| | N SERVICES ARE/MEDICAID CERTIFICATION TO BE COMPLETED BY THE STA | AND TRANSMITTAL | DICARE & MEDICAID SERVICES ID: U48A 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 & I (L4) 2957 REDWOOD AVENUE SOUTH (L5) SLAYTON, MN | | 4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. O. Off. W. W. W. 9. Other |
| 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 02/01/2017 | 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD | <u>02</u> (L7) 13 PTIP 22 CLIA | 7. On-Site Visit 9. Other 8. Full Survey After Complaint |
| 6. DATE OF SURVEY 12/18/2017 ^(L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other | 02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/II 04 SNF 08 OPT/SP 12 RHC | 14 CORF D 15 ASC 16 HOSPICE | FISCAL YEAR ENDING DATE: (L35) 12/31 |
| 11LTC PERIOD OF CERTIFICATION | 10.THE FACILITY IS CERTIFIED AS: | | |

| From (a): | | | A. In Complianc | e With | And/Or App | roved Waivers O | f The Follow | ing Requirements: | |
|-------------------------|--------------|----------|-------------------|-----------------------|---------------|------------------|--------------|---------------------------|--|
| To (b): | | | Program Requ | | 2. Te | chnical Personne | el _ 6 | . Scope of Services Limit | |
| | | | Compliance E | Based On: | 3. 24 | Hour RN | 7 | . Medical Director | |
| 12.Total Facility Beds | | 55 (L18) | 1. Acce | eptable POC | 4. 7-1 | Day RN (Rural S | SNF) _ 8 | . Patient Room Size | |
| 12. Total Facility Deus | | 33 (L10) | | | 5 Lii | fe Safety Code | c | . Beds/Room | |
| 13.Total Certified Beds | | 55 (L17) | B. Not in Complia | nce with Program | <u></u> 5. En | te Safety Code | | | |
| | | | Requirements an | d/or Applied Waivers: | * Code: | Α | (L12) | | |
| 14. LTC CERTIFIED BE | ED BREAKDOWN | V | | | 15. FACILITY | (MEETS | | | |
| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID | 1861 (e) (1) | or 1861 (j) (1): | | (L15) | |
| | 55 | | | | | | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) | | | | | |

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

| 17. SURVEYOR SIGNATURE | | Date : | 18. STATE SURVEY AGENCY APPROV | /AL Date: |
|--|--|--|---|---|
| Nicole Osterloh, HFE NE II | | 1/25/2018 (L19) | Kamala Fiske-Downing, Enfor | cement Specialist 1/25/2018 (L20) |
| PA | ART II - TO BE COMP | LETED BY HCFA REGIONA | L OFFICE OR SINGLE STATE | AGENCY |
| DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible | Participate | 20. COMPLIANCE WITH CIVIL RIGHTS ACT: | 21. 1. Statement of Financial Solve 2. Ownership/Control Interest 3. Both of the Above : | |
| 22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 | 23. LTC AGREEMENT BEGINNING DATE | 24. LTC AGREEMENT ENDING DATE | 26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement | (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement |
| (L24) 25. LTC EXTENSION DATE: (L27) | (L41) 27. ALTERNATIVE SANG A. Suspension of Admis B. Rescind Suspension | (L44) | 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal | OTHER 07-Provider Status Change 00-Active |
| | ľ | (L45) | | |
| 28. TERMINATION DATE: | 01 | MEDIARY/CARRIER NO. 111 | 30. REMARKS | |
| | (L28) | (L31) | _ | |
| 31. RO RECEIPT OF CMS-1539 | 32. DETER | MINATION OF APPROVAL DATE | | |
| | (L32) | (L33) | DETERMINATION APPROVAL | , |

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

| 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.

Facility ID: 00915



Protecting, Maintaining and Improvingthe 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File



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: 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:

Slayton Rehabilitation & Healthcare Center January 25, 2018 Page 2

• 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. 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.

Slayton Rehabilitation & Healthcare Center January 25, 2018 Page 3 Feel free to contact me if you have questions.

Sincerely,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u> cc: Licensing and Certification File



Protecting, Maintaining and Improvingthe 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

| DEPARTMENT OF HEALTH AND HUM | AN SERVICES | CENTERS FOR MEI | DICARE & MEDICAID SERVICES |
|-----------------------------------|--|-----------------|---|
| MEDIO | CARE/MEDICAID CERTIFICATION AND |) TRANSMITTAL | ID: U48A |
| PART I | - TO BE COMPLETED BY THE STATE S | SURVEY AGENCY | Facility ID: 00915 |
| 1. MEDICARE/MEDICAID PROVIDER NO. | 3. NAME AND ADDRESS OF FACILITY (L3) SLAYTON REHABILITATION & HEAI | THCADE CENTED | 4. TYPE OF ACTION: $\underline{2}$ (L8) |
| (L1) 245386 | (L3) SLAY ION KEHABILITATION & HEAD | JIHCAKE CENTEK | 1. Initial 2. Recertification |

| 2.STATE VENDOR OR MEDICAID NO. (L4) 2957 REDWOOD AVENUE S (L2) 660385800 (L5) SLAYTON, MN | | (L6) 56172 | 3. Termination 4. CHOW 5. Validation 6. Complaint |
|---|--|---|--|
| 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 02/01/2017 | 7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD | <u>02</u> (L7) 13 PTIP 22 CLIA | 7. On-Site Visit 9. Other 8. Full Survey After Complaint |
| 6. DATE OF SURVEY 10/26/2017 (L34) 8. ACCREDITATION STATUS: | 02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/III 04 SNF 08 OPT/SP 12 RHC | 14 CORF D 15 ASC 16 HOSPICE | FISCAL YEAR ENDING DATE: (L35) 12/31 |
| 11LTC PERIOD OF CERTIFICATIONFrom(a) :To(b) :12.Total Facility Beds55 (L18)13.Total Certified Beds55 (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 ' 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B * | 6. Scope of Services Limit 7. Medical Director |
| 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 55 (L37) (L38) | | 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): | (L15) |
| 16. STATE SURVEY AGENCY REMARKS (IF APPLI | CABLE SHOW LTC CANCELLATION DATE): | - | |
| 17. SURVEYOR SIGNATURE JOSEPH Garvey, HFE NE II | Date : 11/27/2017 (L19) | 18. STATE SURVEY AGENCY Kamala Fiske-Downing | APPROVAL Date: g, Enforcement Specialist 12/04/2017 (L20) |
| PART II - TO B | E COMPLETED BY HCFA REGIONAL | L OFFICE OR SINGLE S | TATE AGENCY |
| DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate | 20. COMPLIANCE WITH CIVIL RIGHTS ACT: | | ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : |

| 1. | Facility is Eligible to Participate |
|--------|-------------------------------------|
| 2. | Facility is not Eligible |

| 2. Facility is not Eligible | e (L21) | | | _ |
|--|---|---|---|---|
| 22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 | 23. LTC AGREEMENT BEGINNING DATE | 24. LTC AGREEMENT ENDING DATE | 26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure | (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety |
| (L24) 25. LTC EXTENSION DATE: (L27) | (L41) 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: B. Rescind Suspension Date: | (L25) (L44) (L45) | 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal | 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active |
| 28. TERMINATION DATE:31. RO RECEIPT OF CMS-1539 | 29. INTERMEDIA 01111 (L28) 32. DETERMINAT | RY/CARRIER NO. (L31) ION OF APPROVAL DATE | 30. REMARKS | |
| | (L32) | (L33) | DETERMINATION APPROVAL | |



Protecting, Maintaining and Improving the Health of All Minnes otans

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:

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

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

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

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

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

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

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; <u>OR</u>
- 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) <u>AND</u> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Tomston

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

| Minneso | ota Department of He | ealth | | | | ATTROVED |
|--------------------------|---|--|---------------------|--|-------------------|--------------------------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | (X3) DATE COMP | SURVEY PLETED |
| | | 00915 | B. WING | | 10/2 | 26/2017 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION 8 | L HEALTHCARE C | WOOD AVE | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | *****ATTE | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess | hether a violation has been | | | | |
| | that may result from orders provided that the Department wit | hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. | | | | |
| | receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a | o participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are | | | | |
| LABORATOR' | epartment of Health Y DIRECTOR'S OR PROVIE ically Signed | ER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | TITLE | | (X6) DATE 11/17/17 |

If continuation sheet 1 of 29

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|------------------------|---|---|---------------------------|--|-------------------------------|------------------------|--|
| | | | A. BUILDING: _ | | | | |
| | | 00915 | B. WING | | 10/ | 26/2017 | |
| AME OF F | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, ST | ATE, ZIP CODE | | | |
| | N REHABILITATION 8 | | DWOOD AVEN N, MN 56172 | UE SOUTH | | | |
| X4) ID REFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO | TION SHOULD BE | (X5) COMPLE DATE | |
| IAO | | | iAo | DEFICIENC | | | |
| 2 000 | Continued From pa | ige 1 | 2 000 | | | | |
| | you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th | Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. | | | | | |
| | of this Department's provider and the fol issued. Please ind | 25 and 26, 2017, surveyors s staff, visited the above llowing correction orders are icate in your electronic plan of have reviewed these orders, e when they will be | | | | | |
| | the State Licensing federal software. Ta | nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for | | | | | |
| | column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follo | umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection. | | | | | |
| | FOURTH COLUMN | ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS | | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E SURVEY PLETED |
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| | | 00915 | B. WING | 10/ | 26/2017 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | |
| SLAYTO | N REHABILITATION 8 | | WOOD AVE I, MN 56172 | NUE SOUTH | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
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| | | ERAL DEFICIENCIES ONLY. R ON EACH PAGE. | | | |
| | PLAN OF CORREC | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. | | | |
| 2 570 | MN Rule 4658.040 Plan of Care; Revis | 5 Subp. 4 Comprehensive sion | 2 570 | | 12/15/1 |
| | care must be review interdisciplinary tea physician, a register for the resident, and disciplines as deter needs, and, to the participation of the guardian or chosen quarterly and within | A comprehensive plan of wed and revised by an im that includes the attending ered nurse with responsibility d other appropriate staff in mined by the resident's extent practicable, with the resident, the resident's legal representative at least a seven days of the revision of resident assessment required subpart 3, item B. | | | |
| | by: Based on observative review, the facility f for 1 of 2 residents assistance to mana Findings include: During observation was watching telev wheelchair. A full lif place under R43's | ent is not met as evidenced ion, interview and document ailed to revise the plan of care (R43) reviewed who required age urinary incontinence. on 10/24/17 at 1:25 p.m., R43 ision while seated in her it sling was observed to be in buttocks in the wheelchair. At issistant (NA)-A and NA-B | | 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 | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE : COMPL | | | | | |
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| | | 00915 | B. WING | | 10/2 | 6/2017 | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | 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 (X5) COMPLETE DATE | | | | | | | | | | |
| | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | | (EACH CORRECTIVE ACT | ION SHOULD BE THE APPROPRIATE | COMPLET | | | | |
| 2 570 | Continued From pa | age 3 | 2 570 | | | | | | | |
| | an opportunity for F stated staff offer R4 resident requests it nursing assistants a bathroom. NA-A sa mechanical lifts in a accessible for toiled to transfer her [R43 these lifts came in a the sling problem h attention of nursing telling us they are w explained that the f sling available so s R43 to the bathrood well, we could trans toilet, so she could | 3 into bed from the r NA-A offered the bedpan or R43 to use the toilet. NA-A 43 the bedpan when the t. NA-A further reported the are unable to get R43 into the aid the facility had gotten new July 2017 but no sling ting was available. "We used b to the toilet all the time, until July." NA-A and NA-B stated had been brought to the g management, but "they keep working on it." NA-A further facility's old lifts had a split taff could assist residents like m. She stated, "they worked sfer R43 to the bathroom empty, now since the new lifts dpan, but she is more | | continue to offer to transf per her care plan. All nursing staff have bee follow care sheets/care p and using equipment per Random audits will contin conducted on residents r mechanical lifts for toiletii designee. The results will the QAPI Committee for up. DNS will monitor | en re-educated to lan/toileting plan assessments. nue to be equiring ng by the DNS or I be forwarded to | | | | | |
| | 10/24/17, R43 state toilet but was resolv no longer take her having the right me "I used to be more wet, I don't like to b would be so much again." | with R43 at 2:33 p.m. on ed she would prefer to use the ved to the fact that staff could into the bathroom due to not echanical lift sling. R43 stated, continent, and was not always be wet." R43 also stated, "It better for me to use the toilet with NA-B on 10/24/17 at ated R43 uses the call light to | | | | | | | | |
| | request the bedpar came she was usus The retired mechar could sit someone | ated R43 uses the call light to and added, "when R43 first ally dry, with minor dribbling. nical lifts were made so you on the toilet, the sling was split oilet use." NA-B said R43 had | | | | | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED |
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| AME OF I | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| LAYTO | N REHABILITATION 8 | | DWOOD AVEN N, MN 56172 | UE SOUTH | | |
| X4) ID REFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLE DATE |
| 2 570 | Continued From pa | ige 4 | 2 570 | | | |
| | NA-B stated, "I wisl The problem with th reported to our sup it as far as I know." R43's diagnosis ide | h was uncomfortable then h we had our other lifts back. he lifts and slings has been ervisors, they are working on entified on the resident care 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, weaknes bearing status, dep inability to move lef frequent uncontrolle movements and ch indicated the reside able to request ass dependent with tran | ied to include multiple s, non-ambulatory, non weight endency with transfers, it leg and right shoulder, ed head, neck and left arm ronic pain. Further, the CAA ent was alert, oriented, and ist with toileting, but was nsfers on/off toilet using a was dependent with cleansing | | | | |
| | and clothing manages specific tests or references would proceed to c | gement. The CAA indicated no errals were planned, but they are plan risks associated with dribbling and incontinence. | | | | |
| | R43's quarterly Min 9/27/17, identified a continence. | imum Data Set (MDS) from a decline in urinary | | | | |
| | also reflected an in | ty's toileting documentation crease in urinary incontinence d replaced their mechanical | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE COM | E SURVEY PLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLE DATE |
| 2 570 | Continued From pa | age 5 | 2 570 | | | |
| | indicated R43 was urine beginning in i | frequently incontinent with mid July. | | | | |
| | 10/3/17, reflected F since 8/25/17, with medication. Interver with bedpan use an per lift. Dependent management. Offe a.m. rounds, provid In addition, the care urinary dribbling an The care plan had | are plan last updated on R43's increase in incontinence the initiation of a diuretic entions included: dependent and transfers on and off toilet with cleansing and clothing r bedpan on midnight and 4 le incontinence care if needed. e plan included: frequent and incontinence. | | | | |
| | day, or the inability | of staff to put the resident on lementation of the new | | | | |
| | Director of Nursing develop, review, ar procedures to ensu- updated and revise of Nursing Services all appropriate staff procedures. The D | THOD OF CORRECTION: The (DON) or designee could ind/or revise policies and are resident care plans are ed as appropriate. The Director is or designee could educate f on the policies and irector of Nursing Services or velop monitoring systems to mpliance. | | | | |
| | TIME PERIOD FOI Twenty-One (21) D | | | | | |
| 2 910 | MN Rule 4658.052 Incontinence | 5 Subp. 5 A.B Rehab - | 2 910 | | | 12/15/1 |
| | | nce. A nursing home must program of bowel and bladder | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ATE SURVEY |
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| NAME OF F | PROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, | STATE, ZIP CODE | |
| SLAYTO | N REHABILITATION & | | WOOD AVE , MN 56172 | NUE SOUTH | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | , ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
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| 2 910 | Continued From pa | ge 6 | 2 910 | | |
| | management to rec | luce incontinence and the | | | |
| | | f catheters. Based on the | | | |
| | comprehensive res | ident assessment, a nursing | | | |
| | home must ensure | | | | |
| | | ho enters a nursing home | | | |
| | | ng catheter is not catheterized 's clinical condition indicates | | | |
| | | was necessary; and | | | |
| | | no is incontinent of bladder | | | |
| | receives appropriat | e treatment and services to | | | |
| | | t infections and to restore as | | | |
| | | er function as possible. | | | |
| | This MN Requiremo | ent is not met as evidenced | | | |
| | | on, interview, and document | | It is the practice of Slayton Rehabilitation | ר |
| | | ailed to comprehensively | | and Healthcare Center to provide all | |
| | | e care to manage urinary | | residents with all needed accommodation | n |
| | | of 2 residents (R43) reviewed | | of needs and preferences. | |
| | 5 | ence. This caused harm for | | All residents utilizing a full body lift have | |
| | | line in urinary continence s implemented, and a new | | been reassessed and have proper sling Proper toileting sling for resident R43 wa | |
| | mechanical lift was | • | | obtained during survey on October 25, | U U |
| | | | | 2017 to provide the resident the | |
| | Findings include: | | | opportunity to use the bedpan or the toil | et |
| | - | | | per resident's choice. | |
| | | ty's toileting documentation | | Resident R43 is refusing to transfer to | |
| | | an increase in incontinence | | toilet utilizing the lift and sling. Staff will | |
| | | in July 2017 when the I lifts were replaced. | | continue to offer to transfer her to toilet per her care plan. | |
| | | ng documentation, R43 | | All nursing staff have been re-educated | to |
| | 5 | incontinent after 7/10/17. | | follow care sheets/care plan/toileting pla and using equipment per assessments. | |
| | During observation | on 10/24/17 at 1:25 p.m., R43 | | Random audits will continue to be | |
| | was watching telev | ision while seated in her ng was observed to be in | | conducted on residents requiring mechanical lifts for toileting by the DNS | or |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE COMPI | SURVEY LETED |
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| | | | A. BUILDING | : | | |
| | | 00915 | B. WING | | 10/2 | 6/2017 |
| IAME OF F | PROVIDER OR SUPPLIER | STREET AI | DRESS, CITY, | STATE, ZIP CODE | | |
| | N REHABILITATION 8 | A HEALTHCARE C | DWOOD AVE N, MN 56172 | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 | ION SHOULD BE | (X5) COMPLET DATE |
| IAG | | | IAG | DEFICIENC | | |
| 2 910 | Continued From pa | age 7 | 2 910 | | | |
| | 2:11 p.m. nursing a were observed to ta and transferred R4 wheelchair. Neither an opportunity for F stated staff offer R4 resident requests it nursing assistants a bathroom. NA-A sa mechanical lifts in a accessible for toilet to transfer her [R43 these lifts came in a the sling problem h attention of nursing telling us they are we explained that the f sling available so s R43 to the bathrood well, we could trans- toilet, so she could | buttocks in the wheelchair. At assistant (NA)-A and NA-B ake the resident to her room, 3 into bed from the r NA-A offered the bedpan or R43 to use the toilet. NA-A 43 the bedpan when the the NA-A further reported the are unable to get R43 into the aid the facility had gotten new July 2017 but no sling ting was available. "We used B] to the toilet all the time, until July." NA-A and NA-B stated ad been brought to the management, but "they keep working on it." NA-A further facility's old lifts had a split taff could assist residents like m. She stated, "they worked sfer R43 to the bathroom empty, now since the new lifts dpan, but she is more | | designee. The results wil the QAPI Committee for up. DNS will monitor | | |
| | 10/24/17, R43 state toilet but was resolv no longer take her having the right me "I used to be more wet, I don't like to b would be so much again." During an interview | with R43 at 2:33 p.m. on ed she would prefer to use the ved to the fact that staff could into the bathroom due to not echanical lift sling. R43 stated, continent, and was not always be wet." R43 also stated, "It better for me to use the toilet with NA-B on 10/24/17 at ated R43 uses the call light to | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | | A. BUILDING: | | | |
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| AME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | |
| LAYTO | N REHABILITATION 8 | LIFALTHCARE C | DWOOD AVEN N, MN 56172 | UE SOUTH | | |
| (X4) ID | | TEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF | | (X5) |
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| 2 910 | Continued From pa | age 8 | 2 910 | | | |
| | could sit someone and adaptable for t told her the bedpar NA-B stated, "I wisi The problem with th reported to our sup it as far as I know." R43's medical reco identified from the r updated 10/3/17 in Multiple sclerosis, o shoulder, low back depressive disorde Review of nursing r R43 required 2 stat to/from wheelchair, and to toilet. The no mechanical lift was transfers with 1-2 stat | ord was reviewed. Diagnoses resident care plan, last cluded: chronic pain, pain in left pain, osteoarthritis, and major r. notes dated 7/4/17 indicated ff assist with all transfers to bed, bed to wheel chair ote further indicated a utilized at all times for taff assist for toilet use. | | | | |
| | dated 7/9/17, indica bowel and had occ assessment further oriented and able to but was dependent | and bladder assessment ated R43 was continent of asional urinary dribbling. The r indicated R43 was alert, o request assist with toileting, t with transfers on and off the nical lift and staff assistance. | | | | |
| | assessment referent identified R43 as of than 7 episodes of | inimum data set (MDS), with nce date (ARD) 7/10/17, ccasionally incontinent (less incontinence in the look back ed R43 required total ff for toileting. | | | | |
| | The Care Area Ass | essment (CAA) dated 7/16/17, | | | | |

| | ota Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00915 | B. WING | | 10/ | 26/2017 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION 8 | HEALTHCARE C | DWOOD AVEN N, MN 56172 | UE SOUTH | | |
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| 2 910 | identified R43 as ha incontinence care p with toileting and or incontinence. Contr to include multiple non-ambulatory, no dependency with tr leg and right should head, neck and left pain. Further, the C alert, oriented, and toileting, but was de toilet using a mech- with cleansing and CAA indicated no s planned, but they w risks associated wir and incontinence. Review of the reside aware of increased extremities on 8/24 prescribed Lasix (a every day. A note f Lasix had later bee day due to ongoing lower extremities. Review of a bowel dated 9/26/17, indid bowel incontinence factors were identif constipation with so dependence with to assessment also in frequent urinary dri included: "Resident | aving triggered for a urinary olan related to dependence ccasional urinary ributing factors were identified sclerosis, weakness, on weight bearing status, ansfers, inability to move left der, frequent uncontrolled arm movements and chronic CAA indicated the resident was able to request assist with ependent with transfers on/off anical lift and was dependent clothing management. The pecific tests or referrals were vould proceed to care plan th occasional urinary dribbling lent's physician orders ent's physician had been made edema in R43's lower /17, and had subsequently diuretic) 20 milligrams (mg) from 9/11/17, indicated the n increased to 40 mg every edema in R43's bilateral and bladder assessment cated R43 had occasional episodes. Contributing ied as including a diagnosis of cheduled laxative therapy, and | | | | |

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| LAYTO | N REHABILITATION 8 | | DWOOD AVEN N, MN 56172 | UE SOUTH | | |
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| 2 910 | Continued From pa | age 10 | 2 910 | | | |
| | extremity edema. F able to request ass wakeful hours, but and transfers on ar Requires prompted bedpan placement R43's quarterly MD identified the reside declined and the re- incontinent (7 or mo | PS, with ARD date 9/27/17, ent's urinary continence had esident was now frequently ore episodes of urinary t least one episode of | | | | |
| | 10/3/17, indicated a since 8/25/17 with therapy. Interventic bedpan use and tra Dependent with cle management. Offer a.m. rounds, provid | are plan last updated on an increase in incontinence the initiation of diuretic ons included: dependent with ansfers on and off toilet per lift. eansing and clothing r bedpan on midnight and 4 le incontinence care if needed e plan included: frequent ad incontinence. | | | | |
| | (LPN)-A on 10/25/1 staff had been tran to the facility having confirmed not having | with licensed practical nurse 7 at 9:01 a.m., LPN-A verified sferring R43 to the toilet prior g purchased new lifts. LPN-A ng access to the split slings for nite problem that would need esidents like R43. | | | | |
| | (DON) on 10/25/17 confirmed she was the lift, and the fact | with the director of nursing at 9:14 a.m., the DON aware of the challenges with there were currently no lable for the current lifts. The | | | | |

| IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | SURVEY |
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| PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | STATE, ZIP CODE | | |
| N REHABILITATION 8 | & HEALTHCARE C | | | | |
| (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION SH | IOULD BE | (X5) COMPLET DATE |
| Continued From pa | age 11 | 2 910 | | | |
| corporate office to correct slings to ad residents who are to transferring from of further stated the a with discussion with | authorize purchasing the lapt to the toileting needs of totally dependent on staff for ne surface to another. She idministrator was also involved h the corporate office to obtair | 1 | | | |
| The DON could rev procedures related provide additional t designee could aud | view/revise policies and to bladder incontinence and training to staff. The DON or dit bladder assessments for | | | | |
| TIME PERIOD FOI (21) days. | R CORRECTION: Twenty-one | • | | | |
| | | 21015 | | | 12/15/1 |
| procedures and co | nditions must be maintained ir | ו | | | |
| by: Based on observat review, the facility f used for food prepa sanitary manner. T all 35 residents in t prepared in the kito | ion, interview and document failed to ensure equipment to aration was maintained in a his had the potential to affect he facility who received meals | 5 | and Healthcare Center to main preparation in a sanitary many Dietary Manager updated the schedule to include all areas of preparation. Corporate Dietitia Dietary Manager will provide a | ntain all food or. cleaning of food in and/ or in in-service | |
| | PROVIDER OR SUPPLIER N REHABILITATION & SUMMARY STA (EACH DEFICIENC REGULATORY OR L Continued From pa DON stated she has corporate office to correct slings to ad residents who are for transferring from of further stated the a with discussion wit approvals to purch for toileting. SUGGESTED MET The DON could rev procedures related provide additional for designee could aud changes in contien TIME PERIOD FOD (21) days. MN Rule 4658.061 Requirements- Sa Subp. 7. Sanitary procedures and co the operation of the times. This MN Requirem by: Based on observat review, the facility for used for food prepa- sanitary manner. T all 35 residents in t | D0915 PROVIDER OR SUPPLIER STREET A N REHABILITATION & HEALTHCARE C 2957 RE SLAYTO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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. MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- 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. | 00915 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S N REHABILITATION & HEALTHCARE C 2957 REDWOOD AVEI SLAYTON, MN 56172 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 11 2 910 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 incontinence and provide additional training to staff. The DON or designee could audit bladder assessments for changes in contience and educate staff. 21015 TIME PERIOD FOR CORRECTION: The DDF FOR CORRECTION: Twenty-one (21) days. 21015 MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi 21015 Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. 21015 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 maintain | A BULLING: 00915 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NREHABILITATION & HEALTHCARE C 2957 REDWOOD AVENUE SOUTH SLAYTON, NN 56172 SUMMARY STATEMENT OF DEPICIENCY (EACH OPERCIENCY MULE BE PRECIDENCIES (EACH OPERCIENCY MULE BE PRECIDENCIES (EACH OPERCIENCY MULE BE PRECIDENCY) ID PREFIX (EACH OPERCIENCY MULE COORE (EACH OPERCIENCY) Continued From page 11 2 910 DEFICIENCY) DON stated she had been working with the corporate office to authorize purchasing the 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. 2 910 SUGGESTED METHOD OF CORRECTION: The DON could review/revise policies and procedures related to bladder incontinence and procedures related to bladder incontinence and procedures and conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. 1t is the practice of Slayton Rei and Healthcare Center to main preparation in a sanitary mano sanitary manner. This had the potential to affect all 35 residents in the facility who received meals preparation in the kitchen. | Image: Note of the second se |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | | (X3) DATE S COMPL | |
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| | | 00915 | B. WING | | 10/2 | 6/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | STATE, ZIP CODE | | |
| LAYTO | N REHABILITATION & | HEALTHCARE C | DWOOD AVE N, MN 56172 | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 21015 | Continued From pa | ige 12 | 21015 | | | |
| | 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. | | | Random kitchen audits w Dietary Manager and Cou The Dietary Manager and attend QAPI meeting for recommendations with D quarterly. Dietary Manger is respon forwarded to QAPI Meetin recommendations. | porate Dietitian. Dietitian are to review and ietitian attending sible to | |
| | be covered with del coffee servers had around the serving 1/4 to 1/2 inch up fr | offee units were observed to bris. The spigot on one of the a thick brownish buildup edge of the spigot, extending rom the edge of the spigot. that the water builds up with | | | | |
| | observed to be coa The observation wa | er and knife holder rack were ted with a thick layer of dust. as confirmed by the DM who ts needed to be cleaned. | | | | |
| | to practice proper s equipment to preve illness, and to train use these technique The director of dinir | e dining services department anitation techniques for clean ent the outbreak of food borne Dining Service employees to | | | | |

| STATEMEN | ota Department of He NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00915 | B. WING | | 10/26/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | | WOOD AVEN , MN 56172 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETE DATE |
| 21015 | (A) Equipment food shall be clean to sig (C) Non food conta be kept free of an a residue and other of SUGGESTED MET dietary manager co policies and educat of the kitchen area. assigned and revie tasks are being cor sanitary dietary foo | - -contact surfaces and utensils ght and touch. ct surfaces of equipment shall ccumulation of dust, dirt, food | 21015 | | | |
| 21535 | Drug Usage; Gener Subpart 1. Genera must be free from u unnecessary drug i A. in excessive drug therapy; B. for excessiv C. without adea D. in the prese which indicate the o discontinued. In addition to the d in part 4658.1310, comply with provisi Guidelines for Code 42, section 483.25 State Operations M for Long-Term Care Department of Hea | al. A resident's drug regimen innecessary drugs. An s any drug when used: dose, including duplicate | 21535 | | | 12/15/17 |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E SURVEY |
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| | | 2957 RED | | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE C SLAYTON | , MN 56172 | 2 | |
| (X4) ID | | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | COMPLET DATE |
| | | | | DEFICIENCY) | |
| 21535 | Continued From pa | nge 14 | 21535 | | |
| | available through th | corporated by reference. It is ne Minitex interlibrary loan ite Law Library. It is not | | | |
| | subject to frequent | | | | |
| | This MN Requiremo | ent is not met as evidenced | | | |
| | | ion, interview and document | | It is the practice of Slayton rehabilitation | |
| | | ailed to ensure a gradual dose | | and Healthcare Center to use the least | |
| | | ipsychotic (Seroquel) was 5 residents (R21) reviewed for | | amount of psychotropic medication to provide minimal effective dose to all | |
| | unnecessary medic | | | residents prescribed psychotropic | |
| | anneocoodry medic | | | medication. | |
| | Findings include: | | | During survey, Resident R21's physician | |
| | R21's face sheet d | ated 10/26/17, listed active | | initiated reduction of Seroquel from 25mg 3x/day x 7 days down to 12.5mg daily x 7 | |
| | | g: restlessness and agitation, | | days then discontinue. | |
| | | tia without behavioral | | Since the reduction, the resident has bee | n |
| | | nant neoplasm of the bone, | | awake calling out most of the night with | |
| | and legal blindness | | | no non- pharmacological approaches | |
| | | | | relieving calling out. | |
| | | annual Minimum Data Set | | Resident complaints of pain have | |
| | | dated 10/6/17, indicated R21 | | increased since reduction. Discussion | |
| | | otic medications on a daily | | with resident's PCP (primary care | |
| | not been completed | al dose reduction (GDR) had | | provider) has resulted in adjusting of pair medications and resident continues to ca | |
| | | the antipsychotic had been | | out. | " |
| | | 7. Additionally, the MDS | | Discussions continue with resident's PCF | b |
| | | a Brief Interview for Mental | | who states it is a failed dose reduction. | , |
| | | e, indicating severe cognitive | | Seroquel 12.5mg was restarted on | |
| | | at no mood or behavioral | | 11/17/17 due to failed dose reduction tria | |
| | | served during the look back | | Resident will continue to be re-assessed | |
| | period. | | | by nursing staff and med committee. | |
| | | | | Nursing has been re-educated on | |
| | | ssessment (CAA) for | | behavioral symptom intervention and | |
| | | use dated 10/10/17, indicated | | documentation. | |
| | | chotic medications daily, and | | All residents on anti-psychotropic | |
| | inal stall should co | ntinue to monitor for | | medications will be reviewed by the | |

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| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE COMP | |
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| | | 00915 | B. WING | | 10/2 | 6/2017 |
| AME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| LAYTO | N REHABILITATION 8 | | | NUE SOUTH | | |
| | | SLAYIO | N, MN 56172 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLE DATE |
| 21535 | Continued From pa | age 15 | 21535 | | | |
| | monitor for any esc indicators, and mor effects directly relat med therapy. R21's most current identified a mood a of antipsychotic me resident exhibited in did not comprehene more confused, and calling out which wa goal of not exhibitin depression or beha identified included to resident enjoys, vis allowing a chance to concerns, monitori | rrent medication regime, calation of mood/behavior nitor for medication side ted to prescribed psychotropic care plan dated 10/25/17, and behavior problem with use edications, and that the ntermittent irritability when she d a situation or when she was d a behavior of frequent as disruptive to others. The ng indicators of acute aviors was listed. Interventions to encourage activities the sits with friends and family, to share feelings and ing for escalations in mood or us, and if behavioral concerns erve for causes. | | consulting pharmacist mo will be reviewed at the mo Committee for Minimum I regarding physician recor Any refusals of recomme followed up with the PCP be followed up with the PCP be followed up with the m The results will be forwar committee for review and Random audits will be co or Designee. DNS will monitor. | onthly Med Effective Dose mmendations. ndations will be . All refusals will nedical director. ded to the QAPI follow up. | |
| | the previous three in September 2017) re- calling out behavior time period, with see during the month of included statement tearfulness, hallucin others/calling out. resident to express comfort/support/rea and encourage resi of interest. R21's Medication A for October 2017, in | br observation flow sheets for months (July, August, and evealed she had exhibited rs a total of 13 days during this even of the episodes occurring f July 2017. Behaviors listed s of feeling depressed, nations and disruptive to Approaches included to allow feelings, offer assurance/validate feelings ident to participate in activities | | | | |

| | NT OF DEFICIENCIES | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | E SURVEY PLETED |
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| | | | A. BOILDING. | | | |
| | | 00915 | B. WING | | 10/ | 26/2017 |
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| AYTO | N REHABILITATION 8 | | DWOOD AVEN N, MN 56172 | UE SOUTH | | |
| X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF | | (X5) |
| RÉFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLE DATE |
| 21535 | Continued From pa | age 16 | 21535 | | | |
| | an original start date listed as 5/27/16. | | | | | |
| | included an entry re "Behavior team rev antidepressant and target mood/behav progress notes fror plan interventions f periods of calling o of crying and being to her impaired visi cancer dx (diagnos interventions are at recommendations a monitor. Noted has mets to the bone w between shoulders | antipsychotic medications, ior log from the past 30 days, in the past 30 days; and care for mood. Continues to have ut. Also noted to have periods angry at staff. Can be related ion or pain r/t (related to) sis). Non-pharmacological ttempted. No at this time. Will continue to s dx of breast cancer with <i>i</i> th 12 cancer markers and the pelvis." | | | | |
| | During observation 8:47 a.m. R21 was nursing assistant (I assisting R21 to the standing lift. At that spoke and that the from R21 included me, help me," whic need to use the toil R21 demonstrated | and interview on 10/25/17, at observed in her room with NA)-D. NA-D had just finished e toilet with the use of a t time, NA-D stated R21 rarely only behaviors she had noted the resident calling out, "help the was usually related to her let. During the observation no observable indicators of closed, and did not open them | | | | |

| | | ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| LAYTO | N REHABILITATION 8 | | DWOOD AVEN N, MN 56172 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21535 | Continued From pa | age 17 | 21535 | | | |
| | director of nursing dose reductions of however the physic dose. The DON pro- consultant recomm 6/22/17, which reco dosage be reviewe occasions, the physi "does better at curr However, their was justification indicati reduction or how/w further documented more detail regardi would be contraind During interview or stated R21 did not verbalized, but was needed to use the | 10/25/17, at 12:59 p.m. NA-C have any behaviors and rarely able to state when she bathroom. | | | | |
| | facility's consultant could certainly mak reduce R21's Sero facility should refer to the medical direc receptive to consid both herself and the | a 10/25/17, at 2:50 p.m. the pharmacist (CP) stated she are another recommendation to quel dosage, and felt the concerns with GDR attempts ctor if the physician was not ering one. The CP also stated e previous consultant icated a GDR for R21 was | | | | |
| | 9:52 a.m., the DON most recently been due to her persister | th the DON on 10/26/17 at I stated R21's Seroquel had increased about a year ago nt hollering for help in the N said more recently, within | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| LAYTO | N REHABILITATION 8 | | DWOOD AVEN N, MN 56172 | DE 500TH | | | |
| (X4) ID | | | ID | PROVIDER'S PLAN OF | | (X5) COMPLE | |
| PREFIX TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | THE APPROPRIATE | DATE | |
| 21535 | Continued From pa | age 18 | 21535 | | | | |
| | decline in her mobi Vicodin (a narcotic been increased in a The DON stated it I had cancerous turn shoulders and pelv had been working of more specific as to contraindicated how included their medi primary physicians During interview or medical doctor (ME physician, stated sl on the Seroquel be out, not knowing th she was blind. MD additional pain med GDR of her Seroqu some of her behavi pain-related. | wever, verified she had not cal director in speaking with about GDR reductions. 10/26/17, at 10:18 a.m. 0)-A, who was R21's primary ne had originally started R21 cause the resident was calling e time of day or night because -A verified that with the dication on board for R21, a iel would be appropriate as fors may have been Antipsychotic Medication Use | | | | | |
| | antipsychotic media treat specific condit indicated and effec physician and othe document informati behavior, mood, fur specific symptoms, others. SUGGESTED MET The director of nurs | residents will only receive cations when necessary to tions for which they are tive, and the attending r staff will gather and ion to clarify a resident's nction, medical condition, and risks to residents and THOD OF CORRECTION: sing or designee could audit those receiving antipsychotic | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---|---|-------------------------------|--|
| | | 00915 | B. WING | 10 | /26/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION 8 | & HEAI THCARE C | WOOD AVE I, MN 56172 | NUE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLET DATE | |
| 21535 | have been complet contraindicated. T work with the medi for declining any gr identifies why risks affected resident. of audits to the qua further follow up ar ongoing complianc TIME PERIOD FOI | ted unless clinically he director of nursing could cal director to ensure rationale radual dose reductions clearly outweigh the benefits for the The facility could report results ality assurance committee for nd recommendations to ensure | 21535 | | | |
| 21620 | (21) days. MN Rule 4658.134 Drugs used in the r in accordance with | nursing home must be labeled | 21620 | | 12/15/1 | |
| | by: Based on observat review, the facility f was identified on in for use, to determin residents (R5 & R5 failed to reconcile of daily as required by who received contr to ensure expired r from the emergence Findings include: During an observat licensed practical r east/south medicat insulin pens availab | ent is not met as evidenced ion, interview and document failed to ensure an open date issulin pens when first opened ne outdate for use for 2 of 4 i1) reviewed; the facility also controlled substances twice y facility policy for 17 residents rolled medications; and failed medications were removed by kit. | | 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 nurse 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 R 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 | s 9 | |

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| (EACH DEFICIENCY REGULATORY OR L ontinued From paramacy fill date of dicated the medic iter opening. A Hi ith a fill date of 10 when it had beer dicated the medic ays after opening. upposed to date in bened for use. Sh hen these pens h cknowledged staff | A HEALTHCARE C 2957 RED SLAYTON ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 20 of 8/30/17. The package insert cation was good for 28 days umalog insulin pen for R51 0/14/17 was also not dated as n opened. The package insert cation would be good for 28 . LPN-B verified the nurse was nsulin pens when they were ne verified she was unaware ad been opened and f would be unable to | B. WING DRESS, CITY, S WOOD AVE I, MN 56172 ID PREFIX TAG 21620 | STATE, ZIP CODE SNUE SOUTH PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 | /26/2017 (X5) COMPLE DATE |
|--|--|--|--|---|
| SUMMARY STA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From paramacy fill date of dicated the medic ith a fill date of 10 when it had beer dicated the medic ays after opening. A He dicated the medic ays after opening. upposed to date ir bened for use. Sh hen these pens h cknowledged staff etermine when the | A HEALTHCARE C STREET AD 2957 RED SLAYTON ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) SC IDENTIFYING INFORMATION) age 20 of 8/30/17. The package insert cation was good for 28 days umalog insulin pen for R51 0/14/17 was also not dated as n opened. The package insert cation would be good for 28 . LPN-B verified the nurse was nsulin pens when they were ne verified she was unaware ad been opened and f would be unable to Street to | DRESS, CITY, S DWOOD AVE I, MN 56172 ID PREFIX TAG 21620 | STATE, ZIP CODE SNUE SOUTH PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 | (X5) COMPLE DATE |
| SUMMARY STA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From paramacy fill date of dicated the medic ith a fill date of 10 when it had beer dicated the medic ays after opening. A He dicated the medic ays after opening. upposed to date ir bened for use. Sh hen these pens h cknowledged staff etermine when the | A HEALTHCARE C 2957 RED SLAYTON ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 20 of 8/30/17. The package insert cation was good for 28 days umalog insulin pen for R51 0/14/17 was also not dated as n opened. The package insert cation would be good for 28 . LPN-B verified the nurse was nsulin pens when they were ne verified she was unaware ad been opened and f would be unable to | ID PREFIX TAG 21620 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 | COMPLE DATE |
| SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From pa narmacy fill date of dicated the medic ith a fill date of 10 when it had beer dicated the medic ays after opening. upposed to date ir bened for use. Sh hen these pens h cknowledged staff etermine when the | A HEALTHCARE C SLAYTON TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) age 20 of 8/30/17. The package insert cation was good for 28 days umalog insulin pen for R51 0/14/17 was also not dated as n opened. The package insert cation would be good for 28 . LPN-B verified the nurse was nsulin pens when they were ne verified she was unaware ad been opened and f would be unable to | I, MN 56172 ID PREFIX TAG 21620 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 | COMPLE DATE |
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| (EACH DEFICIENCY REGULATORY OR L ontinued From paramacy fill date of dicated the medic iter opening. A Hi ith a fill date of 10 when it had beer dicated the medic ays after opening. upposed to date ir bened for use. Sh hen these pens h cknowledged staff etermine when the | A MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 20 of 8/30/17. The package insert cation was good for 28 days umalog insulin pen for R51 0/14/17 was also not dated as n opened. The package insert cation would be good for 28 . LPN-B verified the nurse was nsulin pens when they were ne verified she was unaware ad been opened and f would be unable to | PREFIX TAG 21620 | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 | COMPLE DATE |
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| | ese insulin pens should be | | 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 | |
| ontrolled substan 5 milligrams (mg) ay. The card ident 25 mg given PRN e remaining half of to the blister pack ad been administer ose. LPN-B state ould have been to nd record appropri | o destroy the other half tablet riately instead of taping a half | | DNS, ADNS or Licensed Designee. Results will be forwarded to the QAPI for review and recommendations. DNS will monitor | |
| ontrolled Substan dicated counts ha aily per facility pol o documentation 0/10, 10/3, 9/22, 9 '26, 4/17 and 4/13 | dees Count form with LPN-B, ad not been conducted twice icy: of evening shift counts: 10/17, 0/9, 9/5, 8/22, 5/24, 5/16, 5/1, 8/17. of either day or evening shift | | | |
| o b e o d ai 0//2 | uld have been to d record appropri- back into the m view of the facili ntrolled Substan- icated counts ha ly per facility pol documentation 10, 10/3, 9/22, 9 6, 4/17 and 4/13 documentation | se. LPN-B stated the appropriate procedure uld have been to destroy the other half tablet d record appropriately instead of taping a half back into the medication card. view of the facility's Shift Verification of ntrolled Substances Count form with LPN-B, icated counts had not been conducted twice ly per facility policy: documentation of evening shift counts: 10/17, 10, 10/3, 9/22, 9/9, 9/5, 8/22, 5/24, 5/16, 5/1, 6, 4/17 and 4/13/17. documentation of either day or evening shift unts: 10/27, 10/26, 5/3, 5/2, 4/22, 4/21 and 8/17. | uld have been to destroy the other half tablet d record appropriately instead of taping a half back into the medication card. view of the facility's Shift Verification of ntrolled Substances Count form with LPN-B, icated counts had not been conducted twice ly per facility policy: documentation of evening shift counts: 10/17, 10, 10/3, 9/22, 9/9, 9/5, 8/22, 5/24, 5/16, 5/1, 6, 4/17 and 4/13/17. documentation of either day or evening shift unts: 10/27, 10/26, 5/3, 5/2, 4/22, 4/21 and 8/17. | uld have been to destroy the other half tablet d record appropriately instead of taping a half back into the medication card. view of the facility's Shift Verification of ntrolled Substances Count form with LPN-B, icated counts had not been conducted twice ly per facility policy: documentation of evening shift counts: 10/17, 10, 10/3, 9/22, 9/9, 9/5, 8/22, 5/24, 5/16, 5/1, 6, 4/17 and 4/13/17. documentation of either day or evening shift unts: 10/27, 10/26, 5/3, 5/2, 4/22, 4/21 and |
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
|---|---|--|---------------------------|--|-----------------------------------|-------------------------|
| | | 00915 | B. WING | | 10/ | 26/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, ST | ATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION 8 | A HEALTHCARE C | DWOOD AVEN N, MN 56172 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21620 | Continued From pa | age 21 | 21620 | | | |
| E a v k e L v L v t t t t t t t t t t t t t t t t | at 2:15 p.m. the ref was noted to conta lorazepam 1 mg/ml expiration date of 9 LPN-B verified the would be outdated LPN-B further verifi routinely monitored on the kits; adding time the medicatior LPN-B reported that through the medicat monthly audits. During an interview the consultant phar responsible to ensu monitored for expir pharmacist stated s | tion with LPN-B on 10/24/17, rigerated E-kit (emergency kit) in two 1 milliliter (ml) vials of I with a manufacturer's 0/1/17 indicated on both vials. medications were expired and if needed in an emergency. ied the E-kits were not I for intact plastic locks located she had no idea when the last as were checked for outdates. at the pharmacy tech looks at the pharmacy tech looks at on 10/25/17 at 12:25 p.m., macist verified being ure the E-kit for the facility was ed medications. The she checked the E-kits idently missed the refrigerated a fluke." | | | | |
| | director of nursing pharmacist comes through the medica rooms. The DON f | on 10/24/17, at 2:45 p.m. the (DON) verified the consultant once a month and looks ation carts and the medication further verified monthly audits acility staff and the results off. | | | | |
| | Substances, indica controlled medicati indicating the nurse nurse going off dut together. The polic | ed policy, Controlled ted nursing staff must count ons at the end of each shift e coming on duty and the y must make the count y further directed staff to ort any discrepancies. | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E SURVEY PLETED | |
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| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION 8 | A HEALTHCARE C | OWOOD AVE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLET DATE | |
| 21620 | Continued From pa | age 22 | 21620 | | | |
| | The director of nurs develop and impler to ensure that all m stored properly. Ec all staff and monito developed to ensur | ETHOD FOR CORRECTION: sing (DON) or designee could ment policies and procedures redications are labeled and ducation could be provided to ring systems could be re ongoing compliance. The eported to the Quality tee. | | | | |
| 21810 | (21) days. MN St. Statute 144 | R CORRECTION: Twenty one | 21810 | | 12/15/1 | |
| | residents shall have medical and person needs. Appropriate care designed to en their highest level of functioning. This ri | ac.Bill of Rights riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means nable residents to achieve of physical and mental ght is limited where the bursable by public or private | 1 | | | |
| | by: Based on observat review, the facility f necessary to accor individual needs fo | ent is not met as evidenced ion, interview and document failed to provide equipment nmodate a resident's r toileting and to promote f 2 residents (R43) reviewed ry continence. | | 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. | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE COMPI | SURVEY LETED | |
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| | | 00915 | B. WING | | 10/2 | 10/26/2017 | |
| AME OF I | PROVIDER OR SUPPLIER | STREET ADI | ORESS, CITY, | STATE, ZIP CODE | | | |
| LAYTO | N REHABILITATION 8 | | WOOD AVE , MN 56172 | NUE SOUTH | | | |
| (X4) ID | SUMMARY STA | | | PROVIDER'S PLAN OF (| CORRECTION | (X5) | |
| TAG | | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | HE APPROPRIATE | COMPLE DATE | |
| 21810 | Continued From pa | age 23 | 21810 | | | | |
| 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 | | | 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. | | | |
| | | | | | | | |

| STATEMEN | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00915 | B. WING | | 10/26/2017 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | | WOOD AVEN I, MN 56172 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21810 | Continued From pa | ige 24 | 21810 | | | |
| | risks associated with occasional urinary dribbling and incontinence. | | | | | |
| | identified the reside declined and the re incontinent (7 or mo | S, with ARD date 9/27/17, ent's urinary continence had sident was now frequently ore episodes of urinary t least one episode of). | | | | |
| | 10/3/17, indicated a since 8/25/17 with t therapy. Interventio bedpan use and tra Dependent with clear management. Offer a.m. rounds, provid | re plan last updated on an increase in incontinence the initiation of diuretic ons included: dependent with ansfers on and off toilet per lift. ansing and clothing bedpan on midnight and 4 le incontinence care if needed. e plan included: frequent d incontinence. | | | | |
| | revealed R43's inco July when the mech replaced. The toilet | ty's toileting documentation ontinence had increased in hanical lifts had been ing documentation revealed the resident was frequently | | | | |
| | 8/16/17, did not ind | n visit notes dated 9/8/17 and icate whether or not the re of R43's increased | | | | |
| | indicated the reside aware of increased extremities on 8/24 prescribed Lasix (a | ent's physician orders ent's physician had been made edema in R43's lower /17, and had subsequently diuretic) 20 milligrams (mg) from 9/11/17, indicated the | | | | |

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|--|-----------------------------------|-------------------------|
| | | 00915 | B. WING | | 10/26/201 | |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| LAYTO | N REHABILITATION 8 | A HEALTHCARE C | DWOOD AVEN | UE SOUTH | | |
| | | SLAYTO | N, MN 56172 | | CORRECTION | ()(5) |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| | Continued From pa | age 25 | 21810 | | | |
| | Lasix had later been increased to 40 mg every day due to ongoing edema in R43's bilateral lower extremities. | | | | | |
| | R43 required 2 stat to/from wheelchair, and to toilet. The ne mechanical lift was | notes dated 7/4/17 indicated ff assist with all transfers to bed, bed to wheel chair ote further indicated a utilized at all times for taff assist for toilet use. | | | | |
| | dated 7/9/17, indica bowel and had occ assessment further oriented and able to but was dependent | and bladder assessment ated R43 was continent of asional urinary dribbling. The r indicated R43 was alert, o request assist with toileting, with transfers on and off the nical lift and staff assistance. | | | | |
| | dated 9/26/17, india bowel incontinence factors were identif constipation with so dependence with to assessment also in frequent urinary dri included: "Residen continence pattern scheduled diuretic extremity edema. F able to request ass wakeful hours, but and transfers on ar | dicated R43 experienced bbling and incontinence and t exhibited a decline in urinary after 8/25/17 initiation of therapy for treatment of lower Resident is alert and oriented, ist with toileting during dependent with bedpan use and off toilet per mechanical lift. I, scheduled toileting and | 1 | | | |
| | | on 10/24/17 at 1:25 p.m., R43 ision while seated in her | 3 | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00915 | B. WING | | 10/26/201 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | TATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION 8 | K HEALTHCARE C | WOOD AVEN , MN 56172 | UE SOUTH | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE | (X5) COMPLET DATE |
| 21810 | Continued From page 26 | | 21810 | | | |
| | place under R43's 2:11 p.m. nursing a were observed to ta and transferred R4 wheelchair. Neither or an opportunity to staff offer R43 the k requests it. NA-A fu assistants are unab bathroom, revealing lifts were obtained toileting was not aw her [R43] to the toil came in July." NA-A sling problem had k of nursing manage they are working on that the facility's old so staff could assiss bathroom. She staft could transfer R43 could empty, now s the bedpan but she During an interview 10/24/17, R43 state toilet but was resolin no longer take her mechanical lift sling felt safe during tran- because the staff a acknowledged, "I w not always wet, I de stated, "It would be the toilet again. During an interview | r NA offered R43 the bedpan o use the toilet. NA-A stated bedpan when the resident urther reported the nursing ole to get R43 into the g that when new mechanical in July 2017, a sling for vailable. "We used to transfer let all the time, until these lifts A and NA-B revealed that the been brought to the attention ment, but "they keep telling us n it." NA-A further explained d lifts had a split sling available st residents like R43 to the ted, "they worked well, we to the bathroom toilet, so she since the new lifts we give her e is more incontinent." | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | 00915 | B. WING | | 10/ | 10/26/2017 | |
| NAME OF | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | TATE, ZIP CODE | | • | |
| SLAYTO | N REHABILITATION 8 | & HEALTHCARE C | DWOOD AVEN N, MN 56172 | UE SOUTH | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| 21810 | request the bedpar came she was usus The retired mechar could sit someone and adaptable for t told her the bedpar NA-B stated, "I wisi The problem with th reported to our sup it as far as I know." During an interview (LPN)-A she reveal complaints and furt responsible for Mea ago. "I know they w bathroom then." LF did get new lifts and the staff had the sp a while we had to v ordering them." Du confirmed not havin toileting was a defin to be resolved. During an interview (DON) on 10/25/17 confirmed she was the lift, and the fact toileting slings avai DON stated she ha corporate office to a correct slings to ad residents who are t transferring from or further stated the a with discussion with | h. and added, "when R43 first ally dry, with minor dribbling. hical lifts were made so you on the toilet, the sling was split oilet use." NA-B said R43 had h was uncomfortable then h we had our other lifts back. he lifts and slings has been pervisors, they are working on | | | | | |

| | T OF DEFICIENCIES OF CORRECTION | Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | - (X3) DATE SURVEY COMPLETED - 10/26/2017 | |
|--------------|---|--|------------------|---|---|----------------|
| | | | A. BUILDING: | | | |
| | | 00915 | B. WING | | | |
| ME OF F | PROVIDER OR SUPPLIER | STREETAL | DDRESS, CITY, ST | ATE, ZIP CODE | | |
| | N REHABILITATION 8 | | | UE SOUTH | | |
| X4) ID | SUMMARY ST | | N, MN 56172 | PROVIDER'S PLAN OF | | (X5) |
| REFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | COMPLE DATE |
| 21810 | Continued From pa | age 28 | 21810 | | | |
| | R43 stated the faci proper sling so that again. R43 stated, able to use the toile bladder. Especially | v on 10/26/17 at 12:31 p.m., lity was going to rent the t she could use the toilet "this is wonderful, I want to be et and totally empty my y with the diuretic. The bedpar especially to use in bed, I do | | | | |
| | The director of nurs assessment to ens and preferences ar be periodically con implement the asse | THOD OF CORRECTION: ses' could conduct an ure residents toileting needs re assessed. An audit could ducted to ensure staff essed need. The results could quality assurance committee | | | | |
| | TIME PERIOD FOI (21) days. | R CORRECTION: Twenty-one | | | | |
| | | | | | | |
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| | epartment 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: 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Slayton Rehabilitation & Healthcare Center November 14, 2017 Page 2 the Suggested Method of Correction and the Time Period For Correction.

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

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

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

| DEPART | MENT OF HEALTH | AND HUMAN SERVICES | | | FORM APPROVED |
|--------------------------|--|--|---------------------|--|------------------------------|
| CENTER | RS FOR MEDICARE | & MEDICAID SERVICES | | | B NO. 0938-0391 |
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION (X | (3) DATE SURVEY COMPLETED |
| | | 245386 | B. WING | | 10/26/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| F 000 | INITIAL COMMENT | ſS | F 000 | | |
| | recertification surve surveyors from the Health (MDH) to de requirements at 42 requirements for Lo | , 25 and 26, 2017, a ey was completed by Minnesota Department of etermine compliance with CFR Part 483, subpart B, ong Term Care Facilities. | | | |
| | The facility's electronic Plan of C will serve as your allegation of co the Department's acceptance. B enrolled in ePOC, your signature at the bottom of the first page of form. Your electronic submission be used as verification of complia | | | | |
| F 246 SS=G | an on-site revisit of conducted to valida with the regulations accordance with yo REASONABLE AC | COMMODATION OF NCES | F 246 | | 12/15/17 |
| | | and Dignity. The resident has I with respect and dignity, | | | |
| | the facility with reas resident needs and do so would endan resident or other re This REQUIREMEN by: | eside and receive services in sonable accommodation of preferences except when to ger the health or safety of the sidents. NT is not met as evidenced tion, interview and document | | It is the practice of Slayton Rehabilit | ation |
| | | ailed to provide equipment | | and Healthcare Center to provide all | |
| LABORATORY | DIRECTOR'S OR PROVID | ER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | TITLE | (X6) DATE |
| Electron | ically 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.

PRINTED: 11/22/2017

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | | E SURVEY PLETED | |
|--------------------------|--|---|---------------------|--|---|---------------------------|--|
| | | 245386 | B. WING | | 10/2 | 10/26/2017 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CC 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | DE | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETIC DATE | |
| F 246 | necessary to accomindividual needs for continence, for 1 of for decline in urinar Findings include: R43's diagnoses ide plan last updated 1 Multiple sclerosis, of shoulder, low back depressive disorder Review of R43's MI completed 7/10/17 of 2 staff for toileting occasionally incontiand and off the toilet wite R43's admission mi assessment referent identified R43 as of than 7 episodes of period) and indicate assistance of 2 staff The Care Area Asses identified R43 as has incontinence care p with toileting and of incontinence. Contri to include multiple non-ambulatory, no dependency with tra- leg and right should head, neck and left pain. Further, the C | modate a resident's toileting and to promote 2 residents (R43) reviewed y continence. entified on the resident care 0/3/17, included: chronic pain, pain in left pain, osteoarthritis, and major r. DS admission assessment revealed R43 required assist g, was dry with trial toileting: inent; and was transferred on th staff assist. inimum data set (MDS), with nccasionally incontinent (less incontinence in the look back ed R43 required total f for toileting. essment (CAA) dated 7/16/17, aving triggered for a urinary olan related to dependence | F 24 | residents with all needed act of needs and preferences. All residents utilizing a full be been reassessed and have p Proper toileting sling for resi obtained during survey on O 2017 to provide the resident opportunity to use the bedpa per resident's choice. Resident R43 is refusing to t toilet utilizing the lift and slin continue to offer to transfer th per her care plan. All nursing staff have been re follow care sheets/care plan and using equipment per ass Random audits will continue conducted on residents require mechanical lifts for toileting I designee. The results will be the QAPI Committee for revi- up. DNS will monitor. | bdy lift have proper slings. dent R43 was ctober 25, the in or the toilet ransfer to g. Staff will her to toilet e-educated to (toileting plan sessments. to be iring by the DNS or forwarded to | | |

| | | AND HUMAN SERVICES | | | | FORM | : 11/22/2017 APPROVED 0938-0391 |
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| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | | E SURVEY PLETED |
| | | 245386 | B. WING | | | 10/2 | 26/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 246 | toileting, but was de toilet using a mecha with cleansing and CAA indicated no s planned, but they w risks associated wit and incontinence. R43's quarterly MD identified the reside declined and the re incontinent (7 or me incontinence, but a continence, but a continence voiding) Review of R43's ca 10/3/17, indicated a since 8/25/17 with t therapy. Intervention bedpan use and tra Dependent with cle management. Offer a.m. rounds, provid In addition, the care urinary dribbling an Review of the faciliti revealed R43's inco July when the mech replaced. The toilet that after July 10th incontinent of urine Review of physician 8/16/17, did not ind | ependent with transfers on/off anical lift and was dependent clothing management. The pecific tests or referrals were yould proceed to care plan th occasional urinary dribbling S, with ARD date 9/27/17, ent's urinary continence had sident was now frequently ore episodes of urinary t least one episode of b. re plan last updated on an increase in incontinence the initiation of diuretic ons included: dependent with ansing and clothing bedpan on midnight and 4 le incontinence care if needed. e plan included: frequent d incontinence. ty's toileting documentation pontinence had increased in nanical lifts had been ing documentation revealed the resident was frequently | F 2 | 446 | | | |

If continuation sheet Page 3 of 30

| TATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | TIPLE CONSTRUCTION | (X3) DA | 0. 0938-039 TE SURVEY MPLETED | |
|--------------------------|---|--|--------------------|--|------------------------------|-------------------------------------|--|
| | | 245386 | B. WING | | 10 | /26/2017 | |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP (2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | CODE | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE E APPROPRIATE | (X5) COMPLETIO DATE | |
| F 246 | Review of the reside aware of increased extremities on 8/24 prescribed Lasix (a every day. A note f Lasix had later bee day due to ongoing lower extremities. Review of nursing r R43 required 2 staf to/from wheelchair, and to toilet. The nor mechanical lift was transfers with 1-2 s Review of a bowel dated 7/9/17, indica bowel and had occa assessment further oriented and able to but was dependent toilet with a mechan Review of a bowel dated 9/26/17, indica bowel incontinence factors were identif constipation with so dependence with to assessment also in frequent urinary dri included: "Resident continence pattern scheduled diuretic f extremity edema. F | ent's physician orders ent's physician had been made edema in R43's lower /17, and had subsequently diuretic) 20 milligrams (mg) from 9/11/17, indicated the n increased to 40 mg every edema in R43's bilateral notes dated 7/4/17 indicated f assist with all transfers to bed, bed to wheel chair ote further indicated a utilized at all times for taff assist for toilet use. and bladder assessment ated R43 was continent of asional urinary dribbling. The indicated R43 was alert, o request assist with toileting, with transfers on and off the nical lift and staff assistance. and bladder assessment cated R43 had occasional episodes. Contributing ied as including a diagnosis of cheduled laxative therapy, and | F 2 | 246 | | | |

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| | OF DEFICIENCIES | & MEDICAID SERVICES | | TIPLE CONSTRUCTION | | TE SURVEY | | |
|--------------------------|--|--|---------------------|--|----------|---------------------------|--|--|
| ND PLAN C | FCORRECTION | IDENTIFICATION NUMBER: | A. BUILDI | NG | CO | MPLETED | | |
| | | 245386 | B. WING | | 10 | /26/2017 | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | E | | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETIO DATE | | |
| F 246 | | dependent with bedpan use | F 24 | 46 | | | | |
| | 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 | | | | | | | |
| | | | | | | | | |
| | assistants are unab bathroom, revealing lifts were obtained it toileting was not av her [R43] to the toil came in July." NA-A | In the reported the nursing ble to get R43 into the g that when new mechanical in July 2017, a sling for railable. "We used to transfer et all the time, until these lifts A and NA-B revealed that the been brought to the attention | | | | | | |
| | they are working or that the facility's old so staff could assis bathroom. She stat could transfer R43 could empty, now s | ment, but "they keep telling us in it." NA-A further explained d lifts had a split sling available t residents like R43 to the ed, "they worked well, we to the bathroom toilet, so she since the new lifts we give her e is more incontinent." | | | | | | |
| | 10/24/17, R43 state toilet but was resolv no longer take her i mechanical lift sling | with R43 at 2:33 p.m. on ed she would prefer to use the ved to the fact that staff could into the bathroom due to the g. R43 stated she has always usfers with the mechanical lift | | | | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 11/22/2017 APPROVED 0938-0391 |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | LE CONSTRUCTION | | E SURVEY PLETED |
| | | 245386 | B. WING | i | | 10/2 | 26/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 246 | because the staff a acknowledged, "I w not always wet, I do stated, "It would be the toilet again. During an interview 2:50 p.m., NA-B sta request the bedpan came she was usua The retired mechan could sit someone of and adaptable for to told her the bedpan NA-B stated, "I wish The problem with th reported to our sup it as far as I know." During an interview (LPN)-A she reveal complaints and furt responsible for Meo ago. "I know they w bathroom then." LP did get new lifts and the staff had the sp a while we had to w ordering them." Dur confirmed not havir toileting was a defir to be resolved. During an interview (DON) on 10/25/17 confirmed she was the lift, and the fact | - | F | 246 | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 11/22/2017 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | | E CONSTRUCTION | | E SURVEY PLETED |
| | | 245386 | B. WING | | | 10/: | 26/2017 |
| | PROVIDER OR SUPPLIER | HEALTHCARE CENTER | | | TREET ADDRESS, CITY, STATE, ZIP CODE 957 REDWOOD AVENUE SOUTH | | |
| OLAITO | | | 1 | S | SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 246 F 280 SS=D | DON stated she ha corporate office to a correct slings to ada residents who are to transferring from on further stated the ad with discussion with approvals to purch for toileting. During an interview R43 stated the facil proper sling so that again. R43 stated, ' able to use the toile bladder. Especially is not comfortable en not like it." RIGHT TO PARTIC CARE-REVISE CP CFR(s): 483.10(c)(2 483.10 (c)(2) The right to p and implementation plan of care, includi (i) The right to partie to be included in the to request meetings revisions to the person amount, frequency, | d been working with the authorize purchasing the apt to the toileting needs of otally dependent on staff for ne surface to another. She dministrator was also involved in the corporate office to obtain ase lift slings that would work on 10/26/17 at 12:31 p.m., ity was going to rent the she could use the toilet 'this is wonderful, I want to be at and totally empty my with the diuretic. The bedpan especially to use in bed, I do | | 2246 | | | 12/15/17 |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | 11/22/2017 APPROVED 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DAT | E SURVEY PLETED |
| | | 245386 | B. WING | | 10/2 | 26/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 280 | Continued From pa | ge 7 | F 280 | D | | |
| | (iv) The right to reco included in the plan | eive the services and/or items of care. | | | | |
| | | the care plan, including the gnificant changes to the plan | | | | |
| | right to participate i | nall inform the resident of the n his or her treatment and sident in this right. The nust | | | | |
| | (i) Facilitate the incl resident representa | lusion of the resident and/or tive. | | | | |
| | (ii) Include an asses strengths and need | ssment of the resident's s. | | | | |
| | | resident's personal and s in developing goals of care. | | | | |
| | 483.21 (b) Comprehensive | Care Plans | | | | |
| | (2) A comprehensiv | e care plan must be- | | | | |
| | (i) Developed withir the comprehensive | n 7 days after completion of assessment. | | | | |
| | (ii) Prepared by an includes but is not l | interdisciplinary team, that imited to | | | | |
| | (A) The attending p | hysician. | | | | |
| | (B) A registered nur resident. | rse with responsibility for the | | | | |

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| | | AND HUMAN SERVICES | | | FORM | 11/22/2017 APPROVED 0938-0391 | | |
|--------------------------|---|---|---|---|--|-------------------------------------|--|--|
| STATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE | E SURVEY PLETED | | |
| | | 245386 | B. WING | | 10/2 | 26/2017 | | |
| - | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE | | |
| F 280 | resident. (D) A member of fo (E) To the extent pr the resident and the An explanation mus- medical record if th and their resident r not practicable for the resident's care plane (F) Other appropriate disciplines as deternor as requested by (iii) Reviewed and re- team after each assist comprehensive and assessments. This REQUIREMENT by: Based on observations review, the facility for 1 of 2 residents assistance to mana Findings include: During observations was watching televy wheelchair. A full lift place under R43's 2:11 p.m. nursing a were observed to ta and transferred R4 | th responsibility for the od and nutrition services staff. racticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined the development of the n. the staff or professionals in rmined by the resident's needs the resident. revised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced tion, interview and document failed to revise the plan of care (R43) reviewed who required age urinary incontinence. on 10/24/17 at 1:25 p.m., R43 ision while seated in her it sling was observed to be in buttocks in the wheelchair. At issistant (NA)-A and NA-B ake the resident to her room, | F 280 | This is a rollover tag from F246 It is the practice of Slayton Rehabilit and Healthcare Center to provide al residents with all needed accommo of needs and preferences. All residents utilizing a full body lift f been reassessed and have proper s Proper toileting sling for resident R4 obtained during survey on October 2017 to provide the resident the opportunity to use the bedpan or the per resident's choice. Resident R43 is refusing to transfer toilet utilizing the lift and sling. Staff continue to offer to transfer her to to | II dation nave slings. 13 was 25, e toilet to will | | | |

Facility ID: 00915

If continuation sheet Page 9 of 30

| TATEMEN | OF DEFICIENCIES | K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | TIPLE CONSTRUCTION | | E SURVEY PLETED |
|--------------------------|---|--|--------------------|--|--|---------------------------|
| | SI CORRECTION | IDENTIFICATION NONIDER. | A. BUILD | ING | COM | FLLILD |
| | | 245386 | B. WING | | | 26/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION 8 | HEALTHCARE CENTER | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETIC DATE |
| F 280 | an opportunity for F stated staff offer R4 resident requests it nursing assistants a bathroom. NA-A sa mechanical lifts in a accessible for toilet to transfer her [R43 these lifts came in a the sling problem h attention of nursing telling us they are w explained that the f sling available so s R43 to the bathroot well, we could trans toilet, so she could we give her the bed incontinent." During an interview 10/24/17, R43 state toilet but was resolv no longer take her having the right me "I used to be more wet, I don't like to b would be so much again." During an interview 2:50 p.m., NA-B sta request the bedpar came she was usu | A43 to use the toilet. NA-A 43 the bedpan when the 5. NA-A further reported the are unable to get R43 into the aid the facility had gotten new July 2017 but no sling ting was available. "We used B] to the toilet all the time, until July." NA-A and NA-B stated ad been brought to the management, but "they keep working on it." NA-A further facility's old lifts had a split taff could assist residents like m. She stated, "they worked sfer R43 to the bathroom empty, now since the new lifts dpan, but she is more with R43 at 2:33 p.m. on ed she would prefer to use the wed to the fact that staff could into the bathroom due to not echanical lift sling. R43 stated, continent, and was not always be wet." R43 also stated, "It better for me to use the toilet with NA-B on 10/24/17 at ated R43 uses the call light to n and added, "when R43 first ally dry, with minor dribbling. nical lifts were made so you on the toilet, the sling was split oilet use." NA-B said R43 had | F 2 | | vileting plan ssments. b be ng the DNS or prwarded to | |

| | | AND HUMAN SERVICES | | | | FORM | 11/22/2017 APPROVED 0938-0391 |
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| STATEMEN | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | | E SURVEY PLETED |
| | | 245386 | B. WING | | | 10/2 | 26/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | · I | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 280 | NA-B stated, "I wish The problem with the reported to our sup it as far as I know." R43's diagnosis ide plan, last updated of Multiple sclerosis, of shoulder, low back depressive disorde A Care Area Assess identified R43 as re- care plan related to and occasional urin factors were identifing sclerosis, weakness bearing status, dep inability to move lefe frequent uncontroller movements and che indicated the resider able to request assist dependent with trans mechanical lift and and clothing manages specific tests or refer would proceed to co occasional urinary of R43's quarterly Min 9/27/17, identified a continence. Review of the facilitit also reflected an in- since the facility ha | h we had our other lifts back. he lifts and slings has been ervisors, they are working on entified on the resident care on 10/3/17, identified: chronic pain, pain in left pain, osteoarthritis, and major r. sment (CAA) dated 7/16/17, equiring a urinary incontinence o dependence with toileting hary incontinence. Contributing ied to include multiple s, non-ambulatory, non weight endency with transfers, t leg and right shoulder, ed head, neck and left arm ronic pain. Further, the CAA ent was alert, oriented, and ist with toileting, but was nsfers on/off toilet using a was dependent with cleansing gement. The CAA indicated no errals were planned, but they are plan risks associated with dribbling and incontinence. | F 2 | 80 | | | |

If continuation sheet Page 11 of 30

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED NAME OF PROVIDER OR SUPPLIER 245386 B. WING 10/26/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | | AND HUMAN SERVICES | | | | FORM | : 11/22/2017 APPROVED 0938-0391 |
|---|-----------|---|---|---------|----|---|----------|---------------------------------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SI AYTON REHABILITATION & HEALTHCARE CENTER 2957 REDWOOD AVENUE SOUTH | STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | • • | | LE CONSTRUCTION | (X3) DAT | E SURVEY |
| SLAYTON REHABILITATION & HEALTHCARE CENTER 2957 REDWOOD AVENUE SOUTH | | | 245386 | B. WING | ÷ | | 10/: | 26/2017 |
| SLAYTON REHABILITATION & HEALTHCARE CENTER | NAME OF I | PROVIDER OR SUPPLIER | | | | | | |
| | SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | | | |
| | PREFIX | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | PREF | IX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | BE | (X5) COMPLETION DATE |
| F 280 Continued From page 11 indicated R43 was frequently incontinent with uine beginning in mid July. F 280 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. F 315 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 315 F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) F 315 (e) Incontinence. F 315 (f) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence. F 315 (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 indvelling catheter is not catheterized unless the resident's clinical condition demonstrates that | F 315 | indicated R43 was urine beginning in r Review of R43's ca 10/3/17, reflected F since 8/25/17, with medication. Interve with bedpan use ar per lift. Dependent management. Offer a.m. rounds, provid In addition, the care urinary dribbling an The care plan had routine use of the b day, or the inability the toilet since impl mechanical lift. NO CATHETER, Pl BLADDER CFR(s): 483.25(e)((e) Incontinence. (1) The facility mus continent of bladde receives services a continence unless f or becomes such th to maintain. (2)For a resident wo on the resident's co facility must ensure (i) A resident who e indwelling catheter | re plan last updated on R43's increase in incontinence the initiation of a diuretic ntions included: dependent ad transfers on and off toilet with cleansing and clothing bedpan on midnight and 4 e incontinence care if needed. e plan included: frequent d incontinence. not been revised to reflect the edpan during all hours of the of staff to put the resident on ementation of the new REVENT UTI, RESTORE 1)-(3) t ensure that resident who is r and bowel on admission nd assistance to maintain his or her clinical condition is hat continence is not possible th urinary incontinence, based omprehensive assessment, the that- nters the facility without an is not catheterized unless the | | | | | 12/15/17 |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 11/22/2017 APPROVED 0938-0391 |
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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION (| | E SURVEY PLETED |
| | | 245386 | B. WING | | | 10/2 | 26/2017 |
| NAME OF F | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ЗE | (X5) COMPLETION DATE |
| F 315 | Continued From pa catheterization was | • | F: | 315 | | | |
| | indwelling catheter is assessed for rem as possible unless | enters the facility with an or subsequently receives one loval of the catheter as soon the resident's clinical ates that catheterization is | | | | | |
| | receives appropriat | is incontinent of bladder e treatment and services to t infections and to restore xtent possible. | | | | | |
| | on the resident's co facility must ensure incontinent of bowe treatment and servi normal bowel function | with fecal incontinence, based omprehensive assessment, the that a resident who is al receives appropriate ces to restore as much ion as possible. NT is not met as evidenced | | | | | |
| | Based on observat review, the facility fa assess and provide incontinence for 1 c for urinary incontine R43 who had a dec | tion, interview, and document ailed to comprehensively care to manage urinary of 2 residents (R43) reviewed ence. This caused harm for line in urinary continence s implemented, and a new instituted. | | | This is a rollover tag from F246 and It is the practice of Slayton Rehabilit and Healthcare Center to provide al residents with all needed accommod of needs and preferences. All residents utilizing a full body lift h been reassessed and have proper so Proper toileting sling for resident R4 obtained during survey on October 2 | tation I dation nave slings. I3 was | |
| | revealed R43 had a episodes beginning facility's mechanica | y's toileting documentation an increase in incontinence in July 2017 when the I lifts were replaced. ng documentation, R43 | | | 2017 to provide the resident the opportunity to use the bedpan or the per resident's choice. Resident R43 is refusing to transfer toilet utilizing the lift and sling. Staff continue to offer to transfer her to to per her care plan. | e toilet to will | |

Facility ID: 00915

| | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPLE | | | 0938-039 |
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| | FCORRECTION | IDENTIFICATION NUMBER: | . , | | | | PLETED |
| | | 245386 | B. WING _ | | | 10/2 | 26/2017 |
| IAME OF F | PROVIDER OR SUPPLIER | | | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION 8 | HEALTHCARE CENTER | | | 57 REDWOOD AVENUE SOUTH LAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETIC DATE |
| F 315 | Continued From pa | ige 13 | F 3 ⁻ | 15 | | | |
| | became frequently | incontinent after 7/10/17. | | | All nursing staff have been re-educ | | |
| | During chaoniction | $an \frac{10}{24}$ | | | follow care sheets/care plan/toiletin | | |
| | | on 10/24/17 at 1:25 p.m., R43 ision while seated in her | | | and using equipment per assessm Random audits will continue to be | ents. | |
| | | ng was observed to be in | | | conducted on residents requiring | | |
| | | buttocks in the wheelchair. At | | | mechanical lifts for toileting by the | | |
| | | ssistant (NA)-A and NA-B ake the resident to her room, | | | designee. The results will be forwat the QAPI Committee for review an | | |
| | and transferred R4 | | | | up. DNS will monitor. | u lollow | |
| | | NA-A offered the bedpan or | | | -p | | |
| | | R43 to use the toilet. NA-A | | | | | |
| | | 13 the bedpan when the | | | | | |
| | | . NA-A further reported the are unable to get R43 into the | | | | | |
| | | aid the facility had gotten new | | | | | |
| | | July 2017 but no sling | | | | | |
| | | ing was available. "We used | | | | | |
| | | B] to the toilet all the time, until | | | | | |
| | | July." NA-A and NA-B stated ad been brought to the | | | | | |
| | | management, but "they keep | | | | | |
| | | vorking on it." NA-A further | | | | | |
| | | acility's old lifts had a split | | | | | |
| | | taff could assist residents like m. She stated, "they worked | | | | | |
| | | sfer R43 to the bathroom | | | | | |
| | | empty, now since the new lifts | | | | | |
| | | lpan, but she is more | | | | | |
| | incontinent." | | | | | | |
| | During an interview | with R43 at 2:33 p.m. on | | | | | |
| | 10/24/17, R43 state | ed she would prefer to use the | | | | | |
| | | ved to the fact that staff could | | | | | |
| | 5 | into the bathroom due to not | | | | | |
| | | chanical lift sling. R43 stated, continent, and was not always | | | | | |
| | | | | | | | |
| | | e wet." R43 also stated, "It | | | | | |

| CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09 | 938-0391 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE S COMPLI | SURVEY |
| 245386 B. WING 10/26 | 6/2017 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | |
| SLAYTON REHABILITATION & HEALTHCARE CENTER 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE O TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE O | (X5) COMPLETION DATE |
| F 315 Continued From page 14 F 315 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 | |

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | | E SURVEY PLETED |
| | | 245386 | B. WING | i | | 10/2 | 26/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 315 | assessment referer identified R43 as of than 7 episodes of period) and indicate assistance of 2 staf The Care Area Assi- identified R43 as ha- incontinence care p with toileting and of incontinence. Contr to include multiple non-ambulatory, no dependency with tra- leg and right should head, neck and left pain. Further, the C alert, oriented, and toileting, but was de toilet using a mecha- with cleansing and CAA indicated no s planned, but they w risks associated wit and incontinence. Review of the reside aware of increased extremities on 8/24, prescribed Lasix (a every day. A note f Lasix had later bee day due to ongoing lower extremities. Review of a bowel a | here date (ARD) 7/10/17, ccasionally incontinent (less incontinence in the look back ed R43 required total if for toileting. essment (CAA) dated 7/16/17, aving triggered for a urinary blan related to dependence | F | 315 | | | |

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| | | AND HUMAN SERVICES | | | | FORM | 11/22/2017 APPROVED 0938-0391 |
|--------------------------|---|--|---------------------|----|---|------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | E CONSTRUCTION | | E SURVEY PLETED |
| | | 245386 | B. WING | | | 10/2 | 26/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 315 | bowel incontinence factors were identif constipation with so dependence with to assessment also in frequent urinary dri included: "Resident continence pattern scheduled diuretic extremity edema. F able to request ass wakeful hours, but and transfers on an Requires prompted bedpan placement R43's quarterly MD identified the reside declined and the re- incontinence, but a continence, but a continence voiding) Review of R43's ca 10/3/17, indicated a since 8/25/17 with t therapy. Interventio bedpan use and tra Dependent with cle- management. Offer a.m. rounds, provid In addition, the care urinary dribbling an During an interview (LPN)-A on 10/25/1 staff had been trans | episodes. Contributing ied as including a diagnosis of cheduled laxative therapy, and bileting needs. The dicated R43 experienced bbling and incontinence and t exhibited a decline in urinary after 8/25/17 initiation of therapy for treatment of lower Resident is alert and oriented, ist with toileting during dependent with bedpan use ad off toilet per mechanical lift. , scheduled toileting and at night." S, with ARD date 9/27/17, ent's urinary continence had sident was now frequently ore episodes of urinary t least one episode of re plan last updated on an increase in incontinence the initiation of diuretic ins included: dependent with insfers on and off toilet per lift. ansing and clothing bedpan on midnight and 4 ie incontinence care if needed. e plan included: frequent | F 3 | 15 | | | |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | : 11/22/2017 APPROVED 0938-0391 |
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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | E SURVEY PLETED |
| | | 245386 | B. WING | | | 10/2 | 26/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 315 F 329 SS=D | confirmed not havin toileting was a defin to be resolved for re During an interview (DON) on 10/25/17 confirmed she was the lift, and the fact toileting slings avail DON stated she ha corporate office to a correct slings to ada residents who are to transferring from or further stated the ac with discussion with approvals to purch for toileting. DRUG REGIMEN IS UNNECESSARY D CFR(s): 483.45(d)(of 483.45(d) Unnecess Each resident's dru unnecessary drugs drug when used (1) In excessive do therapy); or (2) For excessive d (3) Without adequa (4) Without adequa | ing access to the split slings for nite problem that would need esidents like R43. with the director of nursing at 9:14 a.m., the DON aware of the challenges with there were currently no able for the current lifts. The d been working with the authorize purchasing the apt to the toileting needs of otally dependent on staff for ne surface to another. She dministrator was also involved in the corporate office to obtain ase lift slings that would work S FREE FROM RUGS e)(1)-(2) sary Drugs-General. g regimen must be free from . An unnecessary drug is any se (including duplicate drug uration; or | | 315 | | | 12/15/17 |

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| | | AND HUMAN SERVICES | | F | NTED: 11/22/2017 ORM APPROVED NO. 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | 3) DATE SURVEY COMPLETED |
| | | 245386 | B. WING | | 10/26/2017 |
| _ | PROVIDER OR SUPPLIER | HEALTHCARE CENTER | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | 10/20/2011 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | |
| F 329 | paragraphs (d)(1) the second second | ns of the reasons stated in hrough (5) of this section. opic Drugs. ehensive assessment of a must ensure that have not used psychotropic these drugs unless the ssary to treat a specific osed and documented in the use psychotropic drugs se reductions, and behavioral se clinically contraindicated, in nue these drugs; NT is not met as evidenced tion, interview and document ailed to ensure a gradual dose psychotic (Seroquel) was 5 residents (R21) reviewed for cation use. | F 329 | It is the practice of Slayton rehabilitat and Healthcare Center to use the leas amount of psychotropic medication to provide minimal effective dose to all residents prescribed psychotropic medication. During survey, Resident R21's physic initiated reduction of Seroquel from 25 3x/day x 7 days down to 12.5mg daily days then discontinue. Since the reduction, the resident has been awake calling out most of the ni with no non- pharmacological approa- relieving calling out. Resident complaints of pain have | st sian 5mg ⁄ x 7 ght |

Facility ID: 00915

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL | TIPLE CONSTRUCTION | | |
|--------------------------|--|--|--------------------|--|---|---------------------------|
| ND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILD | ING | CON | PLETED |
| | | 245386 | B. WING | | 10/ | 26/2017 |
| IAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | ODE | |
| SLAYTO | N REHABILITATION 8 | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | N SHOULD BE | (X5) COMPLETIO DATE |
| F 329 | 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 | F 329 increased since reduction. Discuss with resident's PCP (primary care provider) has resulted in adjusting medications and resident continue out. Discussions continue with resider who states it is a failed dose reduc Seroquel 12.5mg was restarted of 11/17/17 due to failed dose reduc Resident will continue to be re-ast by nursing staff and med committe Nursing has been re-educated on behavioral symptom intervention a documentation. All residents on anti-psychotropic medications will be reviewed by th consulting pharmacist monthly. Re will be reviewed at the monthly Me Committee for Minimum Effective regarding physician recommenda | | | | |
| | identified a mood a of antipsychotic me resident exhibited i did not comprehen- more confused, an calling out which w goal of not exhibitir depression or beha identified included resident enjoys, vis allowing a chance f concerns, monitor | care plan dated 10/25/17, and behavior problem with use edications, and that the ntermittent irritability when she d a situation or when she was d a behavior of frequent as disruptive to others. The ng indicators of acute aviors was listed. Interventions to encourage activities the sits with friends and family, to share feelings and ing for escalations in mood or is, and if behavioral concerns erve for causes. | | Any refusals of recommend followed up with the PCP. <i>A</i> be followed up with the me The results will be forwarde committee for review and for Random audits will be cond or Designee. DNS will monitor. | All refusals will dical director. ed to the QAPI ollow up. | |

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| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | LE CONSTRUCTION | | E SURVEY PLETED |
| | | 245386 | B. WING | i | | 10/: | 26/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 329 | R21's daily behavior the previous three in September 2017) ro- calling out behavior time period, with see during the month of included statement tearfulness, hallucin others/calling out. resident to express comfort/support/rea and encourage resid of interest. R21's Medication A for October 2017, in Seroquel 25 milligra an original start dat R21's nursing prog included an entry re "Behavior team rev antidepressant and target mood/behavior progress notes from plan interventions for periods of calling of of crying and being to her impaired visit cancer dx (diagnos interventions are at recommendations a monitor. Noted has mets to the bone w between shoulders During observation | dministration Record (MAR) ndicated she had received ams three times per day, with e listed as 5/27/16. | F | 329 | | | |

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| | | AND HUMAN SERVICES | | | | FORM | : 11/22/2017 APPROVED 0938-0391 |
|--------------------------|---|--|-------------------|-----|--|----------|---------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | (X3) DAT | E SURVEY PLETED |
| | | 245386 | B. WING | i | | 10/ | 26/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 329 | Continued From pa room, with the light | - | F | 329 | 9 | | |
| | During observation 8:47 a.m. R21 was nursing assistant (N assisting R21 to the standing lift. At that spoke and that the from R21 included me, help me," which need to use the toil R21 demonstrated pain, had her eyes when spoken to. During observation R21 was seated in her eyes closed, an During interview on director of nursing (dose reductions of however the physic dose. The DON pro- consultant recomm 6/22/17, which reco dosage be reviewed occasions, the physic "does better at curr However, their was justification indicatii reduction or how/wi further documented more detail regardin would be contraind | and interview on 10/25/17, at observed in her room with VA)-D. NA-D had just finished a toilet with the use of a time, NA-D stated R21 rarely only behaviors she had noted the resident calling out, "help h was usually related to her et. During the observation no observable indicators of closed, and did not open them on 10/26/17, at 10:23 a.m. a recliner in her room, with ad was non verbal. 10/25/17, at 9:30 a.m. the DON) stated they had tried R21's Seroquel in the past, ian had refused to reduce the ovided copies of pharmacy endations from 12/13/16 and ommended the medication d for reduction. On both sician response indicated R21 ent dose, do not decrease." no documented physician ng evidence of attempted hy it had failed. There was no d rationale provided with any ng why a dose reduction | | | | | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | : 11/22/2017 APPROVED 0938-0391 |
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| | | 245386 | B. WING | ; | | 10/ | 26/2017 |
| | PROVIDER OR SUPPLIER | HEALTHCARE CENTER | | : | STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 329 | needed to use the k During interview on facility's consultant could certainly mak reduce R21's Seroo facility should refer to the medical direct receptive to conside both herself and the pharmacist had indi- warranted. During interview wit 9:52 a.m., the DON most recently been due to her persister afternoon. The DON the last six months, decline in her mobil Vicodin (a narcotic been increased in J The DON stated it h had cancerous tum shoulders and pelvi had been working of more specific as to contraindicated how included their media primary physicians During interview on medical doctor (MD physician, stated sh on the Seroquel be- out, not knowing the | able to state when she pathroom. 10/25/17, at 2:50 p.m. the pharmacist (CP) stated she e another recommendation to quel dosage, and felt the concerns with GDR attempts stor if the physician was not ering one. The CP also stated e previous consultant icated a GDR for R21 was the the DON on 10/26/17 at stated R21's Seroquel had increased about a year ago of hollering for help in the N said more recently, within R21 had experienced a ity and had been started on pain medication) which had huly 2017 for pain symptoms. nad been discovered that R43 ors of the bone between her is. The DON also stated they on getting physicians to be | F | 329 | | | |

If continuation sheet Page 23 of 30

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 11/22/2017 APPROVED 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | (X3) DAT | E SURVEY PLETED |
| | | 245386 | B. WING | i | | 10/2 | 26/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 329 F 371 SS=F | additional pain med GDR of her Seroqu some of her behavi pain-related. The facility's policy undated, indicated antipsychotic medic treat specific condit indicated and effect physician and other document informati behavior, mood, fur specific symptoms, others. FOOD PROCURE, SANITARY CFR(s): 483.60(i)(1 (i)(1) - Procure food considered satisfact authorities. (i) This may include from local producer and local laws or re (ii) This provision de facilities from using gardens, subject to safe growing and for (iii) This provision de from consuming food facility. (i)(2) - Store, prepa | Antipsychotic Medication Use residents will only receive cations when necessary to ions for which they are tive, and the attending r staff will gather and on to clarify a resident's notion, medical condition, and risks to residents and STORE/PREPARE/SERVE -)-(3) If from sources approved or tory by federal, state or local | | 329 | | | 12/15/17 |

If continuation sheet Page 24 of 30

| TATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | (X3) DATE | 0938-039 E SURVEY PLETED |
|--------------------------|---|--|---|--|---|--------------------------------|
| | | 245386 | B. WING | | 10/: | 26/2017 |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | 10/20/2017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETIC DATE |
| F 371 | Continued From pa service safety. | ige 24 | F 37 | 1 | | |
| | foods brought to revisitors to ensure schandling, and cons This REQUIREMEND by: Based on observatoreview, the facility fused for food preparatives anitary manner. The standard for the kitch of the second for the kitch of the second for the kitch of the second for the second f | NT is not met as evidenced tion, interview and document ailed to ensure equipment to aration was maintained in a his had the potential to affect he facility who received meals then. chen tour with the dietary 10/23/17 at 3:03 p.m., the problems were noted and | | It is the practice of Slayton Reha and Healthcare Center to mainta food preparation in a sanitary ma Dietary Manager updated the cle schedule to include all areas of fo preparation. Corporate Dietitian a Dietary Manager will provide an it to the dietary team with education Random kitchen audits will be do the Dietary Manager and Corpora Dietitian. The Dietary Manager a Dietitian are to attend QAPI meet review and recommendations with Dietitian attending quarterly. Dietary Manger is responsible to forwarded to QAPI Meeting for re- recommendations. | n all nor. aning bod ind/ or n-service n given. ne by ate ing for h | |

If continuation sheet Page 25 of 30

| | - | AND HUMAN SERVICES | | | FORM | APPROVED 0938-0391 |
|--------------------------|--|--|--------------------------|--|---|----------------------------|
| STATEMENT | OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245386 | B. WING _ | | 10/: | 26/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u>, </u> | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 371 | Continued From pa sediment. | ige 25 | F 37 | 1 | | |
| | observed to be coa The observation wa | ter and knife holder rack were ated with a thick layer of dust. as confirmed by the DM who its needed to be cleaned. | | | | |
| F 431 SS=E | to practice proper s equipment to preve illness, and to train use these technique The director of dinir monitoring proper s compliance. (A) Equipment food shall be clean to sig (C) Non food conta- be kept free of an a residue and other d DRUG RECORDS, BIOLOGICALS CFR(s): 483.45(b)(3 The facility must pro- drugs and biologica them under an agre §483.70(g) of this p unlicensed personn law permits, but onl supervision of a lice (a) Procedures. A f pharmaceutical ser- that assure the acc | e dining services department sanitation techniques for clean ent the outbreak of food borne Dining Service employees to es. Ing is responsible for training, sanitation techniques and d-contact surfaces and utensils ght and touch. Inct surfaces of equipment shall accumulation of dust, dirt, food debris. LABEL/STORE DRUGS & 2)(3)(g)(h) ovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit hel to administer drugs if State ly under the general | F 43 | 1 | | 12/15/17 |

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PRINTED: 11/22/2017

| | | AND HUMAN SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|--|--|-------------------------|----|---|-----------|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245386 | B. WING | | | 10/: | 26/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 431 | (b) Service Consult employ or obtain the pharmacist who (2) Establishes a sy disposition of all co- detail to enable and (3) Determines that that an account of a maintained and per (g) Labeling of Drug Drugs and biological labeled in accordance professional princip appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance w the facility must sto locked compartmer controls, and permi have access to the (2) The facility must permanently affixed comprehensive Drug Control Act of 1976 abuse, except when package drug distri | t the needs of each resident. tation. The facility must be services of a licensed ystem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and t drug records are in order and all controlled drugs is riodically reconciled. gs and Biologicals. als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when ys and Biologicals. with State and Federal laws, re all drugs and biologicals in nts under proper temperature it only authorized personnel to | F 4: | 31 | DEFICIENCY | | |
| | can be readily dete | | | | | | |

If continuation sheet Page 27 of 30

PRINTED: 11/22/2017

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | | E SURVEY PLETED | | |
|--------------------------|---|---|---------------------|---|---|---------------------------|--|--|
| | | 245386 | B. WING _ | | 10/ | 26/2017 | | |
| NAME OF I | PROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP | • | | | |
| SLAYTO | N REHABILITATION & | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | _ | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE E APPROPRIATE | (X5) COMPLETIC DATE | | |
| F 431 | by: Based on observat review, the facility f was identified on in for use, to determin residents (R5 & R5 failed to reconcile of daily as required by who received contri- to ensure expired in from the emergence Findings include: During an observat licensed practical in east/south medicat insulin pens availat when opened. A No pharmacy fill date of indicated the medic after opening. A He with a fill date of 10 to when it had beer indicated the medic days after opening. supposed to date in opened for use. Sh when these pens h acknowledged staff | NT is not met as evidenced tion, interview and document ailed to ensure an open date sulin pens when first opened he outdate for use for 2 of 4 1) reviewed; the facility also controlled substances twice v facility policy for 17 residents olled medications; and failed medications were removed | F 43 | It is the practice of Slayto and Healthcare Center to medications are dated, no controlled medication are shift. Staff education was provid during survey. Insulin pen- discarded and replaced fo and R51 when the Survey issue. New insulin pens w when opened. The half tab in blister pack was destroyed per policy of survey. Nurses who worked on 100 5.03, 4/22, 4/21, 4/18, 10/7 9/22, 9/09, 9/05, 8/22, 4/24 have been counselled reg incomplete controlled substitute The E-Kit was replaced or discovered during survey. All licensed nurses were effacility policies regarding of medication when open, dis controlled substances, con controlled substances dur changes and verifying the current. Random audits will be cor medication cart for approp medication dates, narcotic | ensure all t expired, and counted every ded to all nurses s were r Residents R5 or identified the ill be dated (for resident R9 during the //27, 10/26, 21, 10/11, 4/23, 6, and 4/17 arding stance counts. In the day it was educated on dating sposing of unting of ing shift E-Kits are inducted on oriate | | | |
| | R9 had a blister pa (controlled substan 0.5 milligrams (mg) | ck card of Clonazepam ce used for anxiety) labeled take 1 tab by mouth twice a tified in hand writing there was | | controlled substance cour E-Kit by DNS, ADNS or Li Designee. Results will be forwarded review and recommendati | its, and expired censed to the QAPI for | | | |

Facility ID: 00915

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 11/22/2017 APPROVED 0938-0391 |
|--------------------------|---|--|---------------------|----------------|---|------|-------------------------------------|
| | | • • | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 245386 | B. WING | | | 10/2 | 26/2017 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION & | HEALTHCARE CENTER | | | 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 431 | 0.25 mg given PRN the remaining half of into the blister pack had been administer dose. LPN-B stated would have been to and record appropri- tab back into the ma Review of the facilit Controlled Substan indicated counts had daily per facility poli No documentation of 10/10, 10/3, 9/22, 9 4/26, 4/17 and 4/13 No documentation of counts: 10/27, 10/2 4/18/17. No documentation of 5/11 and 4/23/17. During an observat at 2:15 p.m. the refit was noted to contai lorazepam 1 mg/ml expiration date of 9 LPN-B verified the if would be outdated LPN-B further verifit routinely monitored on the kits; adding st time the medication LPN-B reported that through the medication anothly audits. | I (as needed) on 10/23/17 with of the tablet being taped back a. LPN-B stated a half tablet ered as an as needed (PRN) d the appropriate procedure o destroy the other half tablet iately instead of taping a half edication card. by's Shift Verification of ces Count form with LPN-B, id not been conducted twice icy: of evening shift counts: 10/17, /9, 9/5, 8/22, 5/24, 5/16, 5/1, | F 4 | 31 | DNS will monitor. | | |

If continuation sheet Page 29 of 30

| | | AND HUMAN SERVICES | | | | FORM | : 11/22/2017 APPROVED 0938-0391 |
|--------------------------|---|---|--|-----|--|------|---------------------------------------|
| STATEMENT | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | E SURVEY PLETED |
| | | 245386 | B. WING | i | | 10/ | 26/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| SLAYTO | N REHABILITATION & | | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 431 | Continued From pa | - | F4 | 431 | | | |
| | responsible to ensu- monitored for expire pharmacist stated s monthly but had ev box stating, "It was | macist verified being ure the E-kit for the facility was ed medications. The she checked the E-kits idently missed the refrigerated a fluke." | | | | | |
| | director of nursing (pharmacist comes through the medica rooms. The DON f | (DON) verified the consultant once a month and looks ition carts and the medication urther verified monthly audits acility staff and the results | | | | | |
| | Substances, indication controlled medication indicating the nurse nurse going off duty together. The policy | ed policy, Controlled ted nursing staff must count ons at the end of each shift e coming on duty and the y must make the count y further directed staff to ort any discrepancies. | | | | | |
| | | | | | | | |
| | | | | | | | |

Facility ID: 00915

If continuation sheet Page 30 of 30

| ND DLAN OF CORDECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIP A. BUILDING | | E SURVEY | |
|------------------------------|---|--|----------------------------|--|----------|-------------------------|
| | | 245386 | B. WING | | 10 | /24/2017 |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2957 REDWOOD AVENUE SOUTH | | |
| LAYTO | N REHABILITATION 8 | HEALTHCARE CENTER | | SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLET DATE |
| K 000 | INITIAL COMMENT | ГS | K 000 | | | |
| | FIRE SAFETY | | | | | |
| | ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM | OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. | | | | |
| | ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA | OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. | | | | |
| | Minnesota Departm Fire Marshal Divisio Slayton Rehabilitati found not to be in c requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) Standard 1 | | | | | |
| | PLEASE RETURN CORRECTION FO DEFICIENCIES (K- | R THE FIRE SAFETY | | EPOC | N., 7 | |
| | State Fire Marshal | Distates | | | | |

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

| | OF DEFICIENCIES | & MEDICAID SERVICES | | | | 0938-039 SURVEY |
|--|---|--|---|--|------|---------------------------|
| | OF CORRECTION | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | PLETED |
| 245386 | | | B, WING | | | 24/2017 |
| AME OF F | PROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTON REHABILITATION & HEALTHCARE CENTER | | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETIO DATE |
| K 000 | Continued From pa | age 1 | K 000 | | | |
| | Angela.Kappenma | nitney@state.mn.us> and | | | | |
| | | ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: | | | | |
| | 1. A description of to correct the defic | what has been, or will be, done iency. | | | | |
| | 2. The actual, or p | roposed, completion date. | | | | |
| | responsible for cor | or title of the person rection and monitoring to ence of the deficiency. | | | | |
| | was constructed a The original buildir one-story, has no | ng was constructed in 1965, it is basement, is fully fire sprinkler determined to be of Type | | | | |
| | detection at smoke open to the corrido automatic fire dep | ire alarm system with smoke a barrier doors and in spaces ors, which is monitored for artment notification. The facility 55 beds and had a census of 35 ey. | | | | |
| 1/ 655 | NOT MET as evid | - | 14 000 | | | 10/45/4 |
| | Doors with Self-Cl CFR(s): NFPA 101 | | K 223 | 5 | | 12/15/1 |

| | OF DEFICIENCIES | & MEDICAID SERVICES | | PLE CONSTRUCTION | OMB NO. | SURVEY |
|--|---|---|---------------------|--|--|---------------------------|
| | AN OF CORRECTION | | | G 01 - MAIN BUILDING 01 | COMPLETED | |
| 245386 | | | B. WING | 10/2 | 24/2017 | |
| AME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTON REHABILITATION & HEALTHCARE CENTER | | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | |
| (X4) ID PREFIX T A G | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETIC DATE |
| K 223 | Continued From pa | age 2 | K 22 | 3 | | |
| | or horizontal exit, s area enclosure are closed position, un device complying v closes all such doo compartment or er * Required manual * Local smoke dete smoke passing thr smoke detection sy * Automatic sprinkl * Loss of power. 18.2.2.2.7, 18.2.2.2 This REQUIREME by: Based on observa failed to maintain of in accordance with This could effect 3 Doors with Self-Ck Doors in an exit pa or horizontal exit, s area enclosure are closed position, un device complying v closes all such doo compartment or er * Required manua * Local smoke dete smoke passing thr smoke detection s * Automatic sprink * Loss of power. | ssageway, stairway enclosure, moke barrier, or hazardous self-closing and kept in the less held open by a release with 7.2.1.8.2 that automatically ors throughout the smoke ntire facility upon activation of: fire alarm system; and ectors designed to detect ough the opening or a required ystem; and er system, if installed; and 2.8, 19.2.2.2.7, 19.2.2.2.8 NT is not met as evidenced ation and interview, the Facility doors with self-closing devices 19.2.2.2.7 and 19.2.2.2.8. 5 of 35 residents. Dising Devices assageway, stairway enclosure, smoke barrier, or hazardous a self-closing and kept in the less held open by a release with 7.2.1.8.2 that automatically ors throughout the smoke ntire facility upon activation of: a fire alarm system; and ectors designed to detect ough the opening or a required | | It is the practice of Slayton Reha and Healthcare Center to ensure facility doors will have automatic closure to provide fire safety. Door closures have been ordere be installed by December 15, 20 Maintenance Director will establ procedure to install and audit wo condition. | e all door d and will 17. sh correct | |

Facility ID: 00915

If continuation sheet Page 3 of 5

| | | & MEDICAID SERVICES | | PLE CONSTRUCTION | (X3) DATE | SURVEY |
|---|---|---|--|--|--|---------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | G 01 - MAIN BUILDING 01 | COMPLETED 10/24/2017 | |
| | | 245386 | B. WING | | | |
| NAME OF PROVIDER OR SUPPLIER SLAYTON REHABILITATION & HEALTHCARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | DE | |
| | | | 2957 REDWOOD AVENUE SOUTH SLAYTON, MN 56172 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETIO DATE |
| K 223 | Continued From pa | - | K 22 | 3 | | |
| | on 10/24/2017, obs from the kitchen th Corridor Exit Acces Room does not hav | veen 10:00 AM and 1:00 PM servation revealed the door at opens into the Service as and into the Resident Dining ve a self closing device. Both e observed in the open | | 200 20 | | 73 |
| | Maintenance Direc | ice was verified by the Facility tor. Qualifications and Training | K 92 | 6 | | 12/15/17 |
| | Personnel Personnel concern maintenance and h cylinders are traine provide continuing guidelines and usa serviced only by per maintenance and continuing 11.5.2.1 (NFPA 99) | Qualifications and Training of ed with the application, handling of medical gases and ed on the risk. Facilities education, including safety ge requirements. Equipment is ersonnel trained in the operation of equipment. | | | | |
| | Gas Equipment - Personnel Personnel concern maintenance and h cylinders are traine provide continuing guidelines and usa serviced only by per maintenance and co | Qualifications and Training of ed with the application, nandling of medical gases and ed on the risk. Facilities education, including safety ge requirements. Equipment is ersonnel trained in the operation of equipment. | | It is the Practice of Slayton Rehab and Healthcare Center to ensure a employees are educated on the application and maintenance and I of medical gasses and cylinders of risk of such. Maintenance Director has complete qualifications and training. All staff will be completed by December 15 Training will continue annually and hires. Maintenance Director will br | all handling n the ted the training 5, 2017. I for new | |

Facility ID: 00915

If continuation sheet Page 4 of 5

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 11/27/2017 APPROVED 0938-0391 |
|--------------------------|---|---|--|-----|--|-------------------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
| 245386 | | | B. WING | | | 10/24/2017 | |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| SLAYTO | N REHABILITATION 8 | HEALTHCARE CENTER | | 1 C | 957 REDWOOD AVENUE SOUTH LAYTON, MN 56172 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 926 | Continued From pa | ge 4 | ĸ | 926 | | | |
| | FINDINGS INCLUE | DE: | | | results to QAPI Meeting. | | |
| | During documentat and 1:00 PM on 10 could not be locate handle gas cylinder guidelines and usag cylinders. | ion review between 10:00 AM /24/2017, documentation d to show that all staff that rs have received safety training ge requirements of gas ice was verified by the Facility | | | | | |
| 1 | | | | | | | |

If continuation sheet Page 5 of 5