming the pen: J. Perform an air shot. K. Turn dose selector to "2" units. L. Holding pen with needle pointing up, tap the cartridge. 1)This moves any collected air to the top of the cartridge. M. Press the injection button all the in until the dose selector is back to "0". N. Select	F 425	DON. DON will review and report to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 44 dose by tuning the dose selector to the number of units to be administered. On 8/24/17, at 1:43 p.m. the director of nursing (DON) stated when administering insulin via an insulin pen, the pen should be primed with 2 units so the correct dose was given.	F 425		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 441		9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 45 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement procedures to prevent the potential spread of infection related	F 441	R 56 was reviewed for any possible negative outcomes, none observed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 46 to the cleansing of multi-use blood glucose monitoring machines. This had the potential to affect 2 of 2 residents (R52 and R56) reviewed who had blood glucose checks were monitored from this medication cart. The facility also failed to handle clean and soiled linens in a manner to prevent the spread of infection which had the potential to affect 41 of 62 residents who resided on the south unit of the facility. Findings include: GLUCOMETER CARE: On 8/22/17, at 6:32 p.m., trained medical assistant (TMA)-B was observed to conduct a blood glucose test for R56. Once the monitoring had been completed, TMA-B returned to the medication cart and cleaned the glucometer with an alcohol prep pad. TMA-B stated this was done to length of the "ABC song" to assure proper cleansing. TMA-B then placed the glucometer back in the drawer for subsequent use. A container of Sani-Cloths was observed to in place on the top of the medication cart but was not used in the cleaning process. Policies were requested for both the manufacturer instruction booklet and facility policy for cleaning of glucometers, The facility policy Glucometer Cleaning, dated 5/23/11, identified after each patient use the nurse was to wipe down the Glucometer machine with a Germicidal wipe, or 1:10 bleach solution. Do not use alcohol as it may damage the machine. The policy identified when using the germicidal wipe, the wet solution must be in contact with the machine for two minutes. An additional application with a new wipe may be necessary to keep the machine	F 441	LINEN: Soiled linen handling policy was reviewed and updated. Staff are expected to bag all dirty/soiled linen prior to leaving residents room to aid in infection prevention. Staff educated on policy update. Clean linen handling also reviewed at staff inservice on proper carrying technique. Infection Preventionist will audit hallways for linen handling to ensure compliance with policy. Audits will be conducted for 5 observations weekly x4 weeks, then 2 observations weekly until compliance determined by QA, with ongoing random audits. GLUCOMETERS: Four new glucometers were ordered so each med cart will have 2, this will allow for nurse to use one while the other is disinfecting. Nursing was re-educated on the glucometer cleaning policy. Infection Preventionist will audit glucose cleaning procedure to ensure compliance. Audit will be conducted 5 checks per week x4 weeks, then 2 checks per week until compliance determined by QA. Infection Preventionist will report data to DON. DON will review and report to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 47	F 441		

moist for two minutes. The machine was then to air dry for two minutes.

During interview on 8/22/17, at 7:38 p.m., TMA-B stated glucose checks were performed on that unit for R52 and R56. Upon review of policy, TMA-B stated she was unaware of the facility/manufacturer policy regarding use of Super Sani-Cloths and had always cleaned the monitor with alcohol prep pads.

During interview on 8/24/17, at 1:40 p.m. the director of nursing (DON) stated glucometers were to be cleaned with Sani-Wipes and the machine was to stay wet for 2 minutes. The DON stated this was necessary to completely disinfect the machine and if not followed, the machine would not be completely disinfected. The DON stated this would be important to minimize exposure risks for all residents.

The Assure Prism Multi blood glucose monitoring system user manual, dated 8/15, identified the cleaning process was needed to clean dirt, blood, or other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure was needed to prevent the transmission of blood-borne pathogens. The policy identified that Super Sani-Cloth Germicidal Disposable Wipes have been tested and approved for cleaning and disinfecting of the Assure Prism multi Blood Glucose Monitoring System.

LINEN HANDLING:

During initial tour, on 8/21/2017, at 8:59 a.m. nursing assistant (NA)-J was noted to be walking down the hall holding linens against the front of

F 441 Continued From page 48 F 441

her uniform in one arm with the end of a sheet trailing. NA-J entered a room, and placed the linens on a nightstand to prepare for making the bed. NA-J stated the bottom sheets did not fold well for this model of bed. NA-J stated she would not carry soiled linens like that but the linens brought in to the room were clean.

On 8/23/17, at 7:03 a.m., NA-F was noted to be walking down the hall with soiled linens and entered the tub room. NA-F exited the room without linens and exited down the hall. At 7:34 a.m., NA-F was observed carrying soiled linens in to the tub room and placing soiled linens into the covered linen barrel. NA-F exited the room following placement of linens in the barrel.

On 8/24/17, at 2:06 p.m., NA-F stated soiled linens were taken from resident rooms into the tub room, where the covered linen barrel was placed. NA-F stated linens were not to be carried against the care provider. NA-F stated at times, during morning cares, the linen barrels were in the hallway, but in general were kept in the shower room. NA-F stated hand hygiene is performed following disposal of soiled linens into the covered barrels.

On 8/24/17, at 1:45 p.m. the director of nursing (DON) stated soiled linens should be handled in a plastic bag. The DON added it would be an infection control concern if this were not completed. The DON further stated clean linens were held away from the body.

On 8/24/17, at 2:14 p.m., registered nurse (RN)-B stated soiled linens should never touch the caregivers uniform. RN-B further stated the linens should be placed in the cart [barrel] and taken to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49 the laundry. RN-B stated linens for people with infection control precautions should be bagged in special bags to identify them. An undated policy, Infection Control-Laundry Department, identified the purpose of the policy to prevent cross-contamination by proper technique of collecting, storing, handling and transporting clean and scolded linens and clothing. The policy identified clean linen was to be handled as little as possible and residents clean personal clothes were to be brought into the room in covered baskets or on hangers. The policy did not identify how linens were to be transported to rooms. The policy identified soiled linen was placed in easily cleanable-covered laundry containers which were to be positioned outside the door of the resident, or across the hall to maintain clear traffic flow. The policy further identified soiled linen was handled as little as possible to prevent the spread of infection.	F 441		
F 456 SS=F	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure repairs were completed timely for 1 of 1 walk-in freezers in the main production kitchen which had ice build up on	F 456	The repairs were completed to the walk in freezer door. The tiles were replaced where the water had pooled.	9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 50 the entry door causing pooling of water on the floor. This had potential to affect all 64 residents, visitors and staff who consumed food stored and prepared in the kitchen. Findings include: On 8/21/17, at 8:33 a.m. the initial kitchen tour was completed with assistant dietary director (ADD)-A. A CrownTonka brand walk-in cooler was opened which had a single entry door to a separate CrownTonka walk-in freezer along the far back wall. The exterior of the freeze door had approximately 2 -3 inches of thick ice build up along the bottom which went up the door approximately 6-8 inches. Below the freezer door were several subway-style visibly broken floor tiles and pooled water extending away from the bottom of the freezer door several feet going underneath the shelving in the cooler with thawing meat and other food items sitting on top. A yellow colored, "Caution: Wet Floor," sign was set in front of the freezer door in pooled water on the floor. The freezer was inspected and contained frozen raw meat products, ice creams and other various frozen items. Review of the facility A.M. Cooks Refrigerator & (and) Freezer Temps listing dated 8/2017, identified the freezer temperature were monitored on a daily basis and recorded on a flowsheet. The temperatures recorded for the, "Deep Freeze [walk-in cooler]," ranged from -20 degrees Fahrenheit (F) to -10 degrees F. Review of the facility P.M. Cooks Refrigerator & (and) Freezer Temps listing dated 8/2017, identified the freezer temperature were monitored on a daily basis and recorded on a flowsheet.	F 456	Staff educated regarding the use of TELS for maintenance work orders for any items needing repair or maintenance attention. Director of Maintenance will manage all repair needs coming in to TELS, prioritize and complete repairs in a timely manner. Administrator will review TELS log bi-weekly to ensure timely repairs are being done and present to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 51 The temperatures recorded for the, "Deep Freeze [walk-in cooler]," ranged from -18 degrees F to (positive) 2 degrees F. When interviewed during the tour, ADD-A stated the freezer door had been like this for a, "year and a half," adding the ice builds up, "so bad," at times the staff would use a hammer to break it off to get the door open which caused the broken floor tiles. ADD-A stated she was unaware if any parts had been ordered to repair the freezer and added there had been no concerns with the freezer not holding cold temperatures. During interview on 8/21/17, at 10:27 a.m. the director of maintenance (DOM) stated he had ordered a new seal for the door, "some time ago," and just had not installed it yet. DOM stated the seal had been at the facility for, "about a month and a half, two months," already adding he was aware the staff, "got to do some work in there [freezer]," and the freezer was in, "pretty rough shape." DOM stated the freezer should be kept in good repair to, "keep the food at a certain temperature," and, "for safety." During interview on 8/23/17, at 11:43 a.m. corporate registered dietician (RD)-A stated she had observed the freezer door to have ice build up before adding the kitchen staff, "clean it often," and the ice build up, "continues to reoccur." RD-A stated she sent an email to several people regarding this concern, and fixing it was, "in the works," to her knowledge. RD-A stated the freezer should be in good working condition as, "we want to maintain temperature and quality of the food within it." Further, RD-A stated all residents in the facility consumed food stored and prepared from the main production kitchen.	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 52 The manufacturer's instructions and owners manual were requested from the facility, however, were not provided.	F 456		
F 465 SS=C	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain 1 of 1 microwave(s) and 1 of 1 stacked convection oven(s) used in the main production kitchen in a clean and sanitary manner. This had potential to affect all 64 residents, visitors and staff who consumed food from the kitchen. Furthermore, the facility failed to ensure bathroom ventilation ducts were kept clean and free of clumping dust and debris in 5 of 13 resident bathrooms (Rm. 104, 111, 404, 414, 416) observed which affected 5 residents who used them. Findings include: MICROWAVE / OVEN:	F 465	Room 104, 111, 404, 414, and 416 bathroom vents were cleaned. Kitchen microwave and stacked oven were cleaned. Cleaning schedules have been revised to include which specific positions in the kitchen should be cleaning what equipment and how often. All dietary staff have been re-educated on appropriate storage of baking racks and where the proper location is, facility policy and procedure for and cleaning schedules for large equipment. CDM will audit the cleaning schedule weekly x4 then monthly x3 to ensure compliance.	9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 53 During observation on 8/21/17, at 8:33 a.m. an initial tour of the facility main production kitchen was completed with assistant dietary director (ADD)-A. A single Amana RCS10MPSA microwave oven was sitting on a serving counter. The inside of the microwave door had visible, dried yellow and red colored splattering on the bottom, and viewing screen, along with visible splattering in the corners of the device and along each of the inside walls. Further, the ventilation openings in the top of the microwave had the same, red and yellow colored dried and clumped visible splattering. The ADD-A stated she had not used the microwave oven today. Dietary Aide (DA)-A, who was also present in the kitchen during the tour, stated she had not used the microwave yet, either. ADD-A stated the microwave was, "a disaster," and, "needs to be cleaned," adding it should have been cleaned the evening prior according to the assigned cleaning tasks. During the same kitchen tour, a single stacked Vulcan convection oven was observed to be in use. The top of the oven had visible black colored, clumping dust and greasy debris present with several metallic baking racks stored directly on top. Further, there were several visible markings in the black colored greasy substance of where the racks had been removed from the top of the oven and dragged through the debris. During subsequent observation on 8/22/17, at 3:07 p.m. the oven continued to have the black colored clumped dust and greasy substance present on top of the oven, along with four metallic baking racks stored directly on top. When interviewed on 8/22/17, at approximately 3:10 p.m. DA-B stated the ovens were scheduled	F 465	Bathroom vent cleaning added to the housekeeping checklist for cleaning. Staff educated on expectation and need for overall cleanliness of environment for residents. Environmental Services Director will audit 10 bathroom vents per week x3 weeks, then 10 monthly x3 months to ensure compliance with cleaning schedule. Audits will be turned in to Administrator. Administrator will review and report to QA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 54	F 465		

to be wiped down on a daily basis or, "if something spills." The stacked convection oven was scheduled for a, "deep clean," with the tops being wiped down, "at least once a week." DA-B observed the top of the convection oven and stated it, "needs to be wiped down," as it had, "dust." Further, DA-B stated the racks stored on top of the oven were used inside of the oven as needed for cooking.

A Weekly Cooks Cleaning Schedule dated 8/14/17 through 8/20/17, identified a task of, "Clean Ovens" with a scheduled day weekly on Sunday. Further, the schedule identified an additional task for the evening cooks to complete labeled, "Clean [and] Sanitize your work area and equipment used." This was initialed by staff as having been completed the evening prior to the kitchen tour on 8/21/17. The scheduled lacked any specific cleaning schedule for the microwave to be cleaned.

On 8/23/17, at 11:43 a.m. the corporate registered dietician (RD)-A and ADD-A were interviewed. RD-A stated she had observed the microwave and, "it was dirty," and should be cleaned according to the facility cleaning schedule. ADD-A stated she cleaned the convection oven this morning adding it had dust and debris on top which appeared, "like it hadn't been cleaned in awhile." Further, RD-A stated the oven should be cleaned, "to ensure proper running and operation," and, "so it [dust and debris] doesn't get in the food as well."

A facility provided Amana Product Safety Manual for Commercial Microwave Oven dated 10/04, identified several steps to, "avoid personal injury or property damage," and included, "Clean oven

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 55	F 465		

regularly and remove any food deposits," further directing, "To avoid surface deterioration, keep the oven in a clean condition. Infrequent cleaning could adversely affect the life of the appliance and possibly result in a hazardous situation."

A facility provided, unlabeled policy dated 12/2016, identified directions for cleaning and sanitizing large kitchen equipment which included directions of, "Surfaces of equipment must be thoroughly cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris."

RESIDENT BATHROOMS:

R126's During interview on 8/22/17, at 1:13 p.m. R126 stated she did not feel her bathroom was kept clean adding staff, "could do better."

During various observation(s) on 8/21/17, between 10:50 a.m. and 2:53 p.m., the following resident bathrooms were identified to have a single ventilation duct above the toilet which had visible gray colored, heavy accumulation of clumping dust and debris covering most of the surface, at times nearly occluding the vent:
> Rm. 104
> Rm. 111
> Rm. 404
> Rm. 416
> Rm. 414

On 8/24/17, at 10:12 a.m. an environmental tour was completed with the director of maintenance (DOM). The above identified rooms continued to have visible gray colored, clumping dust and debris present on the bathroom ventilation

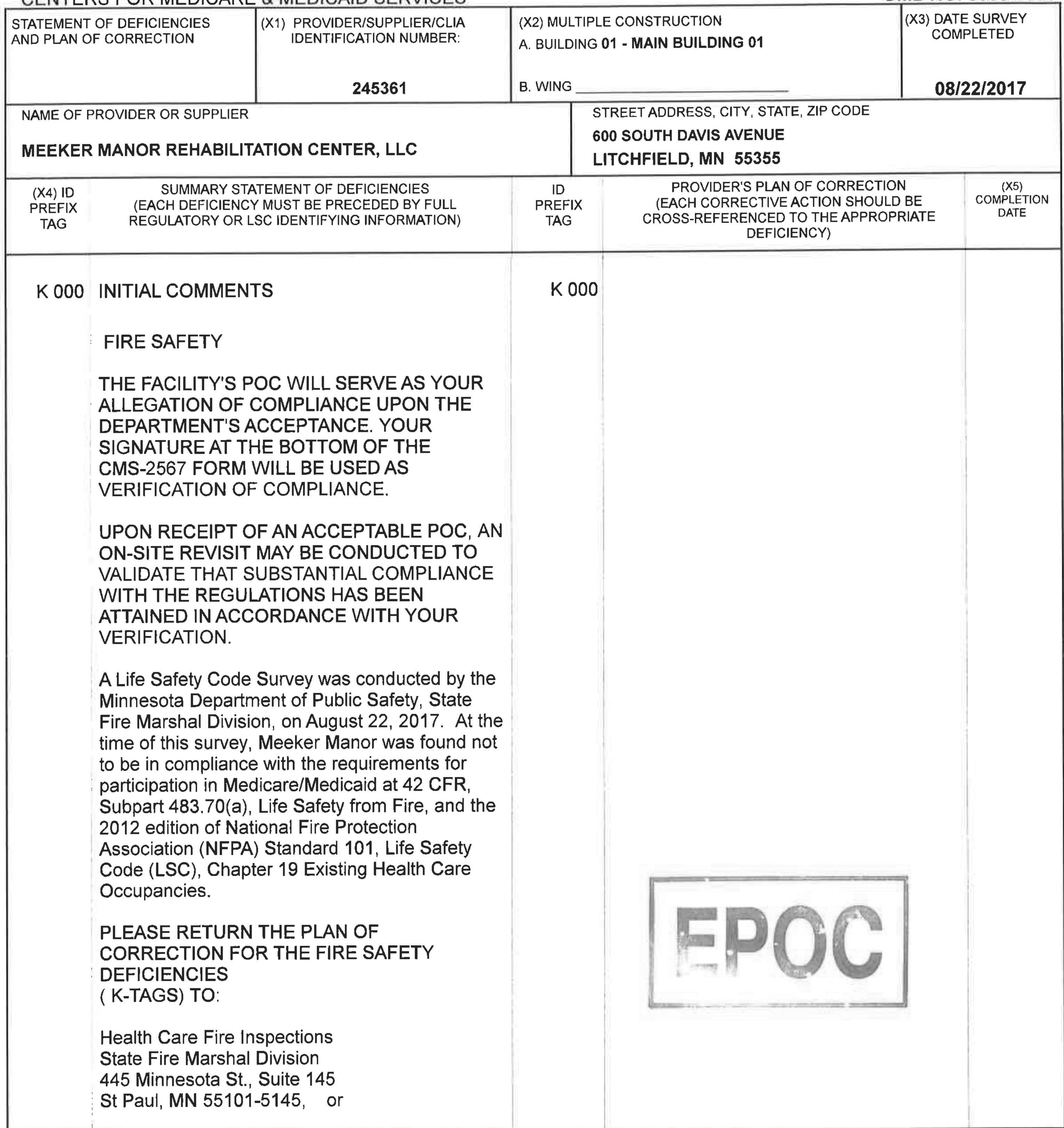
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING ______ B. WING ______	C 08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 56 openings. DOM stated he had, "never looked at that," before and added the vents, "need to be cleaned." DOM stated he was unaware if the ventilation openings were on a scheduled cleaning list or not. At 10:16 a.m. DOM spoke with housekeeper (HSK)-A in the hallway with the surveyor. HSK-A stated the ventilation openings in the resident bathrooms were not on a cleaning schedule, but staff were aware, "we should keep the vents clean." DOM stated the ventilation openings in the resident bathrooms should be kept clean, "to draw the smell out of it." An undated North Lane1/Lane2 cleaning schedule directed staff should clean the resident bathrooms on a daily basis, Monday through Friday. An undated Job Routine listing, identified several specific items for staff to clean when cleaning the resident bathrooms, however, did not include the ventilation openings above the toilets.	F 465		

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

PRINTED: 09/25/2017
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/22/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 August 22, 2017. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 09/22/2017

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/22/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Meeker Manor is a one-story building with partial basement. The original building was constructed in 1978, with building additions constructed in 1979 and 1988. The original building and both building additions are fully fire sprinkler protected, and were determined to be of Type V(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 65 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills	K 712		9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/22/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 2	K 712		

Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.
18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7
This **STANDARD** is not met as evidenced by:
Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.
18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7

Findings include:

During the facilities documentation review on 08/22/2017, during the documentation review of the available fire drill reports for the last 12 months and interview with the Maintenance Supervisor, it was revealed that the facility failed to conduct 3 fire drills. Two in the second quarter on the second and the night shift and one in the

Provider's Plan of Correction (K 712):

Staff educated on proper process for conducting/managing a fire drill.
Environmental Services Director will communicate with the PM or NOC shift charge nurse when drills are to be conducted on those shifts.
The charge nurse will then ensure proper drill procedures are carried out and documentation is completed.
EVS Director will review documentation, follow up if needed, then file appropriately.
EVS Director will provide annual inservice to include review of fire drill/actual procedures.

Administrator will audit the 3rd week of the month to ensure documentation completed for monthly drill monthly x6.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/22/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 3 fourth quarter on the night shift during the calendar year. This deficient condition was confirmed by the Maintenance Supervisor.	K 712		
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories 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 STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the 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. The deficient practice could affect all residents. Findings include: During documentation review between 8:00 AM and 1:30 PM on 08/22/2017, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the	K 901	The initial facility risk assessment has been completed. The Environmental Services Director will be responsible to review and reassess the facility risk assessment annually.	9/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/22/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 901	Continued From page 4 Facility Administrator and the Maintenance Supervisor.	K 901		