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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: U48A

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245386**
2.STATE VENDOR OR MEDICAID NO.
(L2) **660385800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SLAYTON REHABILITATION & HEALTHCARE CENTER**
(L4) **2957 REDWOOD AVENUE SOUTH**
(L5) **SLAYTON, MN** (L6) **56172**

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) **02/01/2017**

6. DATE OF SURVEY **12/18/2017** (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 **55** (L18)
13.Total Certified Beds **55** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Nicole Osterloh, HFE NE II 1/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/25/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On December 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 28, 2017 the Minnesota Department of Public Safety completed a PCR of the facility to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued at the standard survey, completed on October 26, 2017 and the FMS Survey completed on November 28, 2017. Based on the PCR, we have determined that the facility has corrected the deficiencies based on our standard survey, completed on October 26, 2017 and the FMS Survey completed on November 28, 2017, effective December 15, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 15, 2017.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245386

January 25, 2018

Ms. Theresa Pridal, Administrator
Slayton Rehabilitation & Healthcare Center
2957 Redwood Avenue South
Slayton, MN 56172

Dear Ms. Pridal:

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 December 15, 2017 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
January 25, 2018

Ms. Theresa Pridal, Administrator
Slayton Rehabilitation & Healthcare Center
2957 Redwood Avenue South
Slayton, MN 56172

RE: Project Numbers S5386028, F5386026, F5386027

Dear Ms. Pridal:

On November 14, 2017, we informed you that the following enforcement remedy was being imposed:

- **State Monitoring effective November 19, 2017. (42 CFR 488.422)**

In addition, on November 14, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- **Mandatory denial of payment for new Medicare and Medicaid admissions effective January 26, 2018. (42 CFR 488.417 (b))**

- **Civil money penalty for the deficiencies cited at F246 and F315. (42 CFR 488.430 through 488.444)**

This was based on the deficiencies cited by this Department for a standard survey, completed on October 26, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 28, 2017 a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found 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 December 11, 2017 CMS forwarded the results of the LSC FMS and notified you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- **Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 26, 2018 (42 CFR 488.417(b)).**

Also, the CMS Region V Office notified you in their letter of December 11, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 26, 2018.

On December 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 28, 2017 the Minnesota Department of Public Safety completed a PCR of your facility to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 26, 2017 and the FMS Survey completed on November 28, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 26, 2017 and the FMS Survey completed on November 28, 2017, effective December 15, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 15, 2017.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the remedy outlined in their letter of December 11, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- **Civil Money Penalty for the deficiencies cited at F246 and F315 be imposed. (42 CFR 488.430 through 488.444)**

- **Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 26, 2018 be rescinded. (42 CFR 488.417(b)).**

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 26, 2018 is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 26, 2018, is to be rescinded.

In the CMS letter of December 11, 2017, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 26, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded but keep in mind that NATCEP prohibitions can be triggered by civil money penalty amounts.

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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us
cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 25, 2018

Ms. Theresa Pridal, Administrator
Slayton Rehabilitation & Healthcare Center
2957 Redwood Avenue South
Slayton, MN 56172

Re: Reinspection Results - Project Number S5386028

Dear Ms. Pridal:

On December 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 18, 2017, with orders received by you on November 10, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: U48A

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00915

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245386**
2.STATE VENDOR OR MEDICAID NO.
(L2) **660385800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SLAYTON REHABILITATION & HEALTHCARE CENTER**
(L4) **2957 REDWOOD AVENUE SOUTH**
(L5) **SLAYTON, MN** (L6) **56172**

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) **02/01/2017**

6. DATE OF SURVEY **10/26/2017** (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 **55** (L18)
13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Joseph Garvey, HFE NE II 11/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/04/2017 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
01111 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 14, 2017

Ms. Theresa Pridal, Administrator
Slayton Rehabilitation & Healthcare Center
2957 Redwood Avenue South
Slayton, MN 56172

RE: Project Number S5386028

Dear Ms. Pridal:

On October 26, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- **Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR**
- **Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR**
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criteria and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 19, 2017. (42 CFR 488.422)

In addition, we recommended the following remedy to the CMS Region V Office. The Regional Office

concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 26, 2018. (42 CFR 488.417 (b))

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F246. (42 CFR 488.430 through 488.444)

• Civil money penalty for the deficiency cited at F315. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 26, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 26, 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Acting Branch Manager by phone at (312)353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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
	00915	A. BUILDING: _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLAYTON REHABILITATION & HEALTHCARE C	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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

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	00915	A. BUILDING: _____ B. WING _____	10/26/2017

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 23, 24, 25 and 26, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 2 residents (R43) reviewed who required assistance to manage urinary incontinence. Findings include: During observation on 10/24/17 at 1:25 p.m., R43 was watching television while seated in her wheelchair. A full lift sling was observed to be in place under R43's buttocks in the wheelchair. At 2:11 p.m. nursing assistant (NA)-A and NA-B were observed to take the resident to her room,	2 570	It is the practice of Slayton Rehabilitation and Healthcare Center to provide all residents with all needed accommodation of needs and preferences. All residents utilizing a full body lift have been reassessed and have proper slings. Proper toileting sling for resident R43 was obtained during survey on October 25, 2017 to provide the resident the opportunity to use the bedpan or the toilet per resident's choice. Resident R43 is refusing to transfer to toilet utilizing the lift and sling. Staff will	12/15/17

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2 570	Continued From page 3 and transferred R43 into bed from the wheelchair. Neither NA-A offered the bedpan or an opportunity for R43 to use the toilet. NA-A stated staff offer R43 the bedpan when the resident requests it. NA-A further reported the nursing assistants are unable to get R43 into the bathroom. NA-A said the facility had gotten new mechanical lifts in July 2017 but no sling accessible for toileting was available. "We used to transfer her [R43] to the toilet all the time, until these lifts came in July." NA-A and NA-B stated the sling problem had been brought to the attention of nursing management, but "they keep telling us they are working on it." NA-A further explained that the facility's old lifts had a split sling available so staff could assist residents like R43 to the bathroom. She stated, "they worked well, we could transfer R43 to the bathroom toilet, so she could empty, now since the new lifts we give her the bedpan, but she is more incontinent." During an interview with R43 at 2:33 p.m. on 10/24/17, R43 stated she would prefer to use the toilet but was resolved to the fact that staff could no longer take her into the bathroom due to not having the right mechanical lift sling. R43 stated, "I used to be more continent, and was not always wet, I don't like to be wet." R43 also stated, "It would be so much better for me to use the toilet again." During an interview with NA-B on 10/24/17 at 2:50 p.m., NA-B stated R43 uses the call light to request the bedpan and added, "when R43 first came she was usually dry, with minor dribbling. The retired mechanical lifts were made so you could sit someone on the toilet, the sling was split and adaptable for toilet use." NA-B said R43 had	2 570	continue to offer to transfer her to toilet per her care plan. All nursing staff have been re-educated to follow care sheets/care plan/toileting plan and using equipment per assessments. Random audits will continue to be conducted on residents requiring mechanical lifts for toileting by the DNS or designee. The results will be forwarded to the QAPI Committee for review and follow up. DNS will monitor	

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2 570	Continued From page 4 told her the bedpan was uncomfortable then NA-B stated, "I wish we had our other lifts back. The problem with the lifts and slings has been reported to our supervisors, they are working on it as far as I know." R43's diagnosis identified on the resident care plan, last updated on 10/3/17, identified: Multiple sclerosis, chronic pain, pain in left shoulder, low back pain, osteoarthritis, and major depressive disorder. A Care Area Assessment (CAA) dated 7/16/17, identified R43 as requiring a urinary incontinence care plan related to dependence with toileting and occasional urinary incontinence. Contributing factors were identified to include multiple sclerosis, weakness, non-ambulatory, non weight bearing status, dependency with transfers, inability to move left leg and right shoulder, frequent uncontrolled head, neck and left arm movements and chronic pain. Further, the CAA indicated the resident was alert, oriented, and able to request assist with toileting, but was dependent with transfers on/off toilet using a mechanical lift and was dependent with cleansing and clothing management. The CAA indicated no specific tests or referrals were planned, but they would proceed to care plan risks associated with occasional urinary dribbling and incontinence. R43's quarterly Minimum Data Set (MDS) from 9/27/17, identified a decline in urinary continence. Review of the facility's toileting documentation also reflected an increase in urinary incontinence since the facility had replaced their mechanical lifts in mid- July. The toileting documentation	2 570		

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2 570	Continued From page 5 indicated R43 was frequently incontinent with urine beginning in mid July. Review of R43's care plan last updated on 10/3/17, reflected R43's increase in incontinence since 8/25/17, with the initiation of a diuretic medication. Interventions included: dependent with bedpan use and transfers on and off toilet per lift. Dependent with cleansing and clothing management. Offer bedpan on midnight and 4 a.m. rounds, provide incontinence care if needed. In addition, the care plan included: frequent urinary dribbling and incontinence. The care plan had not been revised to reflect the routine use of the bedpan during all hours of the day, or the inability of staff to put the resident on the toilet since implementation of the new mechanical lift. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident care plans are updated and revised as appropriate. The Director of Nursing Services or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing Services or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 570		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder	2 910		12/15/17

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2 910	Continued From page 6 management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and provide care to manage urinary incontinence for 1 of 2 residents (R43) reviewed for urinary incontinence. This caused harm for R43 who had a decline in urinary continence when a diuretic was implemented, and a new mechanical lift was instituted. Findings include: Review of the facility's toileting documentation revealed R43 had an increase in incontinence episodes beginning in July 2017 when the facility's mechanical lifts were replaced. According to toileting documentation, R43 became frequently incontinent after 7/10/17. During observation on 10/24/17 at 1:25 p.m., R43 was watching television while seated in her wheelchair. A lift sling was observed to be in	2 910	It is the practice of Slayton Rehabilitation and Healthcare Center to provide all residents with all needed accommodation of needs and preferences. All residents utilizing a full body lift have been reassessed and have proper slings. Proper toileting sling for resident R43 was obtained during survey on October 25, 2017 to provide the resident the opportunity to use the bedpan or the toilet per resident's choice. Resident R43 is refusing to transfer to toilet utilizing the lift and sling. Staff will continue to offer to transfer her to toilet per her care plan. All nursing staff have been re-educated to follow care sheets/care plan/toileting plan and using equipment per assessments. Random audits will continue to be conducted on residents requiring mechanical lifts for toileting by the DNS or	

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2 910	Continued From page 7 place under R43's buttocks in the wheelchair. At 2:11 p.m. nursing assistant (NA)-A and NA-B were observed to take the resident to her room, and transferred R43 into bed from the wheelchair. Neither NA-A offered the bedpan or an opportunity for R43 to use the toilet. NA-A stated staff offer R43 the bedpan when the resident requests it. NA-A further reported the nursing assistants are unable to get R43 into the bathroom. NA-A said the facility had gotten new mechanical lifts in July 2017 but no sling accessible for toileting was available. "We used to transfer her [R43] to the toilet all the time, until these lifts came in July." NA-A and NA-B stated the sling problem had been brought to the attention of nursing management, but "they keep telling us they are working on it." NA-A further explained that the facility's old lifts had a split sling available so staff could assist residents like R43 to the bathroom. She stated, "they worked well, we could transfer R43 to the bathroom toilet, so she could empty, now since the new lifts we give her the bedpan, but she is more incontinent." During an interview with R43 at 2:33 p.m. on 10/24/17, R43 stated she would prefer to use the toilet but was resolved to the fact that staff could no longer take her into the bathroom due to not having the right mechanical lift sling. R43 stated, "I used to be more continent, and was not always wet, I don't like to be wet." R43 also stated, "It would be so much better for me to use the toilet again." During an interview with NA-B on 10/24/17 at 2:50 p.m., NA-B stated R43 uses the call light to request the bedpan and added, "when R43 first came she was usually dry, with minor dribbling.	2 910	designee. The results will be forwarded to the QAPI Committee for review and follow up. DNS will monitor	

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2 910	Continued From page 8 The retired mechanical lifts were made so you could sit someone on the toilet, the sling was split and adaptable for toilet use." NA-B said R43 had told her the bedpan was uncomfortable then NA-B stated, "I wish we had our other lifts back. The problem with the lifts and slings has been reported to our supervisors, they are working on it as far as I know." R43's medical record was reviewed. Diagnoses identified from the resident care plan, last updated 10/3/17 included: Multiple sclerosis, chronic pain, pain in left shoulder, low back pain, osteoarthritis, and major depressive disorder. Review of nursing notes dated 7/4/17 indicated R43 required 2 staff assist with all transfers to/from wheelchair, to bed, bed to wheel chair and to toilet. The note further indicated a mechanical lift was utilized at all times for transfers with 1-2 staff assist for toilet use. Review of a bowel and bladder assessment dated 7/9/17, indicated R43 was continent of bowel and had occasional urinary dribbling. The assessment further indicated R43 was alert, oriented and able to request assist with toileting, but was dependent with transfers on and off the toilet with a mechanical lift and staff assistance. R43's admission minimum data set (MDS), with assessment reference date (ARD) 7/10/17, identified R43 as occasionally incontinent (less than 7 episodes of incontinence in the look back period) and indicated R43 required total assistance of 2 staff for toileting. The Care Area Assessment (CAA) dated 7/16/17,	2 910		

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2 910	Continued From page 9 identified R43 as having triggered for a urinary incontinence care plan related to dependence with toileting and occasional urinary incontinence. Contributing factors were identified to include multiple sclerosis, weakness, non-ambulatory, non weight bearing status, dependency with transfers, inability to move left leg and right shoulder, frequent uncontrolled head, neck and left arm movements and chronic pain. Further, the CAA indicated the resident was alert, oriented, and able to request assist with toileting, but was dependent with transfers on/off toilet using a mechanical lift and was dependent with cleansing and clothing management. The CAA indicated no specific tests or referrals were planned, but they would proceed to care plan risks associated with occasional urinary dribbling and incontinence. Review of the resident's physician orders indicated the resident's physician had been made aware of increased edema in R43's lower extremities on 8/24/17, and had subsequently prescribed Lasix (a diuretic) 20 milligrams (mg) every day. A note from 9/11/17, indicated the Lasix had later been increased to 40 mg every day due to ongoing edema in R43's bilateral lower extremities. Review of a bowel and bladder assessment dated 9/26/17, indicated R43 had occasional bowel incontinence episodes. Contributing factors were identified as including a diagnosis of constipation with scheduled laxative therapy, and dependence with toileting needs. The assessment also indicated R43 experienced frequent urinary dribbling and incontinence and included: "Resident exhibited a decline in urinary continence pattern after 8/25/17 initiation of	2 910		

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2 910	Continued From page 10 scheduled diuretic therapy for treatment of lower extremity edema. Resident is alert and oriented, able to request assist with toileting during wakeful hours, but dependent with bedpan use and transfers on and off toilet per mechanical lift. Requires prompted, scheduled toileting and bedpan placement at night." R43's quarterly MDS, with ARD date 9/27/17, identified the resident's urinary continence had declined and the resident was now frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continence voiding). Review of R43's care plan last updated on 10/3/17, indicated an increase in incontinence since 8/25/17 with the initiation of diuretic therapy. Interventions included: dependent with bedpan use and transfers on and off toilet per lift. Dependent with cleansing and clothing management. Offer bedpan on midnight and 4 a.m. rounds, provide incontinence care if needed. In addition, the care plan included: frequent urinary dribbling and incontinence. During an interview with licensed practical nurse (LPN)-A on 10/25/17 at 9:01 a.m., LPN-A verified staff had been transferring R43 to the toilet prior to the facility having purchased new lifts. LPN-A confirmed not having access to the split slings for toileting was a definite problem that would need to be resolved for residents like R43. During an interview with the director of nursing (DON) on 10/25/17 at 9:14 a.m., the DON confirmed she was aware of the challenges with the lift, and the fact there were currently no toileting slings available for the current lifts. The	2 910		

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2 910	Continued From page 11 DON stated she had been working with the corporate office to authorize purchasing the correct slings to adapt to the toileting needs of residents who are totally dependent on staff for transferring from one surface to another. She further stated the administrator was also involved with discussion with the corporate office to obtain approvals to purchase lift slings that would work for toileting. SUGGESTED METHOD OF CORRECTION: The DON could review/revise policies and procedures related to bladder incontinence and provide additional training to staff. The DON or designee could audit bladder assessments for changes in contience and educate staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure equipment to used for food preparation was maintained in a sanitary manner. This had the potential to affect all 35 residents in the facility who received meals prepared in the kitchen. Findings include:	21015	It is the practice of Slayton Rehabilitation and Healthcare Center to maintain all food preparation in a sanitary manor. Dietary Manager updated the cleaning schedule to include all areas of food preparation. Corporate Dietitian and/ or Dietary Manager will provide an in-service to the dietary team with education given.	12/15/17

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21015	Continued From page 12 During the initial kitchen tour with the dietary manager (DM) on 10/23/17 at 3:03 p.m., the following sanitation problems were noted and confirmed by the DM: A large industrial mixer, was observed to be stored with plastic covering the unit. The DM explained that the unit was covered for storage after it had been thoroughly cleaned. The DM removed the cover and the armature was observed to be greasy and covered with a flour like substance under the carriage of the unit. The grime and flour like substance was directly above the mixing bowl. Two service size coffee units were observed to be covered with debris. The spigot on one of the coffee servers had a thick brownish buildup around the serving edge of the spigot, extending 1/4 to 1/2 inch up from the edge of the spigot. The DM confirmed that the water builds up with sediment. The industrial toaster and knife holder rack were observed to be coated with a thick layer of dust. The observation was confirmed by the DM who stated that both units needed to be cleaned. POLICY REVIEW: Title: Sanitation Policy It is the policy of the dining services department to practice proper sanitation techniques for clean equipment to prevent the outbreak of food borne illness, and to train Dining Service employees to use these techniques. The director of dining is responsible for training, monitoring proper sanitation techniques and compliance.	21015	Random kitchen audits will be done by the Dietary Manager and Corporate Dietitian. The Dietary Manager and Dietitian are to attend QAPI meeting for review and recommendations with Dietitian attending quarterly. Dietary Manger is responsible to forwarded to QAPI Meeting for review and recommendations.	

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21015	Continued From page 13 (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (C) Non food contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. SUGGESTED METHOD OF CORRECTION: The dietary manager could review and revise dietary policies and educate staff on the proper cleaning of the kitchen area. Cleaning schedules could be assigned and reviewed daily to assure dietary tasks are being completed to assure a safe and sanitary dietary food prep environment TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992.	21535		12/15/17

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21535	Continued From page 14 This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction of an antipsychotic (Seroquel) was completed for 1 of 5 residents (R21) reviewed for unnecessary medication use. Findings include: R21's face sheet dated 10/26/17, listed active diagnoses including: restlessness and agitation, unspecified dementia without behavioral disturbance, malignant neoplasm of the bone, and legal blindness. R21's most current annual Minimum Data Set (MDS) assessment dated 10/6/17, indicated R21 received antipsychotic medications on a daily basis, that a gradual dose reduction (GDR) had not been completed and that a clinical contraindication for the antipsychotic had been received on 6/22/17. Additionally, the MDS identified R21 had a Brief Interview for Mental Status score of one, indicating severe cognitive impairment, and that no mood or behavioral indicators were observed during the look back period. R21's Care Area Assessment (CAA) for psychotropic drug use dated 10/10/17, indicated R21 utilized antipsychotic medications daily, and that staff should continue to monitor for	21535	It is the practice of Slayton rehabilitation and Healthcare Center to use the least amount of psychotropic medication to provide minimal effective dose to all residents prescribed psychotropic medication. During survey, Resident R21's physician initiated reduction of Seroquel from 25mg 3x/day x 7 days down to 12.5mg daily x 7 days then discontinue. Since the reduction, the resident has been awake calling out most of the night with no non- pharmacological approaches relieving calling out. Resident complaints of pain have increased since reduction. Discussion with resident's PCP (primary care provider) has resulted in adjusting of pain medications and resident continues to call out. Discussions continue with resident's PCP, who states it is a failed dose reduction. Seroquel 12.5mg was restarted on 11/17/17 due to failed dose reduction trial. Resident will continue to be re-assessed by nursing staff and med committee. Nursing has been re-educated on behavioral symptom intervention and documentation. All residents on anti-psychotropic medications will be reviewed by the	

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21535	Continued From page 15 effectiveness of current medication regime, monitor for any escalation of mood/behavior indicators, and monitor for medication side effects directly related to prescribed psychotropic med therapy. R21's most current care plan dated 10/25/17, identified a mood and behavior problem with use of antipsychotic medications, and that the resident exhibited intermittent irritability when she did not comprehend a situation or when she was more confused, and a behavior of frequent calling out which was disruptive to others. The goal of not exhibiting indicators of acute depression or behaviors was listed. Interventions identified included to encourage activities the resident enjoys, visits with friends and family, allowing a chance to share feelings and concerns, monitoring for escalations in mood or behavioral concerns, and if behavioral concerns were noted, to observe for causes. R21's daily behavior observation flow sheets for the previous three months (July, August, and September 2017) revealed she had exhibited calling out behaviors a total of 13 days during this time period, with seven of the episodes occurring during the month of July 2017. Behaviors listed included statements of feeling depressed, tearfulness, hallucinations and disruptive to others/calling out. Approaches included to allow resident to express feelings, offer comfort/support/reassurance/validate feelings and encourage resident to participate in activities of interest. R21's Medication Administration Record (MAR) for October 2017, indicated she had received Seroquel 25 milligrams three times per day, with	21535	consulting pharmacist monthly. Results will be reviewed at the monthly Med Committee for Minimum Effective Dose regarding physician recommendations. Any refusals of recommendations will be followed up with the PCP. All refusals will be followed up with the medical director. The results will be forwarded to the QAPI committee for review and follow up. Random audits will be conducted by DNS or Designee. DNS will monitor.	

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21535	Continued From page 16 an original start date listed as 5/27/16. R21's nursing progress notes dated 8/17/17, included an entry related to mood and behavior: "Behavior team reviewed resident's antidepressant and antipsychotic medications, target mood/behavior log from the past 30 days, progress notes from the past 30 days; and care plan interventions for mood. Continues to have periods of calling out. Also noted to have periods of crying and being angry at staff. Can be related to her impaired vision or pain r/t (related to) cancer dx (diagnosis). Non-pharmacological interventions are attempted. No recommendations at this time. Will continue to monitor. Noted has dx of breast cancer with mets to the bone with 12 cancer markers between shoulders and the pelvis." During observation on 10/24/17, at 1:20 p.m. R21 was observed asleep in her wheelchair in her room, with the lights off. During observation and interview on 10/25/17, at 8:47 a.m. R21 was observed in her room with nursing assistant (NA)-D. NA-D had just finished assisting R21 to the toilet with the use of a standing lift. At that time, NA-D stated R21 rarely spoke and that the only behaviors she had noted from R21 included the resident calling out, "help me, help me," which was usually related to her need to use the toilet. During the observation R21 demonstrated no observable indicators of pain, had her eyes closed, and did not open them when spoken to. During observation on 10/26/17, at 10:23 a.m. R21 was seated in a recliner in her room, with her eyes closed, and was non verbal.	21535		

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21535	Continued From page 17 During interview on 10/25/17, at 9:30 a.m. the director of nursing (DON) stated they had tried dose reductions of R21's Seroquel in the past, however the physician had refused to reduce the dose. The DON provided copies of pharmacy consultant recommendations from 12/13/16 and 6/22/17, which recommended the medication dosage be reviewed for reduction. On both occasions, the physician response indicated R21 "does better at current dose, do not decrease." However, their was no documented physician justification indicating evidence of attempted reduction or how/why it had failed. There was no further documented rationale provided with any more detail regarding why a dose reduction would be contraindicated. During interview on 10/25/17, at 12:59 p.m. NA-C stated R21 did not have any behaviors and rarely verbalized, but was able to state when she needed to use the bathroom. During interview on 10/25/17, at 2:50 p.m. the facility's consultant pharmacist (CP) stated she could certainly make another recommendation to reduce R21's Seroquel dosage, and felt the facility should refer concerns with GDR attempts to the medical director if the physician was not receptive to considering one. The CP also stated both herself and the previous consultant pharmacist had indicated a GDR for R21 was warranted. During interview with the DON on 10/26/17 at 9:52 a.m., the DON stated R21's Seroquel had most recently been increased about a year ago due to her persistent hollering for help in the afternoon. The DON said more recently, within	21535		

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21535	Continued From page 18 the last six months, R21 had experienced a decline in her mobility and had been started on Vicodin (a narcotic pain medication) which had been increased in July 2017 for pain symptoms. The DON stated it had been discovered that R43 had cancerous tumors of the bone between her shoulders and pelvis. The DON also stated they had been working on getting physicians to be more specific as to why GDRs were contraindicated however, verified she had not included their medical director in speaking with primary physicians about GDR reductions. During interview on 10/26/17, at 10:18 a.m. medical doctor (MD)-A, who was R21's primary physician, stated she had originally started R21 on the Seroquel because the resident was calling out, not knowing the time of day or night because she was blind. MD-A verified that with the additional pain medication on board for R21, a GDR of her Seroquel would be appropriate as some of her behaviors may have been pain-related. The facility's policy Antipsychotic Medication Use undated, indicated residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective, and the attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to residents and others. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could audit resident records of those receiving antipsychotic medications to ensure gradual dose reductions	21535		

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21535	Continued From page 19 have been completed unless clinically contraindicated. The director of nursing could work with the medical director to ensure rationale for declining any gradual dose reductions clearly identifies why risks outweigh the benefits for the affected resident. The facility could report results of audits to the quality assurance committee for further follow up and recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an open date was identified on insulin pens when first opened for use, to determine outdate for use for 2 of 4 residents (R5 & R51) reviewed; the facility also failed to reconcile controlled substances twice daily as required by facility policy for 17 residents who received controlled medications; and failed to ensure expired medications were removed from the emergency kit. Findings include: During an observation on 10/24/17, at 2:00 p.m. licensed practical nurse (LPN)-B stated the east/south medication cart had two (2) undated insulin pens available for use that were not dated when opened. A Novolog flexpen for R5 had a	21620	It is the practice of Slayton Rehabilitation and Healthcare Center to ensure all medications are dated, not expired, and controlled medication are counted every shift. Staff education was provided to all nurses during survey. Insulin pens were discarded and replaced for Residents R5 and R51 when the Surveyor identified the issue. New insulin pens will be dated when opened. The half tab in blister pack for resident R9 was destroyed per policy during the survey. Nurses who worked on 10/27, 10/26, 5.03, 4/22, 4/21, 4/18, 10/21, 10/11, 4/23, 9/22, 9/09, 9/05, 8/22, 4/26, and 4/17 have been counselled regarding	12/15/17

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21620	Continued From page 20 pharmacy fill date of 8/30/17. The package insert indicated the medication was good for 28 days after opening. A Humalog insulin pen for R51 with a fill date of 10/14/17 was also not dated as to when it had been opened. The package insert indicated the medication would be good for 28 days after opening. LPN-B verified the nurse was supposed to date insulin pens when they were opened for use. She verified she was unaware when these pens had been opened and acknowledged staff would be unable to determine when these insulin pens should be discarded. R9 had a blister pack card of Clonazepam (controlled substance used for anxiety) labeled 0.5 milligrams (mg) take 1 tab by mouth twice a day. The card identified in hand writing there was 0.25 mg given PRN (as needed) on 10/23/17 with the remaining half of the tablet being taped back into the blister pack. LPN-B stated a half tablet had been administered as an as needed (PRN) dose. LPN-B stated the appropriate procedure would have been to destroy the other half tablet and record appropriately instead of taping a half tab back into the medication card. Review of the facility's Shift Verification of Controlled Substances Count form with LPN-B, indicated counts had not been conducted twice daily per facility policy: No documentation of evening shift counts: 10/17, 10/10, 10/3, 9/22, 9/9, 9/5, 8/22, 5/24, 5/16, 5/1, 4/26, 4/17 and 4/13/17. No documentation of either day or evening shift counts: 10/27, 10/26, 5/3, 5/2, 4/22, 4/21 and 4/18/17. No documentation of day shift counts: 10/21/17, 5/11 and 4/23/17.	21620	incomplete controlled substance counts. The E-Kit was replaced on the day it was discovered during survey. All licensed nurses were educated on facility policies regarding dating medication when open, disposing of controlled substances, counting of controlled substances during shift changes and verifying the E-Kits are current. Random audits will be conducted on medication cart for appropriate medication dates, narcotic, destruction, controlled substance counts, and expired E-Kit by DNS, ADNS or Licensed Designee. Results will be forwarded to the QAPI for review and recommendations. DNS will monitor	

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21620	Continued From page 21 During an observation with LPN-B on 10/24/17, at 2:15 p.m. the refrigerated E-kit (emergency kit) was noted to contain two 1 milliliter (ml) vials of lorazepam 1 mg/ml with a manufacturer's expiration date of 9/1/17 indicated on both vials. LPN-B verified the medications were expired and would be outdated if needed in an emergency. LPN-B further verified the E-kits were not routinely monitored for intact plastic locks located on the kits; adding she had no idea when the last time the medications were checked for outdates. LPN-B reported that the pharmacy tech looks through the medication carts and conducted monthly audits. During an interview on 10/25/17 at 12:25 p.m., the consultant pharmacist verified being responsible to ensure the E-kit for the facility was monitored for expired medications. The pharmacist stated she checked the E-kits monthly but had evidently missed the refrigerated box stating, "It was a fluke." When interviewed on 10/24/17, at 2:45 p.m. the director of nursing (DON) verified the consultant pharmacist comes once a month and looks through the medication carts and the medication rooms. The DON further verified monthly audits are conducted by facility staff and the results were posted for staff. The facility's undated policy, Controlled Substances, indicated nursing staff must count controlled medications at the end of each shift indicating the nurse coming on duty and the nurse going off duty must make the count together. The policy further directed staff to document and report any discrepancies.	21620		

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21620	Continued From page 22 A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that all medications are labeled and stored properly. Education could be provided to all staff and monitoring systems could be developed to ensure ongoing compliance. The findings could be reported to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide equipment necessary to accommodate a resident's individual needs for toileting and to promote continence, for 1 of 2 residents (R43) reviewed for decline in urinary continence.	21810	It is the practice of Slayton Rehabilitation and Healthcare Center to provide all residents with all needed accommodation of needs and preferences. All residents utilizing a full body lift have been reassessed and have proper slings.	12/15/17

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21810	Continued From page 23 Findings include: R43's diagnoses identified on the resident care plan last updated 10/3/17, included: Multiple sclerosis, chronic pain, pain in left shoulder, low back pain, osteoarthritis, and major depressive disorder. Review of R43's MDS admission assessment completed 7/10/17 revealed R43 required assist of 2 staff for toileting, was dry with trial toileting: occasionally incontinent; and was transferred on and off the toilet with staff assist. R43's admission minimum data set (MDS), with assessment reference date (ARD) 7/10/17, identified R43 as occasionally incontinent (less than 7 episodes of incontinence in the look back period) and indicated R43 required total assistance of 2 staff for toileting. The Care Area Assessment (CAA) dated 7/16/17, identified R43 as having triggered for a urinary incontinence care plan related to dependence with toileting and occasional urinary incontinence. Contributing factors were identified to include multiple sclerosis, weakness, non-ambulatory, non weight bearing status, dependency with transfers, inability to move left leg and right shoulder, frequent uncontrolled head, neck and left arm movements and chronic pain. Further, the CAA indicated the resident was alert, oriented, and able to request assist with toileting, but was dependent with transfers on/off toilet using a mechanical lift and was dependent with cleansing and clothing management. The CAA indicated no specific tests or referrals were planned, but they would proceed to care plan	21810	Proper toileting sling for resident R43 was obtained during survey on October 25, 2017 to provide the resident the opportunity to use the bedpan or the toilet per resident's choice. Resident R43 is refusing to transfer to toilet utilizing the lift and sling. Staff will continue to offer to transfer her to toilet per her care plan. All nursing staff have been re-educated to follow care sheets/care plan/toileting plan and using equipment per assessments. Random audits will continue to be conducted on residents requiring mechanical lifts for toileting by the DNS or designee. The results will be forwarded to the QAPI Committee for review and follow up. DNS will monitor.	

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21810	Continued From page 24 risks associated with occasional urinary dribbling and incontinence. R43's quarterly MDS, with ARD date 9/27/17, identified the resident's urinary continence had declined and the resident was now frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continence voiding). Review of R43's care plan last updated on 10/3/17, indicated an increase in incontinence since 8/25/17 with the initiation of diuretic therapy. Interventions included: dependent with bedpan use and transfers on and off toilet per lift. Dependent with cleansing and clothing management. Offer bedpan on midnight and 4 a.m. rounds, provide incontinence care if needed. In addition, the care plan included: frequent urinary dribbling and incontinence. Review of the facility's toileting documentation revealed R43's incontinence had increased in July when the mechanical lifts had been replaced. The toileting documentation revealed that after July 10th the resident was frequently incontinent of urine. Review of physician visit notes dated 9/8/17 and 8/16/17, did not indicate whether or not the physician was aware of R43's increased incontinence. Review of the resident's physician orders indicated the resident's physician had been made aware of increased edema in R43's lower extremities on 8/24/17, and had subsequently prescribed Lasix (a diuretic) 20 milligrams (mg) every day. A note from 9/11/17, indicated the	21810		

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	00915	A. BUILDING: _____ B. WING _____	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLAYTON REHABILITATION & HEALTHCARE C	2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172

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21810	Continued From page 25 Lasix had later been increased to 40 mg every day due to ongoing edema in R43's bilateral lower extremities. Review of nursing notes dated 7/4/17 indicated R43 required 2 staff assist with all transfers to/from wheelchair, to bed, bed to wheel chair and to toilet. The note further indicated a mechanical lift was utilized at all times for transfers with 1-2 staff assist for toilet use. Review of a bowel and bladder assessment dated 7/9/17, indicated R43 was continent of bowel and had occasional urinary dribbling. The assessment further indicated R43 was alert, oriented and able to request assist with toileting, but was dependent with transfers on and off the toilet with a mechanical lift and staff assistance. Review of a bowel and bladder assessment dated 9/26/17, indicated R43 had occasional bowel incontinence episodes. Contributing factors were identified as including a diagnosis of constipation with scheduled laxative therapy, and dependence with toileting needs. The assessment also indicated R43 experienced frequent urinary dribbling and incontinence and included: "Resident exhibited a decline in urinary continence pattern after 8/25/17 initiation of scheduled diuretic therapy for treatment of lower extremity edema. Resident is alert and oriented, able to request assist with toileting during wakeful hours, but dependent with bedpan use and transfers on and off toilet per mechanical lift. Requires prompted, scheduled toileting and bedpan placement at night." During observation on 10/24/17 at 1:25 p.m., R43 was watching television while seated in her	21810		

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21810	Continued From page 26	21810		

wheelchair. A lift sling was observed to be in place under R43's buttocks in the wheelchair. At 2:11 p.m. nursing assistant (NA)-A and NA-B were observed to take the resident to her room, and transferred R43 into bed from the wheelchair. Neither NA offered R43 the bedpan or an opportunity to use the toilet. NA-A stated staff offer R43 the bedpan when the resident requests it. NA-A further reported the nursing assistants are unable to get R43 into the bathroom, revealing that when new mechanical lifts were obtained in July 2017, a sling for toileting was not available. "We used to transfer her [R43] to the toilet all the time, until these lifts came in July." NA-A and NA-B revealed that the sling problem had been brought to the attention of nursing management, but "they keep telling us they are working on it." NA-A further explained that the facility's old lifts had a split sling available so staff could assist residents like R43 to the bathroom. She stated, "they worked well, we could transfer R43 to the bathroom toilet, so she could empty, now since the new lifts we give her the bedpan but she is more incontinent."

During an interview with R43 at 2:33 p.m. on 10/24/17, R43 stated she would prefer to use the toilet but was resolved to the fact that staff could no longer take her into the bathroom due to the mechanical lift sling. R43 stated she has always felt safe during transfers with the mechanical lift because the staff are close to her but acknowledged, "I was more continent, and was not always wet, I don't like to be wet." R43 also stated, "It would be so much better for me to use the toilet again.

During an interview with NA-B on 10/24/17 at 2:50 p.m., NA-B stated R43 uses the call light to

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21810	Continued From page 27	21810		

request the bedpan. and added, "when R43 first came she was usually dry, with minor dribbling. The retired mechanical lifts were made so you could sit someone on the toilet, the sling was split and adaptable for toilet use." NA-B said R43 had told her the bedpan was uncomfortable then NA-B stated, "I wish we had our other lifts back. The problem with the lifts and slings has been reported to our supervisors, they are working on it as far as I know."

During an interview with licensed practical nurse (LPN)-A she revealed she had not heard any complaints and further reported LPN-A was responsible for Medicare charting a few months ago. "I know they were taking her to the bathroom then." LPN-A confirmed that the facility did get new lifts and as was her understanding the staff had the split slings to use, revealing "for a while we had to wait for our corporation to ok ordering them." During the interview LPN-A confirmed not having access to the split slings for toileting was a definite problem that would need to be resolved.

During an interview with the director of nursing (DON) on 10/25/17 at 9:14 p.m., the DON confirmed she was aware of the challenges with the lift, and the fact there were currently no toileting slings available for the current lifts. The DON stated she had been working with the corporate office to authorize purchasing the correct slings to adapt to the toileting needs of residents who are totally dependent on staff for transferring from one surface to another. She further stated the administrator was also involved with discussion with the corporate office to obtain approvals to purchase lift slings that would work for toileting.

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21810	Continued From page 28 During an interview on 10/26/17 at 12:31 p.m., R43 stated the facility was going to rent the proper sling so that she could use the toilet again. R43 stated, "this is wonderful, I want to be able to use the toilet and totally empty my bladder. Especially with the diuretic. The bedpan is not comfortable especially to use in bed, I do not like it." SUGGESTED METHOD OF CORRECTION: The director of nurses' could conduct an assessment to ensure residents toileting needs and preferences are assessed. An audit could be periodically conducted to ensure staff implement the assessed need. The results could be reviewed at the quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

Electronically delivered
November 14, 2017

Ms. Theresa Pridal, Administrator
Slayton Rehabilitation & Healthcare Center
2957 Redwood Avenue South
Slayton, MN 56172

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5386028

Dear Ms. Pridal:

The above facility was surveyed on October 23, 2017 through October 26, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie, Unit Supervisor at (507) 476-4233 or kathryn.serie@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
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
	245386	A. BUILDING _____ B. WING _____	10/26/2017

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F 000	INITIAL COMMENTS On October 23, 24, 25 and 26, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) 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 246 SS=G	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.10(e)(3) 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide equipment	F 246	It is the practice of Slayton Rehabilitation and Healthcare Center to provide all	12/15/17

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

Electronically Signed | 11/17/2017

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F 246	Continued From page 1 necessary to accommodate a resident's individual needs for toileting and to promote continence, for 1 of 2 residents (R43) reviewed for decline in urinary continence. Findings include: R43's diagnoses identified on the resident care plan last updated 10/3/17, included: Multiple sclerosis, chronic pain, pain in left shoulder, low back pain, osteoarthritis, and major depressive disorder. Review of R43's MDS admission assessment completed 7/10/17 revealed R43 required assist of 2 staff for toileting, was dry with trial toileting: occasionally incontinent; and was transferred on and off the toilet with staff assist. R43's admission minimum data set (MDS), with assessment reference date (ARD) 7/10/17, identified R43 as occasionally incontinent (less than 7 episodes of incontinence in the look back period) and indicated R43 required total assistance of 2 staff for toileting. The Care Area Assessment (CAA) dated 7/16/17, identified R43 as having triggered for a urinary incontinence care plan related to dependence with toileting and occasional urinary incontinence. Contributing factors were identified to include multiple sclerosis, weakness, non-ambulatory, non weight bearing status, dependency with transfers, inability to move left leg and right shoulder, frequent uncontrolled head, neck and left arm movements and chronic pain. Further, the CAA indicated the resident was alert, oriented, and able to request assist with	F 246	residents with all needed accommodation of needs and preferences. All residents utilizing a full body lift have been reassessed and have proper slings. Proper toileting sling for resident R43 was obtained during survey on October 25, 2017 to provide the resident the opportunity to use the bedpan or the toilet per resident's choice. Resident R43 is refusing to transfer to toilet utilizing the lift and sling. Staff will continue to offer to transfer her to toilet per her care plan. All nursing staff have been re-educated to follow care sheets/care plan/toileting plan and using equipment per assessments. Random audits will continue to be conducted on residents requiring mechanical lifts for toileting by the DNS or designee. The results will be forwarded to the QAPI Committee for review and follow up. DNS will monitor.	

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F 246	Continued From page 2	F 246		

toileting, but was dependent with transfers on/off toilet using a mechanical lift and was dependent with cleansing and clothing management. The CAA indicated no specific tests or referrals were planned, but they would proceed to care plan risks associated with occasional urinary dribbling and incontinence.

R43's quarterly MDS, with ARD date 9/27/17, identified the resident's urinary continence had declined and the resident was now frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continence voiding).

Review of R43's care plan last updated on 10/3/17, indicated an increase in incontinence since 8/25/17 with the initiation of diuretic therapy. Interventions included: dependent with bedpan use and transfers on and off toilet per lift. Dependent with cleansing and clothing management. Offer bedpan on midnight and 4 a.m. rounds, provide incontinence care if needed. In addition, the care plan included: frequent urinary dribbling and incontinence.

Review of the facility's toileting documentation revealed R43's incontinence had increased in July when the mechanical lifts had been replaced. The toileting documentation revealed that after July 10th the resident was frequently incontinent of urine.

Review of physician visit notes dated 9/8/17 and 8/16/17, did not indicate whether or not the physician was aware of R43's increased incontinence.

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F 246	Continued From page 3	F 246		

Review of the resident's physician orders indicated the resident's physician had been made aware of increased edema in R43's lower extremities on 8/24/17, and had subsequently prescribed Lasix (a diuretic) 20 milligrams (mg) every day. A note from 9/11/17, indicated the Lasix had later been increased to 40 mg every day due to ongoing edema in R43's bilateral lower extremities.

Review of nursing notes dated 7/4/17 indicated R43 required 2 staff assist with all transfers to/from wheelchair, to bed, bed to wheel chair and to toilet. The note further indicated a mechanical lift was utilized at all times for transfers with 1-2 staff assist for toilet use.

Review of a bowel and bladder assessment dated 7/9/17, indicated R43 was continent of bowel and had occasional urinary dribbling. The assessment further indicated R43 was alert, oriented and able to request assist with toileting, but was dependent with transfers on and off the toilet with a mechanical lift and staff assistance.

Review of a bowel and bladder assessment dated 9/26/17, indicated R43 had occasional bowel incontinence episodes. Contributing factors were identified as including a diagnosis of constipation with scheduled laxative therapy, and dependence with toileting needs. The assessment also indicated R43 experienced frequent urinary dribbling and incontinence and included: "Resident exhibited a decline in urinary continence pattern after 8/25/17 initiation of scheduled diuretic therapy for treatment of lower extremity edema. Resident is alert and oriented, able to request assist with toileting during

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F 246	Continued From page 4	F 246		

wakeful hours, but dependent with bedpan use and transfers on and off toilet per mechanical lift. Requires prompted, scheduled toileting and bedpan placement at night."

During observation on 10/24/17 at 1:25 p.m., R43 was watching television while seated in her wheelchair. A lift sling was observed to be in place under R43's buttocks in the wheelchair. At 2:11 p.m. nursing assistant (NA)-A and NA-B were observed to take the resident to her room, and transferred R43 into bed from the wheelchair. Neither NA offered R43 the bedpan or an opportunity to use the toilet. NA-A stated staff offer R43 the bedpan when the resident requests it. NA-A further reported the nursing assistants are unable to get R43 into the bathroom, revealing that when new mechanical lifts were obtained in July 2017, a sling for toileting was not available. "We used to transfer her [R43] to the toilet all the time, until these lifts came in July." NA-A and NA-B revealed that the sling problem had been brought to the attention of nursing management, but "they keep telling us they are working on it." NA-A further explained that the facility's old lifts had a split sling available so staff could assist residents like R43 to the bathroom. She stated, "they worked well, we could transfer R43 to the bathroom toilet, so she could empty, now since the new lifts we give her the bedpan but she is more incontinent."

During an interview with R43 at 2:33 p.m. on 10/24/17, R43 stated she would prefer to use the toilet but was resolved to the fact that staff could no longer take her into the bathroom due to the mechanical lift sling. R43 stated she has always felt safe during transfers with the mechanical lift

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F 246	Continued From page 5	F 246		

because the staff are close to her but acknowledged, "I was more continent, and was not always wet, I don't like to be wet." R43 also stated, "It would be so much better for me to use the toilet again.

During an interview with NA-B on 10/24/17 at 2:50 p.m., NA-B stated R43 uses the call light to request the bedpan. and added, "when R43 first came she was usually dry, with minor dribbling. The retired mechanical lifts were made so you could sit someone on the toilet, the sling was split and adaptable for toilet use." NA-B said R43 had told her the bedpan was uncomfortable then NA-B stated, "I wish we had our other lifts back. The problem with the lifts and slings has been reported to our supervisors, they are working on it as far as I know."

During an interview with licensed practical nurse (LPN)-A she revealed she had not heard any complaints and further reported LPN-A was responsible for Medicare charting a few months ago. "I know they were taking her to the bathroom then." LPN-A confirmed that the facility did get new lifts and as was her understanding the staff had the split slings to use, revealing "for a while we had to wait for our corporation to ok ordering them." During the interview LPN-A confirmed not having access to the split slings for toileting was a definite problem that would need to be resolved.

During an interview with the director of nursing (DON) on 10/25/17 at 9:14 p.m., the DON confirmed she was aware of the challenges with the lift, and the fact there were currently no toileting slings available for the current lifts. The

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F 246	Continued From page 6 DON stated she had been working with the corporate office to authorize purchasing the correct slings to adapt to the toileting needs of residents who are totally dependent on staff for transferring from one surface to another. She further stated the administrator was also involved with discussion with the corporate office to obtain approvals to purchase lift slings that would work for toileting. During an interview on 10/26/17 at 12:31 p.m., R43 stated the facility was going to rent the proper sling so that she could use the toilet again. R43 stated, "this is wonderful, I want to be able to use the toilet and totally empty my bladder. Especially with the diuretic. The bedpan is not comfortable especially to use in bed, I do not like it."	F 246		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		12/15/17

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F 280	Continued From page 7 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280		

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F 280	Continued From page 8 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 2 residents (R43) reviewed who required assistance to manage urinary incontinence. Findings include: During observation on 10/24/17 at 1:25 p.m., R43 was watching television while seated in her wheelchair. A full lift sling was observed to be in place under R43's buttocks in the wheelchair. At 2:11 p.m. nursing assistant (NA)-A and NA-B were observed to take the resident to her room, and transferred R43 into bed from the wheelchair. Neither NA-A offered the bedpan or	F 280	This is a rollover tag from F246 It is the practice of Slayton Rehabilitation and Healthcare Center to provide all residents with all needed accommodation of needs and preferences. All residents utilizing a full body lift have been reassessed and have proper slings. Proper toileting sling for resident R43 was obtained during survey on October 25, 2017 to provide the resident the opportunity to use the bedpan or the toilet per resident's choice. Resident R43 is refusing to transfer to toilet utilizing the lift and sling. Staff will continue to offer to transfer her to toilet	

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F 280	Continued From page 9 an opportunity for R43 to use the toilet. NA-A stated staff offer R43 the bedpan when the resident requests it. NA-A further reported the nursing assistants are unable to get R43 into the bathroom. NA-A said the facility had gotten new mechanical lifts in July 2017 but no sling accessible for toileting was available. "We used to transfer her [R43] to the toilet all the time, until these lifts came in July." NA-A and NA-B stated the sling problem had been brought to the attention of nursing management, but "they keep telling us they are working on it." NA-A further explained that the facility's old lifts had a split sling available so staff could assist residents like R43 to the bathroom. She stated, "they worked well, we could transfer R43 to the bathroom toilet, so she could empty, now since the new lifts we give her the bedpan, but she is more incontinent." During an interview with R43 at 2:33 p.m. on 10/24/17, R43 stated she would prefer to use the toilet but was resolved to the fact that staff could no longer take her into the bathroom due to not having the right mechanical lift sling. R43 stated, "I used to be more continent, and was not always wet, I don't like to be wet." R43 also stated, "It would be so much better for me to use the toilet again." During an interview with NA-B on 10/24/17 at 2:50 p.m., NA-B stated R43 uses the call light to request the bedpan and added, "when R43 first came she was usually dry, with minor dribbling. The retired mechanical lifts were made so you could sit someone on the toilet, the sling was split and adaptable for toilet use." NA-B said R43 had told her the bedpan was uncomfortable then	F 280	per her care plan. All nursing staff have been re-educated to follow care sheets/care plan/toileting plan and using equipment per assessments. Random audits will continue to be conducted on residents requiring mechanical lifts for toileting by the DNS or designee. The results will be forwarded to the QAPI Committee for review and follow up. DNS will monitor.	

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F 280	Continued From page 10 NA-B stated, "I wish we had our other lifts back. The problem with the lifts and slings has been reported to our supervisors, they are working on it as far as I know." R43's diagnosis identified on the resident care plan, last updated on 10/3/17, identified: Multiple sclerosis, chronic pain, pain in left shoulder, low back pain, osteoarthritis, and major depressive disorder. A Care Area Assessment (CAA) dated 7/16/17, identified R43 as requiring a urinary incontinence care plan related to dependence with toileting and occasional urinary incontinence. Contributing factors were identified to include multiple sclerosis, weakness, non-ambulatory, non weight bearing status, dependency with transfers, inability to move left leg and right shoulder, frequent uncontrolled head, neck and left arm movements and chronic pain. Further, the CAA indicated the resident was alert, oriented, and able to request assist with toileting, but was dependent with transfers on/off toilet using a mechanical lift and was dependent with cleansing and clothing management. The CAA indicated no specific tests or referrals were planned, but they would proceed to care plan risks associated with occasional urinary dribbling and incontinence. R43's quarterly Minimum Data Set (MDS) from 9/27/17, identified a decline in urinary continence. Review of the facility's toileting documentation also reflected an increase in urinary incontinence since the facility had replaced their mechanical lifts in mid- July. The toileting documentation	F 280		

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F 280	Continued From page 11 indicated R43 was frequently incontinent with urine beginning in mid July. Review of R43's care plan last updated on 10/3/17, reflected R43's increase in incontinence since 8/25/17, with the initiation of a diuretic medication. Interventions included: dependent with bedpan use and transfers on and off toilet per lift. Dependent with cleansing and clothing management. Offer bedpan on midnight and 4 a.m. rounds, provide incontinence care if needed. In addition, the care plan included: frequent urinary dribbling and incontinence. The care plan had not been revised to reflect the routine use of the bedpan during all hours of the day, or the inability of staff to put the resident on the toilet since implementation of the new mechanical lift.	F 280		
F 315 SS=G	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (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 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	F 315		12/15/17

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F 315	Continued From page 12 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 comprehensively assess and provide care to manage urinary incontinence for 1 of 2 residents (R43) reviewed for urinary incontinence. This caused harm for R43 who had a decline in urinary continence when a diuretic was implemented, and a new mechanical lift was instituted. Findings include: Review of the facility's toileting documentation revealed R43 had an increase in incontinence episodes beginning in July 2017 when the facility's mechanical lifts were replaced. According to toileting documentation, R43	F 315	This is a rollover tag from F246 and F280 It is the practice of Slayton Rehabilitation and Healthcare Center to provide all residents with all needed accommodation of needs and preferences. All residents utilizing a full body lift have been reassessed and have proper slings. Proper toileting sling for resident R43 was obtained during survey on October 25, 2017 to provide the resident the opportunity to use the bedpan or the toilet per resident's choice. Resident R43 is refusing to transfer to toilet utilizing the lift and sling. Staff will continue to offer to transfer her to toilet per her care plan.	

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F 315	Continued From page 13 became frequently incontinent after 7/10/17. During observation on 10/24/17 at 1:25 p.m., R43 was watching television while seated in her wheelchair. A lift sling was observed to be in place under R43's buttocks in the wheelchair. At 2:11 p.m. nursing assistant (NA)-A and NA-B were observed to take the resident to her room, and transferred R43 into bed from the wheelchair. Neither NA-A offered the bedpan or an opportunity for R43 to use the toilet. NA-A stated staff offer R43 the bedpan when the resident requests it. NA-A further reported the nursing assistants are unable to get R43 into the bathroom. NA-A said the facility had gotten new mechanical lifts in July 2017 but no sling accessible for toileting was available. "We used to transfer her [R43] to the toilet all the time, until these lifts came in July." NA-A and NA-B stated the sling problem had been brought to the attention of nursing management, but "they keep telling us they are working on it." NA-A further explained that the facility's old lifts had a split sling available so staff could assist residents like R43 to the bathroom. She stated, "they worked well, we could transfer R43 to the bathroom toilet, so she could empty, now since the new lifts we give her the bedpan, but she is more incontinent." During an interview with R43 at 2:33 p.m. on 10/24/17, R43 stated she would prefer to use the toilet but was resolved to the fact that staff could no longer take her into the bathroom due to not having the right mechanical lift sling. R43 stated, "I used to be more continent, and was not always wet, I don't like to be wet." R43 also stated, "It would be so much better for me to use the toilet	F 315	All nursing staff have been re-educated to follow care sheets/care plan/toileting plan and using equipment per assessments. Random audits will continue to be conducted on residents requiring mechanical lifts for toileting by the DNS or designee. The results will be forwarded to the QAPI Committee for review and follow up. DNS will monitor.	

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F 315	Continued From page 14 again." During an interview with NA-B on 10/24/17 at 2:50 p.m., NA-B stated R43 uses the call light to request the bedpan and added, "when R43 first came she was usually dry, with minor dribbling. The retired mechanical lifts were made so you could sit someone on the toilet, the sling was split and adaptable for toilet use." NA-B said R43 had told her the bedpan was uncomfortable then NA-B stated, "I wish we had our other lifts back. The problem with the lifts and slings has been reported to our supervisors, they are working on it as far as I know." R43's medical record was reviewed. Diagnoses identified from the resident care plan, last updated 10/3/17 included: Multiple sclerosis, chronic pain, pain in left shoulder, low back pain, osteoarthritis, and major depressive disorder. Review of nursing notes dated 7/4/17 indicated R43 required 2 staff assist with all transfers to/from wheelchair, to bed, bed to wheel chair and to toilet. The note further indicated a mechanical lift was utilized at all times for transfers with 1-2 staff assist for toilet use. Review of a bowel and bladder assessment dated 7/9/17, indicated R43 was continent of bowel and had occasional urinary dribbling. The assessment further indicated R43 was alert, oriented and able to request assist with toileting, but was dependent with transfers on and off the toilet with a mechanical lift and staff assistance. R43's admission minimum data set (MDS), with	F 315		

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F 315	Continued From page 15	F 315		

assessment reference date (ARD) 7/10/17, identified R43 as occasionally incontinent (less than 7 episodes of incontinence in the look back period) and indicated R43 required total assistance of 2 staff for toileting.

The Care Area Assessment (CAA) dated 7/16/17, identified R43 as having triggered for a urinary incontinence care plan related to dependence with toileting and occasional urinary incontinence. Contributing factors were identified to include multiple sclerosis, weakness, non-ambulatory, non weight bearing status, dependency with transfers, inability to move left leg and right shoulder, frequent uncontrolled head, neck and left arm movements and chronic pain. Further, the CAA indicated the resident was alert, oriented, and able to request assist with toileting, but was dependent with transfers on/off toilet using a mechanical lift and was dependent with cleansing and clothing management. The CAA indicated no specific tests or referrals were planned, but they would proceed to care plan risks associated with occasional urinary dribbling and incontinence.

Review of the resident's physician orders indicated the resident's physician had been made aware of increased edema in R43's lower extremities on 8/24/17, and had subsequently prescribed Lasix (a diuretic) 20 milligrams (mg) every day. A note from 9/11/17, indicated the Lasix had later been increased to 40 mg every day due to ongoing edema in R43's bilateral lower extremities.

Review of a bowel and bladder assessment dated 9/26/17, indicated R43 had occasional

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F 315	Continued From page 16	F 315		

bowel incontinence episodes. Contributing factors were identified as including a diagnosis of constipation with scheduled laxative therapy, and dependence with toileting needs. The assessment also indicated R43 experienced frequent urinary dribbling and incontinence and included: "Resident exhibited a decline in urinary continence pattern after 8/25/17 initiation of scheduled diuretic therapy for treatment of lower extremity edema. Resident is alert and oriented, able to request assist with toileting during wakeful hours, but dependent with bedpan use and transfers on and off toilet per mechanical lift. Requires prompted, scheduled toileting and bedpan placement at night."

R43's quarterly MDS, with ARD date 9/27/17, identified the resident's urinary continence had declined and the resident was now frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continence voiding).

Review of R43's care plan last updated on 10/3/17, indicated an increase in incontinence since 8/25/17 with the initiation of diuretic therapy. Interventions included: dependent with bedpan use and transfers on and off toilet per lift. Dependent with cleansing and clothing management. Offer bedpan on midnight and 4 a.m. rounds, provide incontinence care if needed. In addition, the care plan included: frequent urinary dribbling and incontinence.

During an interview with licensed practical nurse (LPN)-A on 10/25/17 at 9:01 a.m., LPN-A verified staff had been transferring R43 to the toilet prior to the facility having purchased new lifts. LPN-A

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F 315	Continued From page 17 confirmed not having access to the split slings for toileting was a definite problem that would need to be resolved for residents like R43. During an interview with the director of nursing (DON) on 10/25/17 at 9:14 a.m., the DON confirmed she was aware of the challenges with the lift, and the fact there were currently no toileting slings available for the current lifts. The DON stated she had been working with the corporate office to authorize purchasing the correct slings to adapt to the toileting needs of residents who are totally dependent on staff for transferring from one surface to another. She further stated the administrator was also involved with discussion with the corporate office to obtain approvals to purchase lift slings that would work for toileting.	F 315		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 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	F 329		12/15/17

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F 329	Continued From page 18 discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. 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 ensure a gradual dose reduction of an antipsychotic (Seroquel) was completed for 1 of 5 residents (R21) reviewed for unnecessary medication use. Findings include: R21's face sheet dated 10/26/17, listed active diagnoses including: restlessness and agitation, unspecified dementia without behavioral disturbance, malignant neoplasm of the bone, and legal blindness. R21's most current annual Minimum Data Set	F 329	It is the practice of Slayton rehabilitation and Healthcare Center to use the least amount of psychotropic medication to provide minimal effective dose to all residents prescribed psychotropic medication. During survey, Resident R21's physician initiated reduction of Seroquel from 25mg 3x/day x 7 days down to 12.5mg daily x 7 days then discontinue. Since the reduction, the resident has been awake calling out most of the night with no non- pharmacological approaches relieving calling out. Resident complaints of pain have	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 19 (MDS) assessment dated 10/6/17, indicated R21 received antipsychotic medications on a daily basis, that a gradual dose reduction (GDR) had not been completed and that a clinical contraindication for the antipsychotic had been received on 6/22/17. Additionally, the MDS identified R21 had a Brief Interview for Mental Status score of one, indicating severe cognitive impairment, and that no mood or behavioral indicators were observed during the look back period. R21's Care Area Assessment (CAA) for psychotropic drug use dated 10/10/17, indicated R21 utilized antipsychotic medications daily, and that staff should continue to monitor for effectiveness of current medication regime, monitor for any escalation of mood/behavior indicators, and monitor for medication side effects directly related to prescribed psychotropic med therapy. R21's most current care plan dated 10/25/17, identified a mood and behavior problem with use of antipsychotic medications, and that the resident exhibited intermittent irritability when she did not comprehend a situation or when she was more confused, and a behavior of frequent calling out which was disruptive to others. The goal of not exhibiting indicators of acute depression or behaviors was listed. Interventions identified included to encourage activities the resident enjoys, visits with friends and family, allowing a chance to share feelings and concerns, monitoring for escalations in mood or behavioral concerns, and if behavioral concerns were noted, to observe for causes.	F 329	increased since reduction. Discussion with resident's PCP (primary care provider) has resulted in adjusting of pain medications and resident continues to call out. Discussions continue with resident's PCP, who states it is a failed dose reduction. Seroquel 12.5mg was restarted on 11/17/17 due to failed dose reduction trial. Resident will continue to be re-assessed by nursing staff and med committee. Nursing has been re-educated on behavioral symptom intervention and documentation. All residents on anti-psychotropic medications will be reviewed by the consulting pharmacist monthly. Results will be reviewed at the monthly Med Committee for Minimum Effective Dose regarding physician recommendations. Any refusals of recommendations will be followed up with the PCP. All refusals will be followed up with the medical director. The results will be forwarded to the QAPI committee for review and follow up. Random audits will be conducted by DNS or Designee. DNS will monitor.	

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	245386	A. BUILDING _____ B. WING _____	10/26/2017

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F 329	Continued From page 20	F 329		

R21's daily behavior observation flow sheets for the previous three months (July, August, and September 2017) revealed she had exhibited calling out behaviors a total of 13 days during this time period, with seven of the episodes occurring during the month of July 2017. Behaviors listed included statements of feeling depressed, tearfulness, hallucinations and disruptive to others/calling out. Approaches included to allow resident to express feelings, offer comfort/support/reassurance/validate feelings and encourage resident to participate in activities of interest.

R21's Medication Administration Record (MAR) for October 2017, indicated she had received Seroquel 25 milligrams three times per day, with an original start date listed as 5/27/16.

R21's nursing progress notes dated 8/17/17, included an entry related to mood and behavior: "Behavior team reviewed resident's antidepressant and antipsychotic medications, target mood/behavior log from the past 30 days, progress notes from the past 30 days; and care plan interventions for mood. Continues to have periods of calling out. Also noted to have periods of crying and being angry at staff. Can be related to her impaired vision or pain r/t (related to) cancer dx (diagnosis). Non-pharmacological interventions are attempted. No recommendations at this time. Will continue to monitor. Noted has dx of breast cancer with mets to the bone with 12 cancer markers between shoulders and the pelvis."

During observation on 10/24/17, at 1:20 p.m. R21 was observed asleep in her wheelchair in her

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F 329	Continued From page 21 room, with the lights off. During observation and interview on 10/25/17, at 8:47 a.m. R21 was observed in her room with nursing assistant (NA)-D. NA-D had just finished assisting R21 to the toilet with the use of a standing lift. At that time, NA-D stated R21 rarely spoke and that the only behaviors she had noted from R21 included the resident calling out, "help me, help me," which was usually related to her need to use the toilet. During the observation R21 demonstrated no observable indicators of pain, had her eyes closed, and did not open them when spoken to. During observation on 10/26/17, at 10:23 a.m. R21 was seated in a recliner in her room, with her eyes closed, and was non verbal. During interview on 10/25/17, at 9:30 a.m. the director of nursing (DON) stated they had tried dose reductions of R21's Seroquel in the past, however the physician had refused to reduce the dose. The DON provided copies of pharmacy consultant recommendations from 12/13/16 and 6/22/17, which recommended the medication dosage be reviewed for reduction. On both occasions, the physician response indicated R21 "does better at current dose, do not decrease." However, their was no documented physician justification indicating evidence of attempted reduction or how/why it had failed. There was no further documented rationale provided with any more detail regarding why a dose reduction would be contraindicated. During interview on 10/25/17, at 12:59 p.m. NA-C stated R21 did not have any behaviors and rarely	F 329		

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F 329	Continued From page 22	F 329		

verbalized, but was able to state when she needed to use the bathroom.

During interview on 10/25/17, at 2:50 p.m. the facility's consultant pharmacist (CP) stated she could certainly make another recommendation to reduce R21's Seroquel dosage, and felt the facility should refer concerns with GDR attempts to the medical director if the physician was not receptive to considering one. The CP also stated both herself and the previous consultant pharmacist had indicated a GDR for R21 was warranted.

During interview with the DON on 10/26/17 at 9:52 a.m., the DON stated R21's Seroquel had most recently been increased about a year ago due to her persistent hollering for help in the afternoon. The DON said more recently, within the last six months, R21 had experienced a decline in her mobility and had been started on Vicodin (a narcotic pain medication) which had been increased in July 2017 for pain symptoms. The DON stated it had been discovered that R43 had cancerous tumors of the bone between her shoulders and pelvis. The DON also stated they had been working on getting physicians to be more specific as to why GDRs were contraindicated however, verified she had not included their medical director in speaking with primary physicians about GDR reductions.

During interview on 10/26/17, at 10:18 a.m. medical doctor (MD)-A, who was R21's primary physician, stated she had originally started R21 on the Seroquel because the resident was calling out, not knowing the time of day or night because she was blind. MD-A verified that with the

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F 329	Continued From page 23 additional pain medication on board for R21, a GDR of her Seroquel would be appropriate as some of her behaviors may have been pain-related. The facility's policy Antipsychotic Medication Use undated, indicated residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective, and the attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to residents and others.	F 329		
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food	F 371		12/15/17

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F 371	Continued From page 24 service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure equipment to used for food preparation was maintained in a sanitary manner. This had the potential to affect all 35 residents in the facility who received meals prepared in the kitchen. Findings include: During the initial kitchen tour with the dietary manager (DM) on 10/23/17 at 3:03 p.m., the following sanitation problems were noted and confirmed by the DM: A large industrial mixer, was observed to be stored with plastic covering the unit. The DM explained that the unit was covered for storage after it had been thoroughly cleaned. The DM removed the cover and the armature was observed to be greasy and covered with a flour like substance under the carriage of the unit. The grime and flour like substance was directly above the mixing bowl. Two service size coffee units were observed to be covered with debris. The spigot on one of the coffee servers had a thick brownish buildup around the serving edge of the spigot, extending 1/4 to 1/2 inch up from the edge of the spigot. The DM confirmed that the water builds up with	F 371	It is the practice of Slayton Rehabilitation and Healthcare Center to maintain all food preparation in a sanitary manor. Dietary Manager updated the cleaning schedule to include all areas of food preparation. Corporate Dietitian and/ or Dietary Manager will provide an in-service to the dietary team with education given. Random kitchen audits will be done by the Dietary Manager and Corporate Dietitian. The Dietary Manager and Dietitian are to attend QAPI meeting for review and recommendations with Dietitian attending quarterly. Dietary Manger is responsible to forwarded to QAPI Meeting for review and recommendations.	

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F 371	Continued From page 25 sediment. The industrial toaster and knife holder rack were observed to be coated with a thick layer of dust. The observation was confirmed by the DM who stated that both units needed to be cleaned. POLICY REVIEW: Title: Sanitation Policy It is the policy of the dining services department to practice proper sanitation techniques for clean equipment to prevent the outbreak of food borne illness, and to train Dining Service employees to use these techniques. The director of dining is responsible for training, monitoring proper sanitation techniques and compliance. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (C) Non food contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris.	F 371		
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 431		12/15/17

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F 431	Continued From page 26 biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an open date was identified on insulin pens when first opened for use, to determine outdate for use for 2 of 4 residents (R5 & R51) reviewed; the facility also failed to reconcile controlled substances twice daily as required by facility policy for 17 residents who received controlled medications; and failed to ensure expired medications were removed from the emergency kit. Findings include: During an observation on 10/24/17, at 2:00 p.m. licensed practical nurse (LPN)-B stated the east/south medication cart had two (2) undated insulin pens available for use that were not dated when opened. A Novolog flexpen for R5 had a pharmacy fill date of 8/30/17. The package insert indicated the medication was good for 28 days after opening. A Humalog insulin pen for R51 with a fill date of 10/14/17 was also not dated as to when it had been opened. The package insert indicated the medication would be good for 28 days after opening. LPN-B verified the nurse was supposed to date insulin pens when they were opened for use. She verified she was unaware when these pens had been opened and acknowledged staff would be unable to determine when these insulin pens should be discarded. R9 had a blister pack card of Clonazepam (controlled substance used for anxiety) labeled 0.5 milligrams (mg) take 1 tab by mouth twice a day. The card identified in hand writing there was	F 431	It is the practice of Slayton Rehabilitation and Healthcare Center to ensure all medications are dated, not expired, and controlled medication are counted every shift. Staff education was provided to all nurses during survey. Insulin pens were discarded and replaced for Residents R5 and R51 when the Surveyor identified the issue. New insulin pens will be dated when opened. The half tab in blister pack for resident R9 was destroyed per policy during the survey. Nurses who worked on 10/27, 10/26, 5.03, 4/22, 4/21, 4/18, 10/21, 10/11, 4/23, 9/22, 9/09, 9/05, 8/22, 4/26, and 4/17 have been counselled regarding incomplete controlled substance counts. The E-Kit was replaced on the day it was discovered during survey. All licensed nurses were educated on facility policies regarding dating medication when open, disposing of controlled substances, counting of controlled substances during shift changes and verifying the E-Kits are current. Random audits will be conducted on medication cart for appropriate medication dates, narcotic, destruction, controlled substance counts, and expired E-Kit by DNS, ADNS or Licensed Designee. Results will be forwarded to the QAPI for review and recommendations.	

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F 431	Continued From page 28 0.25 mg given PRN (as needed) on 10/23/17 with the remaining half of the tablet being taped back into the blister pack. LPN-B stated a half tablet had been administered as an as needed (PRN) dose. LPN-B stated the appropriate procedure would have been to destroy the other half tablet and record appropriately instead of taping a half tab back into the medication card. Review of the facility's Shift Verification of Controlled Substances Count form with LPN-B, indicated counts had not been conducted twice daily per facility policy: No documentation of evening shift counts: 10/17, 10/10, 10/3, 9/22, 9/9, 9/5, 8/22, 5/24, 5/16, 5/1, 4/26, 4/17 and 4/13/17. No documentation of either day or evening shift counts: 10/27, 10/26, 5/3, 5/2, 4/22, 4/21 and 4/18/17. No documentation of day shift counts: 10/21/17, 5/11 and 4/23/17. During an observation with LPN-B on 10/24/17, at 2:15 p.m. the refrigerated E-kit (emergency kit) was noted to contain two 1 milliliter (ml) vials of lorazepam 1 mg/ml with a manufacturer's expiration date of 9/1/17 indicated on both vials. LPN-B verified the medications were expired and would be outdated if needed in an emergency. LPN-B further verified the E-kits were not routinely monitored for intact plastic locks located on the kits; adding she had no idea when the last time the medications were checked for outdates. LPN-B reported that the pharmacy tech looks through the medication carts and conducted monthly audits. During an interview on 10/25/17 at 12:25 p.m.,	F 431	DNS will monitor.	

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F 431	Continued From page 29 the consultant pharmacist verified being responsible to ensure the E-kit for the facility was monitored for expired medications. The pharmacist stated she checked the E-kits monthly but had evidently missed the refrigerated box stating, "It was a fluke." When interviewed on 10/24/17, at 2:45 p.m. the director of nursing (DON) verified the consultant pharmacist comes once a month and looks through the medication carts and the medication rooms. The DON further verified monthly audits are conducted by facility staff and the results were posted for staff. The facility's undated policy, Controlled Substances, indicated nursing staff must count controlled medications at the end of each shift indicating the nurse coming on duty and the nurse going off duty must make the count together. The policy further directed staff to document and report any discrepancies.	F 431		

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	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Slayton Rehabilitation and Healthcare Center 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: State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2017

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.

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Slayton Rehabilitation and Healthcare Center was constructed as follows: The original building was constructed in 1965, it is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 35 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101	K 223		12/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLAYTON REHABILITATION & HEALTHCARE CENTER	**2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172**

(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 223	Continued From page 2 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain doors with self-closing devices in accordance with 19.2.2.2.7 and 19.2.2.2.8. This could effect 35 of 35 residents. Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	K 223	It is the practice of Slayton Rehabilitation and Healthcare Center to ensure all facility doors will have automatic door closure to provide fire safety. Door closures have been ordered and will be installed by December 15, 2017. Maintenance Director will establish correct procedure to install and audit working condition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLAYTON REHABILITATION & HEALTHCARE CENTER	**2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172**

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K 223	Continued From page 3 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 10/24/2017, observation revealed the door from the kitchen that opens into the Service Corridor Exit Access and into the Resident Dining Room does not have a self closing device. Both of these doors were observed in the open position. This deficient practice was verified by the Facility Maintenance Director.	K 223		
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This deficient practive could effect 35 of 35 residents.	K 926	It is the Practice of Slayton Rehabilitation and Healthcare Center to ensure all employees are educated on the application and maintenance and handling of medical gasses and cylinders on the risk of such. Maintenance Director has completed the qualifications and training. All staff training will be completed by December 15, 2017. Training will continue annually and for new hires. Maintenance Director will bring	12/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245386	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SLAYTON REHABILITATION & HEALTHCARE CENTER	**2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172**

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K 926	Continued From page 4 FINDINGS INCLUDE: During documentation review between 10:00 AM and 1:00 PM on 10/24/2017, documentation could not be located to show that all staff that handle gas cylinders have received safety training guidelines and usage requirements of gas cylinders. This deficient practice was verified by the Facility Maintenance Director.	K 926	results to QAPI Meeting.	