DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMI' FE SURVEY AG			ID: V	V4BT ty ID: 00930
1. MEDICARE/MEDICAID PROVI		3. NAME AND AI	ODRESS OF FAC	CILITY	ON & HEALTHCA		4. TYPE OF A	ACTION:	7 (L8)
2.STATE VENDOR OR MEDICAID (L2) 306920600	NO.	(L4) 2209 UTAH (L5) BENSON, M			(L6) 562	215	3. Termination 5. Validation 7. On-Site Visit		4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE O. (L9) 04/01/2006		7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		09 ESRD	03 (L7) 13 PTIP 2	2 CLIA	8. Full Surve		
6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 2 AOA 1 TJC 3 Other	21/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR		ATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKE 18 SNF 18/19 SNI 43 (L37) (L38)	62 (L18) 62 (L17) DOWN F 19 SNF 19	Compliance1. A B. Not in Comp	ance With equirements e Based On: cceptable POC bliance with Progr and/or Applied V	am	And/Or Approved 2. Technica 3. 24 Hour 4. 7-Day R 5. Life Safe * Code: A 15. FACILITY MER 1861 (e) (1) or 186	al Personnel RN N (Rural SN ety Code	6. Scop 7. Medi	e of Services cal Director nt Room Size	
(L37) (L38) 16. STATE SURVEY AGENCY RE	(L39) MARKS (IF APPLICA		(L43)	DATE):					
17. SURVEYOR SIGNATURE Beth Nowling, HFE NEI	I	Date :	05/04/2017	(L19)	18. STATE SURVE				Date: 05/04/2017 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR S	INGLE S'	TATE AGENO	CY	
DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligit	Participate		IPLIANCE WITE HTS ACT:	H CIVIL	2. Owne		icial Solvency (HCI 1 Interest Disclosur :		A-1513)
22. ORIGINAL DATE OF PARTICIPATION 05/01/1986	23. LTC AGREEN BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINATIO VOLUNTARY 01-Merger Closure	N ACTION: _00		(L30) OLUNTAR	<u>Y</u> Health/Safety
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L25)		01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal		oment 06-I	Fail to Meet A HER Provider Stat Active	Agreement
(L27)		spension Date:	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
	(L28)	00454		(L31)					
31 RO RECEIPT OF CMS-1539	32	DETERMINATION	I OF APPROVAT	DATE					

(L33)

DETERMINATION APPROVAL

05/01/2017

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245313

May 4, 2017

Ms. Brooke Dillon, Administrator Meadow Lane Rehabilitation & Healthcare Center 2209 Utah Avenue Benson, MN 56215

Dear Ms. Dillon:

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 April 7, 2017 the above facility is certified for:

- 43 Skilled Nursing Facility/Nursing Facility Beds
- 19 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 43 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 4, 2017

Ms. Brooke Dillon, Administrator Meadow Lane Rehabilitation & Healthcare Center 2209 Utah Avenue Benson, MN 56215

RE: Project Number S5313027

Dear Ms. Dillon:

On March 17, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 2, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On April 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 3, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 2, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 7, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 2, 2017, effective April 7, 2017 and therefore remedies outlined in our letter to you dated March 16, 2017, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: <u>mark.meath@state.mn.us</u>

Phone: (651) 201-4118 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
245313 _{Y1}	B. Wing	Y2	4/21/2017	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
MEADOW LANE REHABILITATION & HEALTHCARE CTR		2209 UTAH AVENUE				
		BENSON, MN 56215				

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix F0431	Correction	ID Prefix	Correction	ID Prefix	Correction
483.45(b)(2)(3)(g)(h) Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/07/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
	REVIEWED BY INITIALS) GA/mm	DATE 05/04/2017	SIGNATURE OF SURVEYOR 34088	•	DATE 04/21/2017
	REVIEWED BY INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/2/2017			ANY UNCORRECTED DEFICIENCIES TED DEFICIENCIES (CMS-2567) SEN		

POST-CERTIFICATION REVISIT REPORT

	ER / SUPPLIER / CLIA /	MULTIPLE CONS			•	DATE C	OF REVISIT	
IDENTIF 245313	ICATION NUMBER	D Wina	- MAIN BUILDING 01			4/3/20 ²	17 _{Y3}	
	OF FACILITY OW LANE REHABILITATION	ON & HEALTHCA	RE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE				
			or for the Medicare, Medica orted on the CMS-2567, Sta					
correcte	ed and the date such corre	ective action was a	accomplished. Each deficie previously shown on the CN	ncy should be fully identifie	ed using either the regu	ulation or LSC		
IT	EM	DATE	ITEM	DATE	ITEM		DATE	
Y	′4	Y5	Y4	Y5	Y4		Y5	
ID Prefix	·	Correction	ID Prefix	Correction	ID Prefix		Correction	
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #		Completed	
LSC	K0363	03/31/2017	LSC		LSC		- -	
ID Prefix	α	Correction	ID Prefix	Correction	ID Prefix		Correction	
Reg.#		Completed	Reg. #	Completed	Reg. #		Completed	
LSC			LSC		LSC		-	
ID Prefix	·	Correction	ID Prefix	Correction	ID Prefix		Correction	
Reg.#		Completed	Reg. #	Completed	Reg. #		Completed	
LSC		_	LSC		LSC		-	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction	
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LSC			LSC		LSC		-	
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Reg.#		Completed	Reg. #	Completed	Reg. #		Completed	
LSC		_	LSC		LSC		_	

SIGNATURE OF SURVEYOR

TITLE

34764

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

Form CMS - 2567B (09/92) EF (11/06) Page 1 of 1

DATE

DATE

05/04/2017

REVIEWED BY

REVIEWED BY

(INITIALS)

X

FOLLOWUP TO SURVEY COMPLETED ON

(INITIALS) TL/mm

REVIEWED BY STATE AGENCY

REVIEWED BY CMS RO

2/28/2017

DATE

DATE

04/03/2017

YES NO



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 4, 2017

Ms. Brooke Dillon, Administrator Meadow Lane Rehabilitation & Healthcare Center 2209 Utah Avenue Benson, MN 56215

Re: Reinspection Results - Project Number S5313027

Dear Ms. Dillon:

On April 21, 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 March 2, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form delivered 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Minnesota Department of Health Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

	STATE FORM. REVISIT REFORT								
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	-					
IDENTIFICATION NUMBER	A. Building								
00930 _{Y1}	B. Wing	Y2	4/21/2017	Y3					
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE							
MEADOW LANE REHABILITATIO	N & HEALTHCARE CTR	2209 UTAH AVENUE							
		BENSON, MN 56215							
This report is completed by a State	e surveyor to show those deficiencies previously	reported that have been corrected and the date such							

corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

	,						
ITE	М	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix	31165	Correction	ID Prefix	Correcti	ion ID Prefix		Correction
Reg. #	MN Rule 4655.78 Subp. 3	Completed	Reg. #	Comple	ted Reg. #		Completed
LSC		04/21/2017	LSC		LSC		
ID Prefix		Correction	ID Prefix	Correcti	ion ID Prefix		Correction
Reg. #		Completed	Reg. #	Comple	ted Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correcti	ion ID Prefix		Correction
Reg.#		Completed	Reg. #	Comple	ted Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correcti	ion ID Prefix		Correction
Reg. #		Completed	Reg. #	Comple	ted Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correcti	ion ID Prefix		Correction
Reg. #		Completed	Reg. #	Comple	ted Reg.#		Completed
LSC			LSC		LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS) GA/mm	DATE 05/04/2017	SIGNATURE OF SURVEYOR 3408			ATE 04/21/2017
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DA	ATE
FOLLOW 3/2/2017	JP TO SURVEY C	OMPLETED ON		ANY UNCORRECTED DEFICIE TED DEFICIENCIES (CMS-256)		O. I. 1999 10	YES NO
				Page 1 of 1		EVENT ID: W4	4BT12

			OTATE EC	DM. DEVICE	DEDODE				
			SIAIEFO	ORM: REVISIT	REPORT				
	PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A. Building								
00930		A. Building B. Wing							
NAME OF FACILITY					EET ADDRESS, CIT	Y, STATE, ZIP CODE		4/2 1/2017 Y3	
MEADO\	W LANE REHABILITATI	ON & HEALTHCA	RE CTR	2209	UTAH AVENUE				
					BENSON, MN 56215				
ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	
	•	61			61			61	
ID Prefix	21630	Correction	ID Prefix		Correction	ID Prefix		Correction	
Reg.#	MN Rule 4658.1350 Subp. 2 A.B.	Completed	Reg. #		Completed	Reg. #		Completed	
LSC		04/07/2017	LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction	
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REVIEWED BY CMS RO

3/2/2017

STATE AGENCY

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Correction

Completed

Correction

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Completed

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REVIEWED BY

REVIEWED BY

(11/06)

(INITIALS)

(INITIALS)

X

FOLLOWUP TO SURVEY COMPLETED ON

ID Prefix

Reg. #

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DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	W4BT	
Faci	lity ID: 00930)

1. MEDICARE/MEDICAID PROVII								
	DER NO.	3. NAME AND AL			4. TYPE OF ACTION: 2 (L8)			
(L1) 245313 2.STATE VENDOR OR MEDICAID	NO	(L4) 2209 UTAH		SILITATIO	ON & HEALTHCARE CTR	1. Initial	2. Recertification	
(L2) 306920600	NO.	(L5) BENSON, M			(L6) 56215	3. Termination 5. Validation	4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF	FOWNERSHIP	7. PROVIDER/SU		∩PV	<u>03</u> (L7)	7. On-Site Visit	9. Other	
(L9) 04/01/2006	OWILLIGHT	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Af	ter Complaint	
	02/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENI	DING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	' IS CERTIFIED	AS:				
From (a):		A. In Complia			And/Or Approved Waivers Of	The Following Require	ments:	
To (b):		_	equirements		2. Technical Personne	1 6. Scope of	Services Limit	
			e Based On:		3. 24 Hour RN	7. Medical 1		
12. Total Facility Beds	62 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SI			
13.Total Certified Beds	62 (L17)	X B. Not in Con	pliance with Prog	ram	5. Life Safety Code	9. Beds/Roo	om	
		Requirements	and/or Applied W	Vaivers:	* Code: B*	(L12)		
14. LTC CERTIFIED BED BREAKD					15. FACILITY MEETS			
18 SNF 18/19 SNF		ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(127) (129)	19	(1.42)	(7.42)					
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REI						was in process d	uring the	
recertification survey. P	reviously the f	acility was Gol	den LivingC	enter - N	Vleadow Lane			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Tammy Williams, HF	E NEII	0	3/23/2017	19	Mark Meath	Enforcement Spec	cialist 04/27/2017	
				(L19)	ACCOMPANIES AND MANAGEMENT OF THE	ALTON CHOOLE OF WAS CALLED THE CHARLES	(L20)	
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGIB	ILITY		PLIANCE WITH	CIVIL	21. 1. Statement of Fina			
X 1. Facility is Eligible to	Participate	RIGE	ITS ACT:		3. Both of the Abov	rol Interest Disclosure Str re:	nt (HCFA-1513)	
2. Facility is not Eligib	ele (L21)							
	(L21)			<u> </u>				
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	LTC AGREEM	IENT	26. TERMINATION ACTION	I:	(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DAT	Έ	VOLUNTARY 0	<u>INVOL</u>	UNTARY	
05/01/1986					01 Manager Classics	05-Fail t	o Meet Health/Safety	
					01-Merger, Closure			
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail t	o Meet Agreement	
(L24) 25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati	on OTHER	- -	
	27. ALTERNATI	IVE SANCTIONS n of Admissions:			02-Dissatisfaction W/ Reimburs	sement 06-Fail to 07-Prov	ider Status Change	
	27. ALTERNATI A. Suspensio		(L25) (L44)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati	on OTHER	ider Status Change	
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspensio	n of Admissions:			02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati	sement 06-Fail to 07-Prov	ider Status Change	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI A. Suspensio B. Rescind S	n of Admissions: uspension Date:	(L44) (L45)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	sement 06-Fail to 07-Prov	ider Status Change	
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspensio B. Rescind S	n of Admissions: uspension Date:	(L44) (L45)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati	sement 06-Fail to 07-Prov	ider Status Change	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI A. Suspensio B. Rescind S	n of Admissions: uspension Date:	(L44) (L45)	(121)	02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	sement 06-Fail to 07-Prov	ider Status Change	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI A. Suspensio B. Rescind S	n of Admissions: uspension Date:	(L44) (L45)	(L31)	02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	sement 06-Fail to 07-Prov	ider Status Change	
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI A. Suspensio B. Rescind S	n of Admissions: uspension Date:	(L44) (L45) CARRIER NO.	. ,	02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	sement 06-Fail to 07-Prov	ider Status Change	
25. LTC EXTENSION DATE: (L27) 28. TERMINATION DATE:	27. ALTERNATI A. Suspensio B. Rescind S (L28)	n of Admissions: uspension Date: D. INTERMEDIARY/ 00454	(L44) (L45) CARRIER NO.	DATE	02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal 30. REMARKS	sement 06-Fail ton <u>OTHER</u> 07-Prov 00-Activ	ider Status Change	
25. LTC EXTENSION DATE: (L27) 28. TERMINATION DATE:	27. ALTERNATI A. Suspensio B. Rescind S	n of Admissions: uspension Date: D. INTERMEDIARY/ 00454	(L44) (L45) CARRIER NO.	. ,	02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	sement 06-Fail ton <u>OTHER</u> 07-Prov 00-Activ	ider Status Change	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 17, 2017

Ms. Brooke Dillon, Administrator Meadow Lane Rehabilitation & Healthcare Center 2209 Utah Avenue Benson, Minnesota 56215

RE: Project Number 245313

Dear Ms. Dillon:

On March 2, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 11, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 2, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 2, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

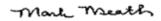
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING			03/	02/2017
	PROVIDER OR SUPPLIER V LANE REHABILITA	TION & HEALTHCARE CTR		2	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE BENSON, MN 56215		
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	revisit of your facilit validate that substa regulations has bee your verification.	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with					
F 431 SS=D	483.45(b)(2)(3)(g)(h LABEL/STORE DR	n) DRUG RECORDS, UGS & BIOLOGICALS	F 4	l31			4/7/17
	drugs and biologica them under an agre §483.70(g) of this p unlicensed personn	ovide routine and emergency als to its residents, or obtain ement described in eart. The facility may permit all to administer drugs if State by under the general ensed nurse.					
	pharmaceutical ser that assure the acc dispensing, and add	facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.					
		ation. The facility must e services of a licensed					
	disposition of all co	rstem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and					
	, ,	drug records are in order and					
I ARODATOD	A DIDECTOR'S OR BROVIE	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATLIDE		TITI F		(X6) DATE

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

(X6) DATE

Electronically Signed

03/20/2017

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	(g) Labeling of Drug Drugs and biological labeled in accordar professional princip appropriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance with facility must sto locked compartmer controls, and perminave access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Drug Control Act of 1976 abuse, except when package drug distriquantity stored is more readily detected This REQUIREMEN by: Based on observative review, the facility for procedures for disp schedule two control (medications that he were implemented (theft of medications).	all controlled drugs is iodically reconciled. gs and Biologicals. als used in the facility must be ace with currently accepted ales, and include the ory and cautionary expiration date when s and Biologicals. with State and Federal laws, re all drugs and biologicals in ants under proper temperature to only authorized personnel to keys. It provide separately locked, and compartments for storage of and other drugs subject to an the facility uses single unit bution systems in which the inimal and a missing dose can and the consure policy and osal of Fentanyl patches, a colled narcotic medication ave a high potential for abuse) to prevent possible diversion for possible illicit use) for 2 of 4) who currently received	F 431	1.Meadow Lane Rehabilitation and Healthcare Center realizes the important of proper destruction and document of Fentanyl patches. The policy are procedures 5.3, controlled medication disposal & 5.4, disposal of fentanyl patches, has been reviewed and implemented for resident R44. Reservalue in the factorial resident at the factorial resident resident resident resident resident at the factorial resident resi	ortance tation d on sident

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		E SURVEY IPLETED
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F 431	cart on 3/1/17, at 9: medication aide (TI book was present of indicated the black documentation of the inthe facility and all narcotics. She state destruction of Fenta patches to be destruction in the nurses would then destruction in the nurses would then destruction in the nurses would then destruction in the nurses and 25 mcg pathat 2 nurses had when the fentanyl patch. When interviewed or registered nurse (Registered nurse) (Registered nurse) (Registered nurses and documentations were to nurses and documentation revenad been destroyed. Review of R2's indifferentanyl patch from 2017, revealed the May, 2016 -5/6/16, Fentanyl patch signed between destroyed, signed between the signed signes	of the East wing medication 14 a.m. with trained MA)-A present, a black bound on the top of the cart. TMA-A bound book was utilized for ne count of narcotics present so for the destruction of ed the usual facility practice for anyl patches was for the oyed with 2 licensed nurses of destruction and the 2 document the witness of arcotic log. Review of the or revealed R2 received a stanyl patches. TMA-A ies on 2/27/17 for R2's 12 atch lacked documentation witnessed the destruction of the on 3/1/17, at 11:25 a.m. N)-C stated all controlled to be destroyed by two licensed entation by the 2 licensed entation by the 3 licensed entation by the 3 licensed entation enta	F 4	2.Immediately after learning fr surveyor the findings of impropedestruction of Fentanyl patche immediately re-educated all lic on the policy and procedures? Policy 5.3 reviews controlled ndisposal, which reviews policy controlled substances in regar storage, special handling, disprecord keeping in the facility in accordance with the federal arguidelines. Policy 5.4 reviews disposal of fentanyl patches waddressed proper documentat disposal of fentanyl patches to potential diversion, abuse and used and un-used fentanyl patholicy and procedure was again and given to all licensed staff of 14th 2017. 3.To prevent potential injury to residents staff have been residents staff have been residents staff have been followill continue to be followed. 4.Bi-Weekly audits will be comproper destruction of fentanyl the DNS/Designee with audit of narcotic logs as well as impler form that monitors the destruction will be taken to QAPI in as needed.	ser s; the DNS ensed staff i.3 & 5.4. dedication of ds to osal, and d state the nich on to the reduce the misuse of ches. In reviewed on March other educated on & 5.4 which disposal es. The wed and opatches by f the nenting a tion for ches. The	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 431	not be found. No fur destruction of the mon the log. June, 2016 -6/16/16, Fentanyl signed by 1 nurse, which indicated the witnessed. July, 2016 -7/13/16, Fentanyl signed by 1 nurse, which indicated the witnessed. August, 2016 -8/24/16, signed do patch not found, ho documentation of the destroyed, signed by 1 nurse, which indicated the witnessed. October, 2016 -10/11/16, 10/14/16 destroyed, signed by 1 nurse, no furth patch was found or November, 2016 -11/4/16, 11/19/16-destroyed, signed by 1 nurse, signed by 1 nurse, no furth patch was found or November, 2016	note identified old patch could orther documentation of hissing used patch was found patch 75 mcg/hr, destroyed, no other signature present, destruction had not been patch 75 mcg/hr, destroyed, no other signature present, destruction had not been patch 75 mcg/hr, destruction had not been patch accumentation indicated other patch accumentation indicated other patch 75 mcg/hr, patch 75 mcg/hr, patch 75 mcg/hr, patch 75 mcg/hr, patch 50 mcg/hr, cated patch not found, signed patch documentation of missing	F 43	1		

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F 431	specified, destroyed signature present, whad not been witned. December, 2016 -12/10/16, 12/16/16 destroyed, signed by present, which indicated the witnessed. -12/31/16, Fentanyl destroyed, signed by present, which indicated the witnessed. January, 2017 -1/3/17, 1/16/17- Fedestroyed, signed by present, which indicated the witnessed. February, 2017 -2/8/17, 2/14/17- Fedestroyed, signed by present, which indicated the witnessed. -2/14/17, Fentanyl signed by 1 nurse, which indicated the witnessed. -2/23/17, Fentanyl signed by 1 nurse,	-Fentanyl patch, no dosage d, signed by 1 nurse, no other which indicated the destruction	F 43			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY IPLETED
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F 431	mcg/hr, destroyed, signature present, whad not been witned research and not been witned research and not been witnessed. -2/27/17, Fentanyl progressed. -2/27/17, Fentanyl progressed. -2/27/17, Fentanyl progressed. -2/27/17, Fentanyl progressed by 1 nurse, which indicated the witnessed. During interview on stated R2 and R44 the facility with currest fentanyl patches. Review of R44's independent of the signature progressed for the signature pr	ry for Fentanyl patch 25 signed by 1 nurse, no other which indicated the destruction ssed. Datch 12 mcg/hr, destroyed, no other signature present, destruction had not been Datch 25 mcg/hr, destroyed, no other signature present, destruction had not been Datch 25 mcg/hr, destroyed, no other signature present, destruction had not been Datch 25 mcg/hr, destroyed, no other signature present, destruction had not been Datch 25 mcg/hr, destroyed, no other signature present, destroyed not been Datch 25 mcg/hr, destroyed, no other signature present, destroyed for the use of Datch 25 mcg/hr, destroyed, no other been signature present, and not been Datch 25 mcg/hr, destroyed, signature present, and not been Datch 25 mcg/hr, destroyed, signed by 1 nurse, no sent, which indicated the destroyed, signed by 1 nurse, no sent, which indicated the setroyed, signed by 1 nurse, no sent, which indicated the destroyed, signed by 1 nurse, no sent, which indicated the setroyed, signed by 1 nurse, no sent, which indicated the	F 43			

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F 431	However, the log lad documentation for vidisposal. 10/14/16, 10/23/16, by 1 nurse, no other indicated the destruction of the indicated the witnessed. February, 2016 -2/6/17, 2/11/17, 2/15 signed by 1 nurse, which indicated the witnessed. February, 2016 -2/6/17, 2/11/17, 2/15 signed by 1 nurse, which indicated the witnessed. When interviewed of harmacy Consultate current facility policion witnessed destruction of nursing (DON) in Fentanyl patch desset staff to dispose of in paper and immediate nurses must verify in the interviewed of nursing (DON) in Fentanyl patch desset in paper and immediate nurses must verify in the interviewed of nursing (DON) in Fentanyl patch desset in paper and immediate nurses must verify in the interviewed of nursing (DON) in Fentanyl patch desset in paper and immediate nurses must verify in the interviewed of nursing (DON) in Fentanyl patch desset in paper and immediate nurses must verify in the indicated the with the interviewed of nursing (DON) in Fentanyl patch desset in paper and immediate nurses must verify in the indicated the with the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in Fentanyl patch desset in the interviewed of nursing (DON) in the	ed disposed old patch.	F 4	31			

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F 431	On 3/1/17, at 1:52 pinterview, DON stats staff on proper narce Fentanyl patch desipast. She stated the most recently on 4/ to the facility were a regarding patch designed	for Fentanyl destruction, that it igned. D.m. during a follow up ted the facility had educated cotic counting procedure, and truction policy in the distant are facility had re-educated staff 1/16 and stated all new hires also educated the facility policy struction. At 2:07 p.m. with the ent, the DON stated the facility puts with education, and all dia post test after the pleted. DON and the distant indicated the audits ic count books. The Meds Audit Tool forms, ded by the facility for board 3/1/16 and 1/4/17, east cart west cart dated 3/4/16 and e audits were completed on or, stock cupboard medication and dry medications, and eye uded topical/external rected to review external ure they were not available for in the open date. All of the ocumentation the narcotic een reviewed and lacked eview of destruction of	F 4:	31		
	Review of the facilit	y form titled Pharmacy				

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED		
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F 431	Patches, revised Appurpose of the policidocumentation of the reduce the potential misuse of used and The policy identified unique situation gives and divers Fentanyl which removed to replace destruction and with documented in the record in order for the policy directed removed to replace destruction and with documented in the record in order for the record in the policy directed removed to replace destruction and with documented in the record in order for the record in order for the record in the policy directed and the policy d	of Fentanyl (Duragesic) oril 2014 indicated the cy was to address proper ne disposal of fentanyl patches did un-used fentanyl patches. did the patches presented a en the potential for abuse, ion and substantial amount of rained in the patch after use. when a patch has been with another patch, the ness of destruction was to be appropriate documentation he facility to provide g of patch destruction.	F 4	31		

F6313025

PRINTED: 03/23/2017 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
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K 000	ALLEGATION OF ODEPARTMENT'S ASSIGNATURE AT THE PAGE OF THE CM USED AS VERIFICATION OF THE CONTROL OF THE CONTRO	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS FORM-2567 WILL BE CATION OF COMPLIANCE. OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE	KO	000		
ABORATOR	REGULATIONS HAACCORDANCE W A Life Safety Code Minnesota Departn Fire Marshal Division the time of this sum Meadow Lane was with the requireme Medicare/Medicaid 483.70(a), Life Safedition of National (NFPA) 101 Life Safedition Health Care FITE NETT CORRECTION FOR DEFICIENCIES (K-TAGS) TO: Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	THE PLAN OF OR THE FIRE SAFETY Dispections Division Suite 145	NATIRE	EPO((X6) DATE

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

Electronically Signed

03/22/2017

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

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		245313	B. WING		02	/28/2017
	PROVIDER OR SUPPLIE V LANE REHABILIT	R ATION & HEALTHCARE CTR		STREET ADDRESS, CITY, STATE, ZIP CO 2209 UTAH AVENUE BENSON, MN 56215	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	By email to: Marian.Whitney@ Angela.Kappenm	estate.mn.us and an@state.mn.us ORRECTION FOR EACH	К0	00		
	FOLLOWING INF	f what has been, or will be, done				
	3. The name and responsible for co	oroposed, completion date. For title of the person prrection and monitoring to brence of the deficiency.				
	building with a pa constructed at 3 c building was cons facility and was de construction. In 1 built that was dete construction. In 1 connect the SNF/ which was determ construction. Bec the 2 additions me	nter - Meadow Lane is a 1 story rtial basement. The building was different times. The original structed in 1958, it is an NF2 etermined to be of Type V(000) 970, the SNF/NF facility was ermined to be of Type II(222) 976 an addition was added to NF building to the NF2 building nined to be of Type II(000) ause the original building and eet the construction types buildings, the facility was building.				
	facility has a fire a detection in the co corridors that is m	lly sprinklered throughout. The alarm system with smoke pridors and spaces open to the nonitored for automatic fire cation. The facility has a				

,				DATE SURVEY COMPLETED		
		245313	B. WING_		02	/28/2017
	PROVIDER OR SUPPLIER V LANE REHABILITA	TION & HEALTHCARE CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	the time of the surv	f 62 and had a census of 45 at ey. 42 CFR, Subpart 483.70(a) is	K 00	00		
K 363 SS=C	NFPA 101 Corridor Corridor - Doors 2012 EXISTING Doors protecting corequired enclosures hazardous areas slas those constructed core wood, or capa 20 minutes. Doors compartments are passage of smoke, means suitable for There is no impedit doors. Clearance be floor covering is no latches are prohibit corridor doors and or combustible mat complying with 7.2, devices that releas pulled are permitted of unlimited height meeting 19.3.6.3.6. Door frames shall to or other materials in the smoke compart window assemblies sprinklered compair restrictions in area frames in window as	orridor openings in other than so of vertical openings, exits, or nall be substantial doors, such ed of 1-3/4 inch solid-bonded ble of resisting fire for at least in fully sprinklered smoke only required to resist the Doors shall be provided with a keeping the door closed, ment to the closing of the etween bottom of door and the exceeding 1 inch. Roller ed by CMS regulations on rooms containing flammable terials. Powered doors 1.9 are permissible. Hold open the when the door is pushed or do. Nonrated protective plates are permitted. Dutch doors are permitted. Dutch doors are permitted. Dutch doors are permitted. Fixed fire is are allowed per 8.3. In the there are no or fire resistance of glass or	K 36	33		3/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245313	B. WING		02/2	28/2017	
	PROVIDER OR SUPPLIER W LANE REHABILITA	TION & HEALTHCARE CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 363	protection ratings, etc. This STANDARD Doors protecting or required enclosure hazardous areas s as those construct core wood, or capa 20 minutes. Doors compartments are passage of smoke a means suitable f There is no impedi doors. Clearance to floor covering is not latches are prohibic corridor doors and or combustible macomplying with 7.2 devices that release pulled are permitted of unlimited height meeting 19.3.6.3.6 shall be labeled and materials in compliance compartment window assemblies sprinklered comparestrictions in aread frames in window as findings include: On facility tour betwoelds.	S details of doors such as fire automatics closing devices, is not met as evidenced by: corridor openings in other than s of vertical openings, exits, or hall be substantial doors, such ed of 1-3/4 inch solid-bonded able of resisting fire for at least in fully sprinklered smoke only required to resist the. Doors shall be provided with or keeping the door closed. ment to the closing of the between bottom of door and of exceeding 1 inch. Roller ted by CMS regulations on rooms containing flammable terials. Powered doors .1.9 are permissible. Hold open se when the door is pushed or d. Nonrated protective plates are permitted. Dutch doors are permitted. Door frames d made of steel or other sance with 8.3, unless the ent is sprinklered. Fixed fire are allowed per 8.3. In rements there are no or fire resistance of glass or assemblies.	K 363	1. The corridor doors to the entra closet and its hardware will be rer This area will be open and utilized informational area for resident's, families and visitors. 2. Proposed completion date of the will be March 31st 2017. 3. Brooke Dillon, Licensed Nursing Administrator will be correcting as monitoring this project to prevent assure a reoccurrence of this definition provides and practice does not occur at the fact going forward.	noved. d as an their is project g Home nd and icient		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DAT COM	(X3) DATE SURVEY COMPLETED			
		245313	B. WING		02/	28/2017
	PROVIDER OR SUPPLIER V LANE REHABILITA	TION & HEALTHCARE CTR	220	REET ADDRESS, CITY, STATE, ZIP CO 19 UTAH AVENUE NSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 363	Continued From pa not have the prope		K 363			
						×



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 17, 2017

Ms. Brooke Dillon, Administrator Meadow Lane Rehabilitation & Healthcare Center 2209 Utah Avenue Benson, Minnesota 56215

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5313027

Dear Ms. Dillon:

The above facility was surveyed on February 27, 2017 through March 2, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@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.

Feel free to contact me if you have guestions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 03/22/2017

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00930 03/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE **MEADOW LANE REHABILITATION & HEALTHC**

BENSON, MN 56215 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will

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.

result in the assessment of a fine even if the item that was violated during the initial inspection was

INITIAL COMMENTS:

corrected.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota

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

TITLE (X6) DATE 03/20/17

Electronically Signed STATE FORM W4BT11 Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	` IDENTIFICATION NUMBED: ` ´		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00930		B. WING		03/0	02/2017	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MEADOV	V LANE REHABILITA	TION & HEALTHC		H AVENUE MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 000	you electronically. is necessary for State enter the word "corrected. You must then State licensure proceompletion date, the corrected prior to el Minnesota Departm On February 27th, surveyors of this Deabove provider and orders are issued. electronic plan of correviewed these ordethey will be completed. Minnesota Departm the State Licensing federal software. To assigned to Minnesota Departm the State Licensing federal software. To assigned to Minnesota Departm the State Licensing federal software. To assigned to Minnesota Departm the State Licensing federal software. To assigned to Minnesota Departm the State Licensing federal software. To assigned the minute out of commany Statement and replaces the "To correction order. The findings which are in after the statement, evidence by." Followare the Suggested.	Althorders being subralthough no plan of cate Statutes/Rules, prected" in the box avaindicate in the electroses, under the heade date your orders welectronically submittingent of Health. 28th, March 1st, 2nd expartment's staff, vision the following correction that you havers, and identify the observation of Health is document o	correction lease ailable for ronic ling ill be ng to the date when sumenting sing en les for the column the des the te statute et as ndings	2 000				
21630	Time period for Cor MN Rule 4658.1350 Medications; Destru) Subp. 2 A.B. Dispo	sition of	21630			4/7/17	

6899

Minnesota Department of Health STATE FORM

W4BT11 If continuation sheet 2 of 8

PRINTED: 03/22/2017 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00930 03/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE **MEADOW LANE REHABILITATION & HEALTHC BENSON, MN 56215** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21630 Continued From page 2 21630 Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced

Minnesota Department of Health

Findings include:

Based on observation, interview and document

review, the facility failed to ensure policy and procedures for witnessed disposal of Fentanyl patches, a schedule two controlled narcotic medication (medications that have a high potential for abuse) were implemented in a manner to prevent possible diversion (theft of medication for possible illicit use) for 1 of 1 residents (R2) who currently received routine

Fentanyl patches in the facility.

STATE FORM 6899 W4BT11 If continuation sheet 3 of 8

Corrected.

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
	00930				03/	02/2017
	PROVIDER OR SUPPLIER W LANE REHABILITA	TION & HEALTHC 2209 UTA	ODRESS, CITY, S AH AVENUE I, MN 56215	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21630	During observation cart on 3/1/17, at 9: medication aide (The book was present of indicated the black documentation of the inthe facility and all narcotics. She stated destruction of Fentapatches to be destruction in the nurses would then destruction in the nurses would then destruction in the nurses would then destruction in the nurses and 25 mcg pathat 2 nurses had when the fentanyl patch. When interviewed or registered nurse (Romedications were to nurses and documentation revenues was to done RN-A confirmed on documentation revenues was to documentation revenues was to documentation revenues was to docum	of the East wing medication 14 a.m. with trained MA)-A present, a black bound on the top of the cart. TMA-A bound book was utilized for ne count of narcotics present so for the destruction of ed the usual facility practice for anyl patches was for the oyed with 2 licensed nurses of destruction and the 2 document the witness of arcotic log. Review of the og revealed R2 received a stanyl patches. TMA-A ies on 2/27/17 for R2's 12 atch lacked documentation witnessed the destruction of the on 3/1/17, at 11:25 a.m. N)-C stated all controlled to be destroyed by two licensed in the narcotic record log. 2/14/17, and 2/23/17, ealed R2's Fentanyl patches of by only one nurse.				

Minnesota Department of Health

STATE FORM 6899 W4BT11 If continuation sheet 4 of 8

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING		00/00/0047	
		00930	B. WING		03/0	2/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEADO\	W LANE REHABILITA	TION & HEALTHC	H AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21630	Continued From pa	ge 4	21630			
		rther documentation of nissing used patch was found				
	signed by 1 nurse,	patch 75 mcg/hr, destroyed, no other signature present, destruction had not been				
	signed by 1 nurse,	patch 75 mcg/hr, destroyed, no other signature present, destruction had not been				
	August, 2016 -8/24/16, signed documentation indicated other patch not found, however lacked further documentation of the missing patch.					
	destroyed, signed b	i- Fentanyl patch 75 mcg/hr, by 1 nurse, no other signature cated the destruction had not				
		cated patch not found, signed per documentation of missing				
	destroyed, signed b	Fentanyl patch 50 mcg/hr, by 1 nurse, no other signature cated the destruction had not				
		-Fentanyl patch, no dosage d, signed by 1 nurse, no other				

Minnesota Department of Health

STATE FORM 6899 W4BT11 If continuation sheet 5 of 8

Minnesota Department of Health

STATEMEN			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00930		B. WING		03/0	2/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
MEADO\	W LANE REHABILITA	TION & HEALTHC	H AVENUE MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
21630	Continued From pa	ge 5	21630				
	signature present, what not been witne	which indicated the destruction ssed.					
	December, 2016 -12/10/16, 12/16/16- Fentanyl 50 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed.						
	-12/31/16, Fentanyl, no dosage specified, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed.						
	January, 2017 -1/3/17, 1/16/17- Fentanyl patch 50 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed.						
	February, 2017 -2/8/17, 2/14/17- Fentanyl patch 25 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed.						
	Pharmacy Consulta current facility polic	on 3/1/17, at 1:18 p.m. ant (PC)-A confirmed the y and stated he recommended on of Fentanyl patches.					
	of nursing (DON) in Fentanyl patch des staff to dispose of in paper and immedia nurses must verify her expectation was	on 3/1/17, at 1:33 p.m. director adicated the facility policy for truction was for 2 licensed to by wrapping it with tissue ately flush it. DON stated two the destruction. DON stated so to ensure nursing staff for Fentanyl destruction, that it igned.					

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED		
00930		B. WING		03/	02/2017		
	PROVIDER OR SUPPLIER W LANE REHABILITA	TION & HEALTHC	2209 UTA	DRESS, CITY, S H AVENUE MN 56215	STATE, ZIP CODE	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21630	On 3/1/17, at 1:52 pinterview, DON starstaff on proper narce Fentanyl patch despast. She stated the most recently on 4/ to the facility were a regarding patch desadministrator presented provided hands staff had completed education was compadministrator stated medication cart audincluded the narcot. Review of the Expir revised 2013, proving and care dated on a dated 3/5/16, and with 1/4/16 revealed the Med Car, refrigerat storage and included medications which medications, stock drops. The tool included medications to ensure 18 months from audit tools lacked documentation of refertanyl patches in Review of the facilities Services, Disposal Patches, revised Appurpose of the police.	o.m. during a follow used the facility had ed cotic counting procedus truction policy in the cost facility had re-educated the facility had re-educated the facility had re-educated the facility had re-educated the facility completed. DON stated the pleted. DON and the distriction of the facility completed its and indicated the facility completed by the facility for 3/1/16 and 1/4/17, eased west cart dated 3/4/16 and 1/4/17, eased various types of included Insulin, liquic oral dry medications, uded topical/externated the open date. All cocumentation the nate of eview of destruction of desired and lackeyiew of destruction of	ucated ure, and distant ated staff ew hires ility policy with the ne facility and all ed audits orms, board st cart is and eted on edication d and eye I mal allable for of the rootic ked of	21630			

Minnesota Department of Health

STATE FORM 6899 W4BT11 If continuation sheet 7 of 8

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00930	B. WING		03/0	2/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MEADO	W LANE REHABILITA	TION & HEALTHC	H AVENUE MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21630	to reduce the potential misuse of used and The policy identified unique situation gives mis-use and divers Fentanyl which remarks and the policy directed removed to replace destruction and with documented in the record in order for the appropriate tracking SUGGESTED MET The director of nurse review and revise per to destruction of Ferindividual resident in nursing or designed educate staff and densure staff are profacility policy for designed.	ge 7 Itial diversion, abuse and dun-used fentanyl patches. It the patches presented a en the potential for abuse, ion and substantial amount of rained in the patch after use. When a patch has been with another patch, the ness of destruction was to be appropriate documentation he facility to provide g of patch destruction. THOD OF CORRECTION: Sing (DON) or designee could colicies and procedures related entanyl patches for each s followed. The director of excould develop a system to evelop a monitoring system to evelop a monitoring system to exiding care as directed by the struction of Fentanyl patches. R CORRECTION: Fourteen	21630			

Minnesota Department of Health STATE FORM

PRINTED: 03/22/2017 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00930 03/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE **MEADOW LANE REHABILITATION & HEALTHC BENSON, MN 56215** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 3 000 INITIAL COMMENTS 3 000 *****ATTENTION***** **BOARDING CARE HOME** LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will

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.

result in the assessment of a fine even if the item that was violated during the initial inspection was

INITIAL COMMENTS:

corrected.

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

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

03/20/17 **Electronically Signed**

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED		
00930			B. WING		03/	02/2017	
	PROVIDER OR SUPPLIER V LANE REHABILITA	TION & HEALTHC	2209 UTA	DRESS, CITY, S H AVENUE MN 56215	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
3 000	delineated on the at Department of Heat you electronically. Is necessary for State enter the word "corrected. You must then State licensure production date, the corrected prior to elements of this Department's provider and the folissued. Please indicorrection that you and identify the date. Minnesota Department's provider and the folissued. Please indicorrection that you and identify the date. Minnesota Department's provider and the folissued. Please indicorrection that you and identify the date. The state Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of computer the statement evidence by." Followare the Suggested Time period for Corplease DISREGA FOURTH COLUMN	ttached Minnesota Ith orders being subm Although no plan of coate Statutes/Rules, planeted in the box avarindicate in the electrocess, under the heading date your orders will ectronically submitting the date your orders will ectronically submitting the formal of Health. 7, 3/1/17 and 3/2/17, so staff, visited the about a staff or the state of Health is document of Health is document. In the Health is document of Health is document of Health is document of Health is document. In the Health is document of Health is document of Health is document. In the Health is document of Health is document of Health is document. In the Health is document of Health is document of Health is document. In the Health is document of Health is document of Health is document. In the Health is document of Health is document of Health is document of Health is document. In the Health is document of Health is docum	orrection ease illable for onic ng libe g to the surveyors ove ers are c plan of orders, ompleted. menting sing n es for efar left the illumn the les the estatute t as indings and of the or the libe of the libe of the estatute of the libe of the estatute of the libe of	3 000			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00930	B. WING		03/0	02/2017
	PROVIDER OR SUPPLIER	2209 LITA	DRESS, CITY, 8	STATE, ZIP CODE		
MEADOV	V LANE REHABILITA	TION & HEALTHC BENSON,	MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
3 000	Continued From pa	ige 2	3 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
31165	MN Rule 4655.7850 Medications; Recor	0 Subp. 3 Disposition of rd	31165			4/7/17
	of such destruction medication, and pre recorded on the res	ding of disposition. A notation giving date, quantity, name of escription number shall by sident's personal care record. nall be witnessed and the both persons.				
	by: Based on interview facility failed to ens witnessed disposal schedule two control (medications that hwere implemented, possible diversion (possible illicit use) for currently resided in	and document review, the ure policy and procedures for of Fentanyl patches, a olled narcotic medication ave a high potential for abuse) in a manner to prevent (theft of medication for for 1 of 1 residents (R44) who the board and care unit and entanyl patches in the facility.		Corrected.		
	Findings include:					
		3/2/17, at 9:54 a.m. RN-A rrent orders for the use of				
		dividual narcotic logs for truction from June 1, 2016 to ealed the following:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION IN IDENTIFICATION NUMBER.		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00930	B. WING		03/0	2/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 55.5	
MEADO\	W LANE REHABILITA	IION & HEALING	H AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31165	Continued From pa	ige 3	31165			
	other signature pre destruction had not July, 2016 -7/4/16, 7/23/16- de	stroyed, signed by 1 nurse, no sent, which indicated the been witnessed. estroyed, signed by 1 nurse, no sent, which indicated the				
	destruction had not	been witnessed.				
		estroyed, signed by 1 nurse, no sent, which indicated the been witnessed.				
	October,2016 -10/11/16 identified disposed old patch. However, the log lacked any further documentation for what staff had been involved in disposal.					
	by 1 nurse, no other	, 10/29/16-destroyed, signed er signature present, which uction had not been witnessed.				
	nurse, no other sign	n/16- destroyed, signed by 1 nature present, which uction had not been witnessed.				
	signed by 1 nurse,	2/16/16, 12/31/16- destroyed, no other signature present, destruction had not been				
		14/17, 2/17/17- destroyed, no other signature present,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00930	B. WING		03/	02/2017
	PROVIDER OR SUPPLIER W LANE REHABILITA	TION & HEALTHC 2209 U	ADDRESS, CITY, S TAH AVENUE DN, MN 56215	TATE, ZIP CODE		
(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 ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
31165	which indicated the witnessed. When interviewed of Pharmacy Consulta current facility policy witnessed destruction. When interviewed of nursing (DON) in Fentanyl patch desstaff to dispose of in paper and immedianurses must verify her expectation was followed the policy be witnessed and some of the facility were a regarding patch desadministrator present had provided hands staff had completed education was compadministrator stated medication cart aud included the narcot prevised 2013, provided and some of the Expirity o	destruction had not been on 3/1/17, at 1:18 p.m. ant (PC)-A confirmed the y and stated he recommended on of Fentanyl patches. on 3/1/17, at 1:33 p.m. directed dicated the facility policy for truction was for 2 licensed to by wrapping it with tissue attely flush it. DON stated two the destruction. DON stated two the destruction. DON stated is to ensure nursing staff for Fentanyl destruction, that igned. o.m. during a follow up attended to the facility had educated cotic counting procedure, and truction policy in the distant defacility had re-educated stated all new hires also educated the facility policistruction. At 2:07 p.m. with the policy with education, and all dispost test after the pleted. DON and the distant indicated the audits	it ff cy le y			

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AND BLAN OF CORRECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00930		B. WING		03/	02/2017
	PROVIDER OR SUPPLIER W LANE REHABILITA	TION & HEALTHC 2209 UT	DDRESS, CITY, S AH AVENUE N, MN 56215	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
31165	storage and include medications which medications, stock drops. The tool incl medications and dimedications to ensure 18 months from audit tools lacked documentation of refentanyl patches in Review of the facilities. Patches, revised Appurpose of the policy documentation of the focumentation of the reduce the potentisuse of used and The policy identified unique situation gives mis-use and divers. Fentanyl which remains and divers from the policy directed removed to replace destruction and with documented in the record in order for the appropriate tracking SUGGESTED MET. The director of nurse review and revise professional develop a mondification.	ed various types of included Insulin, liquid oral dry medications, and eye uded topical/external rected to review external ure they were not available for the open date. All of the ocumentation the narcotic een reviewed and lacked eview of destruction of the facility. Ty form titled Pharmacy of Fentanyl (Duragesic) oril 2014 indicated the eye was to address proper ne disposal of fentanyl patches. It is the patches presented a ren the potential for abuse, ion and substantial amount of rained in the patch after use. When a patch has been with another patch, the ness of destruction was to be appropriate documentation he facility to provide of patch destruction. THOD OF CORRECTION: Sing (DON) or designee could relicies and procedures related estruction for each individual. The director of nursing or relop a system to educate staff as directed by the facility policies directed by the facility policies directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures staff as directed by the facility policies and procedures staff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff as directed by the facility policies and procedures restaff	d.			

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