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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W4BT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00930

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245313**
2.STATE VENDOR OR MEDICAID NO.
(L2) **306920600**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW LANE REHABILITATION & HEALTHCARE CTR**
(L4) **2209 UTAH AVENUE**
(L5) **BENSON, MN** (L6) **56215**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **04/21/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **62** (L18)
13.Total Certified Beds **62** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43	19		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE NEII **05/04/2017** (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist **05/04/2017** (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/01/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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

MDH
Minnesota
Department
of Health

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: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245313 Y1	A. Building 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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0431 Reg. # 483.45(b)(2)(3)(g)(h) LSC	Correction Completed 04/07/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	GA/mm	05/04/2017	34088	04/21/2017
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/2/2017

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245313	A. Building 01 - MAIN BUILDING 01 B. Wing	4/3/2017

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 03/31/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 05/04/2017	**SIGNATURE OF SURVEYOR** 34764	**DATE** 04/03/2017
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/28/2017	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**			

Minnesota Department of Health

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
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00930 Y1	A. Building 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 State 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 31165 Reg. # MN Rule 4655.7850 Subp. 3 LSC	Correction Completed 04/21/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GA/mm	05/04/2017	34088	04/21/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 3/2/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

 EVENT ID: W4BT12

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00930 Y1	A. Building 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 State 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21630 Reg. # MN Rule 4658.1350 Subp. 2 A.B. LSC	Correction Completed 04/07/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	GA/mm	05/04/2017	34088	04/21/2017
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/2/2017	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W4BT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00930

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245313**
2.STATE VENDOR OR MEDICAID NO.
(L2) **306920600**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW LANE REHABILITATION & HEALTHCARE CTR**
(L4) **2209 UTAH AVENUE**
(L5) **BENSON, MN** (L6) **56215**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **03/02/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **62** (L18)
13.Total Certified Beds **62** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43	19		
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): A change of ownership was in process during the recertification survey. Previously the facility was Golden LivingCenter - Meadow Lane

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 03/23/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/27/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

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

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

Remedies - 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;

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

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

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

DEPARTMENT CONTACT

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE REHABILITATION & HEALTHCARE CTR	2209 UTAH AVENUE BENSON, MN 56215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and	F 431		4/7/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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F 431	Continued From page 1 that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure policy and procedures for disposal of Fentanyl patches, a schedule two controlled narcotic medication (medications that have a high potential for abuse) were implemented to prevent possible diversion (theft of medication for possible illicit use) for 2 of 2 residents (R2, R44) who currently received routine Fentanyl patches in the facility.	F 431	1.Meadow Lane Rehabilitation and Healthcare Center realizes the importance of proper destruction and documentation of Fentanyl patches. The policy and procedures 5.3, controlled medication disposal & 5.4, disposal of fentanyl patches, has been reviewed and implemented for resident R44. Resident R2 is no longer a resident at the facility.	

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F 431	Continued From page 2 Findings include: During observation of the East wing medication cart on 3/1/17, at 9:14 a.m. with trained medication aide (TMA)-A present, a black bound book was present on the top of the cart. TMA-A indicated the black bound book was utilized for documentation of the count of narcotics present in the facility and also for the destruction of narcotics. She stated the usual facility practice for destruction of Fentanyl patches was for the patches to be destroyed with 2 licensed nurses present at the time of destruction and the 2 nurses would then document the witness of destruction in the narcotic log. Review of the East cart narcotic log revealed R2 received a current dose of Fentanyl patches. TMA-A confirmed two entries on 2/27/17 for R2's 12 mcg and 25 mcg patch lacked documentation that 2 nurses had witnessed the destruction of the Fentanyl patch. When interviewed on 3/1/17, at 11:25 a.m. registered nurse (RN)-C stated all controlled medications were to be destroyed by two licensed nurses and documentation by the 2 licensed nurses was to done in the narcotic record log. RN-A confirmed on 2/14/17, and 2/23/17, documentation revealed R2's Fentanyl patches had been destroyed by only one nurse. Review of R2's individual Narcotic logs for Fentanyl patch from May 1, 2016 to March 1, 2017, revealed the following: May, 2016 -5/6/16, Fentanyl patch, no dosage specified, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not	F 431	2.Immediately after learning from the surveyor the findings of improper destruction of Fentanyl patches; the DNS immediately re-educated all licensed staff on the policy and procedures 5.3 & 5.4. Policy 5.3 reviews controlled medication disposal, which reviews policy of controlled substances in regards to storage, special handling, disposal, and record keeping in the facility in accordance with the federal and state guidelines. Policy 5.4 reviews the disposal of fentanyl patches which addressed proper documentation to the disposal of fentanyl patches to reduce the potential diversion, abuse and misuse of used and un-used fentanyl patches. Policy and procedure was again reviewed and given to all licensed staff on March 14th 2017. 3.To prevent potential injury to other residents staff have been reeducated on the policy and procedures 5.3 & 5.4 which includes controlled medication disposal and disposal of fentanyl patches. The current practice has been followed and will continue to be followed. 4.Bi-Weekly audits will be completed on proper destruction of fentanyl patches by the DNS/Designee with audit of the narcotic logs as well as implementing a form that monitors the destruction for used controlled substance patches. The results will be taken to QAPI monthly and as needed.	

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F 431	Continued From page 3 been witnessed. -5/29/16, unsigned note identified old patch could not be found. No further documentation of destruction of the missing used patch was found on the log. June, 2016 -6/16/16, Fentanyl patch 75 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. July, 2016 -7/13/16, Fentanyl patch 75 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. August, 2016 -8/24/16, signed documentation indicated other patch not found, however lacked further documentation of the missing patch. October, 2016 -10/11/16, 10/14/16- Fentanyl patch 75 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. -10/29/16, Fentanyl patch 50 mcg/hr, documentation indicated patch not found, signed by 1 nurse, no further documentation of missing patch was found on the log. November, 2016 -11/4/16, 11/19/16- Fentanyl patch 50 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed.	F 431		

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F 431	Continued From page 4 -11/25/16, 11/29/16-Fentanyl patch, no dosage specified, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. 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. -2/14/17, Fentanyl patch 12 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. -2/23/17, Fentanyl patch 12 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed.	F 431		

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F 431	Continued From page 5 -2/23/17, a 2nd entry for Fentanyl patch 25 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. -2/27/17, Fentanyl patch 12 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. -2/27/17, Fentanyl patch 25 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. During interview on 3/2/17, at 9:54 a.m. RN-A stated R2 and R44 were the current residents in the facility with current orders for the use of Fentanyl patches. Review of R44's individual narcotic logs for Fentanyl patch destruction from June 1, 2016 to March 1, 2017, revealed the following: June, 2016 -6/7/16, 6/10/16-destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. July, 2016 -7/4/16, 7/23/16- destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. September, 2016 -9/3/16, 9/11/16- destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed.	F 431		

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F 431	Continued From page 6 October,2016 -10/11/16 -- identified disposed old patch. However, the log lacked any further documentation for what staff had been involved in disposal. 10/14/16, 10/23/16, 10/29/16-destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. November, 2016 -11/7/16, and 11/29/16- destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. December, 2016 12/4/16, 12/8/16,12/16/16, 12/31/16- destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. February, 2016 -2/6/17, 2/11/17, 2/14/17, 2/17/17- destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. When interviewed on 3/1/17, at 1:18 p.m. Pharmacy Consultant (PC)-A confirmed the current facility policy and stated he recommended witnessed destruction of Fentanyl patches. When interviewed on 3/1/17, at 1:33 p.m. director of nursing (DON) indicated the facility policy for Fentanyl patch destruction was for 2 licensed staff to dispose of it by wrapping it with tissue paper and immediately flush it. DON stated two nurses must verify the destruction. DON stated her expectation was to ensure nursing staff	F 431		

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F 431	Continued From page 7 followed the policy for Fentanyl destruction, that it be witnessed and signed. On 3/1/17, at 1:52 p.m. during a follow up interview, DON stated the facility had educated staff on proper narcotic counting procedure, and Fentanyl patch destruction policy in the distant past. She stated the facility had re-educated staff most recently on 4/1/16 and stated all new hires to the facility were also educated the facility policy regarding patch destruction. At 2:07 p.m. with the administrator present, the DON stated the facility had provided handouts with education, and all staff had completed a post test after the education was completed. DON and the administrator stated the facility completed medication cart audits and indicated the audits included the narcotic count books. Review of the Expired Meds Audit Tool forms, revised 2013, provided by the facility for board and care dated on 3/1/16 and 1/4/17, east cart dated 3/5/16, and west cart dated 3/4/16 and 11/4/16 revealed the audits were completed on Med Car, refrigerator, stock cupboard medication storage and included various types of medications which included Insulin, liquid medications, stock oral dry medications, and eye drops. The tool included topical/external medications and directed to review external medications to ensure they were not available for use 18 months from the open date. All of the audit tools lacked documentation the narcotic count books had been reviewed and lacked documentation of review of destruction of Fentanyl patches in the facility. Review of the facility form titled Pharmacy	F 431		

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F 431	Continued From page 8 Services, Disposal of Fentanyl (Duragesic) Patches, revised April 2014 indicated the purpose of the policy was to address proper documentation of the disposal of fentanyl patches to reduce the potential diversion, abuse and misuse of used and un-used fentanyl patches. The policy identified the patches presented a unique situation given the potential for abuse, mis-use and diversion and substantial amount of Fentanyl which remained in the patch after use. The policy directed when a patch has been removed to replace with another patch, the destruction and witness of destruction was to be documented in the appropriate documentation record in order for the facility to provide appropriate tracking of patch destruction.	F 431		

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	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/28/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 28, 2017. At the time of this survey, Golden LivingCenter Meadow Lane was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

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

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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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Golden Living Center - Meadow Lane is a 1 story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1958, it is an NF2 facility and was determined to be of Type V(000) construction. In 1970, the SNF/NF facility was built that was determined to be of Type II(222) construction. In 1976 an addition was added to connect the SNF/NF building to the NF2 building which was determined to be of Type II(000) construction. Because the original building and the 2 additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE REHABILITATION & HEALTHCARE CTR	**2209 UTAH AVENUE** **BENSON, MN 56215**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 licensed capacity of 62 and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 363 SS=C	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363		3/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/28/2017**

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MEADOW LANE REHABILITATION & HEALTHCARE CTR	**2209 UTAH AVENUE** **BENSON, MN 56215**

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K 363	Continued From page 3 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. Findings include: On facility tour between 08:30 AM to 12:30 PM on 02/28/2017, it was observed: 1) The corridor doors to a closet in the entry way did not not positively latch into a frame and did	K 363	1.The corridor doors to the entranceway closet and its hardware will be removed. This area will be open and utilized as an informational area for resident's, their families and visitors. 2.Proposed completion date of this project will be March 31st 2017. 3.Brooke Dillon, Licensed Nursing Home Administrator will be correcting and monitoring this project to prevent and assure a reoccurrence of this deficient practice does not occur at the facility going forward.	

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	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/28/2017**

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K 363	Continued From page 4 not have the proper doors.	K 363		

MDH
Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 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: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00930	A. BUILDING: _____ B. WING _____	03/02/2017

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 27th, 28th, March 1st, 2nd 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction	21630		4/7/17

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21630	Continued From page 2 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 by: 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. Findings include:	21630	Corrected.	

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21630	Continued From page 3 During observation of the East wing medication cart on 3/1/17, at 9:14 a.m. with trained medication aide (TMA)-A present, a black bound book was present on the top of the cart. TMA-A indicated the black bound book was utilized for documentation of the count of narcotics present in the facility and also for the destruction of narcotics. She stated the usual facility practice for destruction of Fentanyl patches was for the patches to be destroyed with 2 licensed nurses present at the time of destruction and the 2 nurses would then document the witness of destruction in the narcotic log. Review of the East cart narcotic log revealed R2 received a current dose of Fentanyl patches. TMA-A confirmed two entries on 2/27/17 for R2's 12 mcg and 25 mcg patch lacked documentation that 2 nurses had witnessed the destruction of the Fentanyl patch. When interviewed on 3/1/17, at 11:25 a.m. registered nurse (RN)-C stated all controlled medications were to be destroyed by two licensed nurses and documentation by the 2 licensed nurses was to done in the narcotic record log. RN-A confirmed on 2/14/17, and 2/23/17, documentation revealed R2's Fentanyl patches had been destroyed by only one nurse. Review of R2's individual Narcotic logs for Fentanyl patch from May 1, 2016 to March 1, 2017, revealed the following: May, 2016 -5/6/16, Fentanyl patch, no dosage specified, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. -5/29/16, unsigned note identified old patch could	21630		

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21630	Continued From page 4 not be found. No further documentation of destruction of the missing used patch was found on the log. June, 2016 -6/16/16, Fentanyl patch 75 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. July, 2016 -7/13/16, Fentanyl patch 75 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. August, 2016 -8/24/16, signed documentation indicated other patch not found, however lacked further documentation of the missing patch. October, 2016 -10/11/16, 10/14/16- Fentanyl patch 75 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. -10/29/16, Fentanyl patch 50 mcg/hr, documentation indicated patch not found, signed by 1 nurse, no further documentation of missing patch was found on the log. November, 2016 -11/4/16, 11/19/16- Fentanyl patch 50 mcg/hr, destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. -11/25/16, 11/29/16-Fentanyl patch, no dosage specified, destroyed, signed by 1 nurse, no other	21630		

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21630	Continued From page 5 signature present, which indicated the destruction had not been witnessed. 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. When interviewed on 3/1/17, at 1:18 p.m. Pharmacy Consultant (PC)-A confirmed the current facility policy and stated he recommended witnessed destruction of Fentanyl patches. When interviewed on 3/1/17, at 1:33 p.m. director of nursing (DON) indicated the facility policy for Fentanyl patch destruction was for 2 licensed staff to dispose of it by wrapping it with tissue paper and immediately flush it. DON stated two nurses must verify the destruction. DON stated her expectation was to ensure nursing staff followed the policy for Fentanyl destruction, that it be witnessed and signed.	21630		

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21630	Continued From page 6 On 3/1/17, at 1:52 p.m. during a follow up interview, DON stated the facility had educated staff on proper narcotic counting procedure, and Fentanyl patch destruction policy in the distant past. She stated the facility had re-educated staff most recently on 4/1/16 and stated all new hires to the facility were also educated the facility policy regarding patch destruction. At 2:07 p.m. with the administrator present, the DON stated the facility had provided handouts with education, and all staff had completed a post test after the education was completed. DON and the administrator stated the facility completed medication cart audits and indicated the audits included the narcotic count books. Review of the Expired Meds Audit Tool forms, revised 2013, provided by the facility for board and care dated on 3/1/16 and 1/4/17, east cart dated 3/5/16, and west cart dated 3/4/16 and 11/4/16 revealed the audits were completed on Med Car, refrigerator, stock cupboard medication storage and included various types of medications which included Insulin, liquid medications, stock oral dry medications, and eye drops. The tool included topical/external medications and directed to review external medications to ensure they were not available for use 18 months from the open date. All of the audit tools lacked documentation the narcotic count books had been reviewed and lacked documentation of review of destruction of Fentanyl patches in the facility. Review of the facility form titled Pharmacy Services, Disposal of Fentanyl (Duragesic) Patches, revised April 2014 indicated the purpose of the policy was to address proper documentation of the disposal of fentanyl patches	21630		

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21630	Continued From page 7 to reduce the potential diversion, abuse and misuse of used and un-used fentanyl patches. The policy identified the patches presented a unique situation given the potential for abuse, mis-use and diversion and substantial amount of Fentanyl which remained in the patch after use. The policy directed when a patch has been removed to replace with another patch, the destruction and witness of destruction was to be documented in the appropriate documentation record in order for the facility to provide appropriate tracking of patch destruction. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to destruction of Fentanyl patches for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the facility policy for destruction of Fentanyl patches. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21630		

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3 000	INITIAL COMMENTS *****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 result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	3 000		

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3 000	Continued From page 1 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/27/17, 2/28/17, 3/1/17 and 3/2/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Board and Care Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	3 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00930	A. BUILDING: _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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3 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3 000		
31165	MN Rule 4655.7850 Subp. 3 Disposition of Medications; Record Subp. 3. Recording of disposition. A notation of such destruction giving date, quantity, name of medication, and prescription number shall by recorded on the resident's personal care record. Such destruction shall be witnessed and the notation signed by both persons. This MN Requirement is not met as evidenced by: Based on 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 (R44) who currently resided in the board and care unit and received routine Fentanyl patches in the facility. Findings include: During interview on 3/2/17, at 9:54 a.m. RN-A stated R44 had current orders for the use of Fentanyl patches. Review of R44's individual narcotic logs for Fentanyl patch destruction from June 1, 2016 to March 1, 2017, revealed the following:	31165	Corrected.	4/7/17

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31165	Continued From page 3 June, 2016 -6/7/16, 6/10/16-destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. July, 2016 -7/4/16, 7/23/16- destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. September, 2016 -9/3/16, 9/11/16- destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not 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. 10/14/16, 10/23/16, 10/29/16-destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. November, 2016 -11/7/16, and 11/29/16- destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. December, 2016 12/4/16, 12/8/16,12/16/16, 12/31/16- destroyed, signed by 1 nurse, no other signature present, which indicated the destruction had not been witnessed. February, 2016 -2/6/17, 2/11/17, 2/14/17, 2/17/17- destroyed, signed by 1 nurse, no other signature present,	31165		

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31165	Continued From page 4 which indicated the destruction had not been witnessed. When interviewed on 3/1/17, at 1:18 p.m. Pharmacy Consultant (PC)-A confirmed the current facility policy and stated he recommended witnessed destruction of Fentanyl patches. When interviewed on 3/1/17, at 1:33 p.m. director of nursing (DON) indicated the facility policy for Fentanyl patch destruction was for 2 licensed staff to dispose of it by wrapping it with tissue paper and immediately flush it. DON stated two nurses must verify the destruction. DON stated her expectation was to ensure nursing staff followed the policy for Fentanyl destruction, that it be witnessed and signed. On 3/1/17, at 1:52 p.m. during a follow up interview, DON stated the facility had educated staff on proper narcotic counting procedure, and Fentanyl patch destruction policy in the distant past. She stated the facility had re-educated staff most recently on 4/1/16 and stated all new hires to the facility were also educated the facility policy regarding patch destruction. At 2:07 p.m. with the administrator present, the DON stated the facility had provided handouts with education, and all staff had completed a post test after the education was completed. DON and the administrator stated the facility completed medication cart audits and indicated the audits included the narcotic count books. Review of the Expired Meds Audit Tool forms, revised 2013, provided by the facility for board and care dated on 3/1/16 and 1/4/17, east cart dated 3/5/16, and west cart dated 3/4/16 and 11/4/16 revealed the audits were completed on Med Car, refrigerator, stock cupboard medication	31165		

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31165	Continued From page 5	31165		

storage and included various types of medications which included Insulin, liquid medications, stock oral dry medications, and eye drops. The tool included topical/external medications and directed to review external medications to ensure they were not available for use 18 months from the open date. All of the audit tools lacked documentation the narcotic count books had been reviewed and lacked documentation of review of destruction of Fentanyl patches in the facility.

Review of the facility form titled Pharmacy Services, Disposal of Fentanyl (Duragesic) Patches, revised April 2014 indicated the purpose of the policy was to address proper documentation of the disposal of fentanyl patches to reduce the potential diversion, abuse and misuse of used and un-used fentanyl patches. The policy identified the patches presented a unique situation given the potential for abuse, mis-use and diversion and substantial amount of Fentanyl which remained in the patch after use. The policy directed when a patch has been removed to replace with another patch, the destruction and witness of destruction was to be documented in the appropriate documentation record in order for the facility to provide appropriate tracking of patch destruction.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to Fentanyl patch destruction for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the facility policy for destruction of Fentanyl patches.

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31165	Continued From page 6 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	31165		