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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YD82

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00390

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245367**

2. STATE VENDOR OR MEDICAID NO. (L2) **346314100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW MANOR**
(L4) **210 EAST GRAND AVENUE, PO BOX 365**
(L5) **GRAND MEADOW, MN** (L6) **55936**

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)

6. DATE OF SURVEY **6/12/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (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			
(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 :
Gary Nederhoff, Unit Supervisor 10/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/31/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245367 September 7, 2017

Mr. Gary Hjelmstad, Administrator
Meadow Manor
210 East Grand Avenue, PO Box 365
Grand Meadow, MN 55936

Dear Mr. Hjelmstad:

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 June 11, 2017 the above facility is recommended for:

43 Skilled Nursing Facility/Nursing Facility 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.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 12, 2017

Mr. Thomas Stevens, Administrator
Meadow Manor
210 East Grand Avenue, PO Box 365
Grand Meadow, MN 55936

RE: Project Number S5367027, H5367025

Dear Mr. Hjelmstad:

On May 15, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 27, 2017 that included an investigation of complaint number H5367025. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 12, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 5, 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 April 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 11, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 27, 2017, effective June 11, 2017 and therefore remedies outlined in our letter to you dated May 15, 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.

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YD82

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(L3) **MEADOW MANOR**
(L4) **210 EAST GRAND AVENUE, PO BOX 365**
(L5) **GRAND MEADOW, MN** (L6) **55936**

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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)

6. DATE OF SURVEY **04/27/2017** (L34)

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

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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

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	43			
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17. SURVEYOR SIGNATURE Date :
Sarah Strenke, HFE NE II 05/31/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/12/2017 (L20)

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

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____ 2. Facility is not Eligible
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29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 15, 2017

Mr. Thomas Stevens, Administrator
Meadow Manor
210 East Grand Avenue, PO Box 365
Grand Meadow, MN 55936

RE: Project Number S5367027

Dear Mr. Stevens:

On April 27, 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. In addition, at the time of the April 27, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5367025.

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

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

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

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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 June 6, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 6, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 27, 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 October 27, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Please contact me if you have questions related to this eNotice.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	**210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936**

(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's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaint H5367025 were completed. The complaints were substantiated and deficiencies were cited at F441.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 157		6/11/17

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

Electronically Signed | 05/25/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	**210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936**

(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 157	Continued From page 1 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician as ordered to reassess diuretic (Lasix) use and overall heath decline related to his diagnosis of congestive	F 157	1. R24 has been discharged to home from facility. 2. Changes in conditions for all residents will result in notification of the Medical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	**210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936**

(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 157	Continued From page 2 heart failure in order for the physician to make timely adjustment in medications for 1 of 3 residents (R24) reviewed for hospitalization. Findings include: R24's hospital discharge summary dated 12/27/16, indicated a final primary diagnosis of severe mitral valve regurgitation, now status post (s/p) mitral valve replacement on 12/21/16. Additional diagnoses included: Coronary artery disease, now s/p coronary artery bypass grafting (12/21/16), s/p permanent pacemaker placement, history of chronic persistent atrial fibrillation, chronic kidney disease stage 3, hypertension, and obstructive sleep apnea. R24's hospital discharge orders to the nursing home dated 12/27/16 indicated daily weights were required due to diuretic therapy, use of furosemide (Lasix) 20 mg (milligram) tablet 1 tablet by mouth one time daily for one week, then reassess. In addition, a new medication potassium chloride (K-Dur) 20 mEq (miliequivalents) tablet sustained release had been added to be taken one time daily for 7 days while on Lasix then to stop. Review of R24's Medication Administration Record (MAR) dated December 2016, included orders to be started 12/28/16 to include: Furosemide (Lasix) tablet 20 mg, 1 tablet by mouth one time a day for diuretic until 1/3/17 (one week) then reassess ongoing need; and potassium chloride extended release (ER) tablet (K-Dur) 20 mEq one tablet by mouth one time a day for Hypokalemia (low potassium) until 1/3/17 (one week) while on Lasix, then to stop.	F 157	Practitioner. 3. Nursing staff were re-educated on change of condition notification to MD/NP. 4. Nursing staff will receive education on 5/24/17 regarding transcription of orders to include co-signature of another nurse for verification. 5. Vitals and weights will be reviewed with each IDT meeting. 6. DNS/designee will audit vitals and weights for 5 residents for 4 weeks, then 3 residents for 4 weeks. 7. The data collected will be presented to the QAPI committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QAPI committee will make the decision/recommendation regarding any necessary follow-up studies. 8. DNS/designee is responsible.	

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R24's MAR was reviewed for January 2017. The MAR included the orders for furosemide 20 mg by mouth one time a day for one week, and the potassium chloride ER 20 mEq daily for one week. Review of the MAR indicated the furosemide and potassium had been initialed as given on 1/1/17, 1/2/17, and 1/4/17 however, neither medication was recorded as having been given 1/3/17.

Review of R24's progress notes from 1/1/17 to 1/5/17, included no information regarding why the medication may not have been administered on 1/3/17.

Review of the TAR for R24 indicated: "1/4/17 Daily weights for one week."

Review of R24's weight record since admission indicated the following:
12/27/17 209 lbs (pounds)- admission weight (wt)
1/3/17 216.6 lbs (7.6 lb wt gain since admission)
1/5/17 220.6 lbs (11.6 lb wt gain since admission, 4 lb wt gain in 48 hours)
1/6/17 220.6 lbs
1/7/17 219.8 lbs
1/8/17 225.8 lbs (16.8 lb wt gain since admission, 6 lb wt gain in 24 hours)
1/10/17 223 lbs
1/11/17 223 lbs
1/12/17 222 lbs

Further review of R24's medical record revealed a fax from the physician dated 1/9/17 at 3:51 p.m. indicating special instructions to staff: "Let Grand Meadow nursing home know lasix should be 20

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mg daily, k dur should be 20 mEq daily. Add ensure or equivalent 1 can daily, this Friday with INR (international normalized ratio-a laboratory measurement of how long it takes blood to form a clot) also get chem 8 panel, complete blood count (CBC), hepatic panel for arteriosclerotic heart disease and fatigue."

Review of the physician progress note dated 1/12/17, included: Weight is 223 pounds, up from 216.6 lbs on 1/3/17. The note also indicated: "LOWER EXTREMITIES: One to two-plus edema bilaterally."

A physician order dated 1/12/17 indicated: Pureed diet, Regular liquids per ST (speech therapy) recommendation.???

Review of a progress note dated 1/13/17, at 4:10 p.m. indicated: "Received phone call for [R24] [family member (FM)-A] stating that [R24] was admitted to the hospital due to enlarged heart and fluid around the lung." This was the only progress note dated 1/13/17. The progress notes did not indicate the circumstances leading up to R24's hospitalization. There was no information of ongoing physical assessments, including vital signs, lung status, decline in mentation recorded or provided by the facility when requested.

Review of the Hospital Admission Note dated 1/13/17, indicated R24 presented with lethargy, weakness, and dysarthria (difficult or unclear articulation of speech that is otherwise linguistically normal). R24 was diagnosed with congestive heart failure and atrial flutter, was dosed with 20 mg of intravenous Lasix and admitted to the Cardiology Floor. Strict intake and output was ordered along with daily weights.

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F 157	Continued From page 5 When interviewed on 4/27/17, at 9:34 a.m. the DM stated if a resident had a wt gain of 5-10 lbs within one week she would ask for a re-weigh and if still a significant gain would notify the nurse. DM reviewed R24's weights and confirmed he had a 7.6 lb weight gain from 12/27/17 - 1/3/17 (a 7 day period). DM stated on 1/3/17 she had interviewed R24 who indicated his normal weight to be around 220 lbs but a healthy weight for him would be 230 lbs. DM confirmed that even though the resident wanted to gain weight the significant weight gain over 7 days was a concern. When interviewed on 4/27/17, at 10:45 a.m. RN-B stated the facility standing orders for residents with congestive heart failure is to report a weight gain of 2.5 lbs in 48 hours or 5 lbs above admission weight. RN-B further stated the facility standard for all residents is to obtain daily weights for one week upon admission and staff had recently be re-educated related to this practice. RN-B confirmed the record did not indicate the physician had been informed of the resident's weight gain or reassessment of the lasix and potassium until the 1/9/17 fax to the doctor who then ordered lasix 20 mg daily and k dur 20 mEq daily. When interviewed on 4/27/17, at 12:28 p.m. the medical director (MD) stated with reassessment of diuretic use would expect staff to call with resident weight upon admission and all weights following up until the time of the call. MD further stated would expect to be notified of a weight gain of 5 lbs or greater within a week. MD verified with R24's weight gain of 7.6 lbs from 12/27/16 to 1/3/17, would have expected the facility to notify the physician. MD confirmed she was not the	F 157		

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F 157	Continued From page 6 medical director of the facility at that time. When interviewed on 4/27/17, at 1:13 p.m. the director of nursing (DON) stated the physician will usually give specific parameters related to (r/t) weight gain and when the physician should be notified. If no specific parameters, would expect staff to use nursing judgement r/t the amount of weight gained, resident health status, and current medications. Related to the reassessment of R24's Lasix DON would have expected staff to call the physician with the resident's weights from admission forward and obtain orders if any. DON stated the nurse giving the last dose of R24's ordered Lasix should have followed through with notifying the physician to reassess the need for the medication. DON confirmed the record lacked documentation of physician notification of medication stop date nor weight gain. DON further confirmed any change in a resident's condition, physician notification or hospitalization should be documented in a progress note, "Anything they do they should document." DON confirmed R24's record lacked documentation r/t weight gain, reassessment of diuretic use. The facility Practice Guideline and Procedure titled, Change in Condition revised 2015, indicated: Purpose: The Change of Condition Tool is to be used by the nurse caring for the resident with a change of condition. The tool provides a standardized guide for assessment, a method of communicating with the physician and then a guide for completing an electronic entry in the resident record. The purpose of the tool is: To communicate effectively with the physician/Nurse Practitioner	F 157		

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F 157	Continued From page 7 To aide in the documentation of the change of condition and the communication between the nurse and the physician/Nurse Practitioner. When to initiate the Change in Condition Tool: When a resident has a change in condition that is sudden in onset, a marked change in relation to the resident's usual signs and symptoms or a symptom that is unrelieved by current measures already prescribed. (See attached guidelines for immediate, non-immediate and routine notifications). Non-immediate and routine notifications are to be made same day during normal business hours or the next day when after hours. The tool is to be used for all changes that require physician/Nurse Practitioner notification unless there are other specific physician/Nurse Practitioner directed orders. Standing orders for all residents on admission included: Immediate Notification: (Unless otherwise specified by Nurse Practitioner or MD orders) Any symptom, sign or apparent discomfort that is: 1. Sudden in onset 2. A marked change (i.e. more severe) in relation to usual symptoms and signs 3. Unrelieved by measures already prescribed Immediate notification also included, Weight gain associated with respiratory symptoms, weight gain greater that 3 lb in one day or 5 lb in one week. The facility's March 2014 Standing Orders included; Admission to Facility Daily vital signs	F 157		

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F 157	Continued From page 8 Weekly weights for patients without congestive heart failure (CHF) unless directed otherwise. For patients with CHF include: ° Daily weights ° Call for weight gain greater than 2.5 pounds(#) in 48 hours or 5# above admission weight ° Assess lung sounds, peripheral edema, and respiratory effort daily.	F 157		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow the care plan for the monthly indwelling Foley catheter changes for 1 of 3 residents (R6) reviewed for urinary catheter use. Findings Include: R6's quarterly Minimum Data Set (MDS) dated 3/24/17, identified resident has an indwelling Foley catheter in place. Also admitted to facility 9/13/14. R6's Continence Evaluation dated 3/24/17, identified resident uses a Foley catheter.	F 282	1.R6 Foley catheter was changed on 4/26/17. 2. All residents with a Foley catheter have had medical records reviewed to ensure plan of care has been followed. 3. All nursing staff will receive re-education on documentation performed by the Medical Director on 5/15/17. 4. Nursing staff will receive re-education 5/24/17 on procedure for identifying necessary equipment. 5. DNS/designee will audit 3 resident records with Foley catheter monthly. 6. The data collected will be presented to the QAPI committee by the Director of Nursing and/or designee. The data will be	6/11/17

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F 282	Continued From page 9 R6's care plan dated 4/12/17, identified R6 has an indwelling Foley catheter related to benign prostatic hypertrophy(BPH) which is a prostate gland enlargement which can block the flow of urine out of the bladder with urinary retention and obstructive uropathy. The care plan identified to change Foley catheter every month and to ensure sterile technique is maintained. R6's Order Summary Report dated 4/25/17 identified to change R6's 18 French Foley catheter monthly and as needed if plugged, every night shift starting on 8/14/16 and ending on the 14th of every month. R6's Progress Notes were reviewed from 2/26/17, to 4/26/17, and there was no documentation found identifying a Foley catheter change during this time period. R6's Treatment Administration Record (TAR) dated 3/2017, identified to change resident's Foley catheter on the night shift every 14th of the month, the space was left blank on 3/14/17.9/13/14 R6's TAR dated April 2017, identified to change resident's Foley catheter on the night shift every 14th of the month, The space on 2/14/17, identified "no supplies" was handwritten in the space. When interviewed on 4/26/17, at 7:29 a.m. registered nurse (RN)-A stated the night nurse is in charge of the Foley catheter change for this resident. He further stated that the night nurse LPN-B "reported to me the catheter change was not done this month due to there not being any supplies." RN-A further stated that LPN-B should	F 282	reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QAPI committee will make the decision/recommendation regarding any necessary follow-up studies. 7. DNS/designee is responsible.	

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F 282	Continued From page 10 have made sure that if there was no supplies on the date that the Foley catheter change was due, to order them or tell someone so they could be ordered. When interviewed on 4/26/17, at 1:06 p.m. R6 reports that he does not remember the last time his Foley catheter was changed, he says, "It is due any time now." He further stated that his Foley catheter gets changed once a month. When interviewed on 4/26/17, at 2:02 p.m. director of nursing (DON) stated that the nurses change R6's Foley catheter according to care plan or physician's order, usually monthly. Furthermore, DON stated that documentation of the Foley catheter change should be signed off in the monthly TAR and documented in the nurse's progress notes. DON verified that R6's physician order states that his Foley catheter should be changed monthly and there was nothing documented for R6's Foley catheter change in the progress notes or the TAR since 2/25/17. DON further verified that 4/2017, TAR identifies that Foley catheter was not changed.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	F 309		6/11/17

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F 309	Continued From page 11 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate nursing care/services according to the physician's orders following a hospital discharge to prevent exacerbation of congestive heart disease for 1 of 3 residents (R24) reviewed who had been hospitalized. This was a closed recored review. Findings include: R24's hospital discharge summary dated 12/27/16, indicated a final primary diagnosis of severe mitral valve regurgitation, now status post	F 309	1. R24 has been discharged to home from facility. 2. MDSC re-educated on notification of weight loss. 3. All resident care plans/NAR care plans have bee reviewed for accuracy. 4. Nursing staff will receive education on 5/24/17 regarding change in condition/care plan review. 5. Vitals and weights will be reviewed with each IDT meeting. 6. DNS/designee will audit 3 care plans per week x 4 weeks, then 2 care plans per	

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F 309	Continued From page 12 (s/p) mitral valve replacement on 12/21/16. Additional diagnoses included: Coronary artery disease, now s/p coronary artery bypass grafting (12/21/16), s/p permanent pacemaker placement, history of chronic persistent atrial fibrillation, chronic kidney disease stage 3, hypertension, and obstructive sleep apnea. R24's hospital discharge orders to the nursing home dated 12/27/16 indicated daily weights were required due to diuretic therapy, use of furosemide (Lasix) 20 mg (milligram) tablet 1 tablet by mouth one time daily for one week, then reassess. In addition, a new medication potassium chloride (K-Dur) 20 mEq (miliequivalents) tablet sustained release had been added to be taken one time daily for 7 days while on Lasix then to stop. R24's admission Minimum Data Set (MDS) assessment dated 1/3/17, identified a Brief Interview for Mental Status score of 11/15 (moderate cognitive impairment), required extensive assistance with bed mobility, transfer, and toilet use, and limited assistance with personal hygiene, walking in room/corridor, and locomotion on/off the unit. The 14-day MDS dated 1/10/17, indicated R24 had experienced a weight gain of 5% or more in the last month, but was not on a physician prescribed weight-gain regimen. Review of R24's medical record did not include a temporary care plan following admission on 12/27/16 to include monitoring of signs and symptoms of congestive heart failure such as weight gain, breathing difficulty, edema, change in mentation, etc. or to direct care staff to monitor and report these signs and symptoms to the	F 309	week x 4 weeks. 7. The data collected will be presented to the QAPI committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QAPI committee will make the decision/recommendation regarding any necessary follow-up studies. 8. DNS/designee is responsible.	

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nurse immediately. The nursing assistant care sheet updated 1/4/17, and the Treatment Administration Record (TAR) dated December 2016, did not include daily weights even though this was ordered by the physician on admission.

Review of R24's Medication Administration Record (MAR) dated December 2016, included physician orders to be started 12/28/16 to include: Furosemide (Lasix) tablet 20 mg, 1 tablet by mouth one time a day for diuretic until 1/3/17 (one week) then reassess ongoing need; and potassium chloride extended release (ER) tablet (K-Dur) 20 mEq one tablet by mouth one time a day for Hypokalemia (low potassium) until 1/3/17 (one week) while on Lasix, then to stop.

Review of the TAR for R24 indicated: "1/4/17 Daily weights for one week."

Review of R24's weight record since admission indicated the following:
12/27/17 209 lbs (pounds)- admission weight (wt)
1/3/17 216.6 lbs (7.6 lb wt gain since admission)
1/5/17 220.6 lbs (11.6 lb wt gain since admission, 4 lb wt gain in 48 hours)
1/6/17 220.6 lbs
1/7/17 219.8 lbs
1/8/17 225.8 lbs (16.8 lb wt gain since admission, 6 lb wt gain in 24 hours)
1/10/17 223 lbs
1/11/17 223 lbs
1/12/17 222 lbs

Further review of R24's medical record revealed a fax from the physician dated 1/9/17 at 3:51 p.m. indicating special instructions to staff: "Let Grand

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F 309	Continued From page 14	F 309		

Meadow nursing home know lasix should be 20 mg daily, k dur should be 20 mEq daily. Add ensure or equivalent 1 can daily, this Friday with INR (international normalized ratio-a laboratory measurement of how long it takes blood to form a clot) also get chem 8 panel, complete blood count (CBC), hepatic panel for arteriosclerotic heart disease and fatigue."

Review of the physician progress note dated 1/12/17, included: Weight is 223 pounds, up from 216.6 lbs on 1/3/17. The note also indicated: "LOWER EXTREMITIES: One to two-plus edema bilaterally."

Review of a progress note dated 1/13/17, at 4:10 p.m. indicated: "Received phone call for [R24] [family member (FM)-A] stating that [R24] was admitted to the hospital due to enlarged heart and fluid around the lung."

Review of the Hospital Admission Note dated 1/13/17, indicated R24 presented with lethargy, weakness, and dysarthria (difficult or unclear articulation of speech that is otherwise linguistically normal). R24 was diagnosed with congestive heart failure and atrial flutter, was dosed with 20 mg of intravenous Lasix and admitted to the Cardiology Floor. Strict intake and output was ordered along with daily weights.

When interviewed on 4/27/17, at 8:56 a.m. licensed practical nurse (LPN)-A stated remembering R24 would get short of breath if walking from the dining room to his bedroom. LPN-A stated she had assumed R24 probably had issues with edema as he was a cardiac patient, "I think he had TED [Thrombo-Embolic Deterrent] stockings that we helped put on and

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MEADOW MANOR	**210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936**

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F 309	Continued From page 15 take off daily." When interviewed on 4/27/17, at 9:34 a.m. the DM stated if a resident had a wt gain of 5-10 lbs within one week she would ask for a re-weigh and if still a significant gain would notify the nurse. DM reviewed R24's weights and confirmed he had a 7.6 lb weight gain from 12/27/17 - 1/3/17 (a 7 day period). DM reviewed R24's medical record but could not find evidence that nursing had been notified of the weight gain or that a re-weigh had been completed. DM reviewed her IDT meeting minutes from 1/5/17 which indicated, "daily weights for 1 wk , DC [discontinue] Lasix & potassium." DM stated she had noted this as that is what nursing would have attributed the weight gain too. DM stated the day R24 was hospitalized the resident was very lethargic and she could tell something wasn't quite right with him. DM stated that day R24 didn't want to eat which was really different; when the DM checked on him she could tell something was wrong. DM stated physical therapy staff also had come into R24's room and felt there was a problem. The director of nursing (DON) was then notified to come and assess R24. DM stated after assessing the resident the DON called the ambulance and the family who met the resident at the hospital. DM confirmed the DON at the time was an interim DON and not the current DON at the facility. DM further confirmed lack of documentation in R24's medical related to the events surrounding hospitalization on 1/13/17. When interviewed on 4/27/17, at 10:45 a.m. RN-B stated upon admission the floor nurses would be responsible for transcribing the admission orders. RN-B stated there was not a system in place where the orders were	F 309		

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double-checked with another nurse. RN-B confirmed resident weights were documented in the electronic health record though sometimes were also written in the TAR. RN-B reviewed R24's December 2016, and January 2017, TAR's and confirmed no weights had been recorded in the TAR until 1/5/17. RN-B stated the DM reviews all the resident weights weekly and is to give nursing a report. RN-B indicated sometimes orders for daily weights will specify parameters on when to notify the physician though R24's 12/27/16, hospital discharge orders had not. RN-B stated the facility standing orders for residents with congestive heart failure is to report a weight gain of 2.5 lbs in 48 hours or 5 lbs above admission weight. RN-B further stated the facility standard for all residents is to obtain daily weights for one week upon admission and staff had recently be re-educated related to this practice. RN-B confirmed the first time R24 had been seen by the physician since admission was on 1/12/17. RN-B further confirmed the record did not indicate the physician had been informed of the resident's weight gain even though it met the range to contact the doctor according to the admission standing orders nor had a reassessment of the lasix and potassium until the 1/9/17 when a fax to the doctor who then ordered lasix 20 mg daily and k dur 20 mEq daily. RN-B stated when a resident is sent to the hospital or has a change in condition she would expect staff to write a progress note in the chart. RN-B reviewed the interdisciplinary team (IDT) notes surrounding R24's admission until hospitalization on 1/13/17, and RN-B could not find any notes related to the resident's weight gain or reassessment of his lasix/potassium. RN-B further reviewed R24's record and confirmed it lacked a temporary care plan following admission

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though the same information would also be on the nursing assistant care sheets. RN-B located an aide care sheet last updated 1/4/17, and confirmed the form did not include daily weights for R24. RN-B stated when a physician order is to be discontinued on a certain date and needing re-evaluation they would sometimes highlight the instructions; otherwise the other dates are x'd out which should be a clue that the order should be reviewed and instructions followed. RN-B stated the medical director/physician who followed R24 had recently retired and R24 is now under the care of a new physician.

When interviewed on 4/27/17, at 12:28 p.m. the medical director (MD) stated with reassessment of diuretic use would expect staff to call with resident weight upon admission and all weights following up until the time of the call. MD further stated would expect to be notified of a weight gain of 5 lbs or greater within a week. MD verified with R24's weight gain of 7.6 lbs from 12/27/16 to 1/3/17, would have expected the facility to notify the physician. MD confirmed she was not the medical director of the facility at that time.

When interviewed on 4/27/17, at 1:13 p.m. the director of nursing (DON) stated the physician will usually give specific parameters related to (r/t) weight gain and when the physician should be notified. If no specific parameters, would expect staff to use nursing judgement r/t the amount of weight gained, resident health status, and current medications. Related to the reassessment of R24's Lasix DON would have expected staff to call the physician with the resident's weights from admission forward and obtain orders if any. DON stated the nurse giving the last dose of R24's ordered Lasix should have followed through with

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notifying the physician to reassess the need for the medication. DON confirmed the record lacked documentation of physician notification of medication stop date nor weight gain. DON further confirmed any change in a resident's condition, physician notification or hospitalization should be documented in a progress note, "Anything they do they should document." DON confirmed R24's record lacked documentation r/t weight gain, reassessment of diuretic use, and health status changes leading to the hospitalization on 1/13/17.

The facility Practice Guideline and Procedure titled, Change in Condition revised 2015, indicated:
Purpose:
The Change of Condition Tool is to be used by the nurse caring for the resident with a change of condition. The tool provides a standardized guide for assessment, a method of communicating with the physician and then a guide for completing an electronic entry in the resident record. The purpose of the tool is:
To communicate effectively with the physician/Nurse Practitioner
To aide in the documentation of the change of condition and the communication between the nurse and the physician/Nurse Practitioner.

When to initiate the Change in Condition Tool:
When a resident has a change in condition that is sudden in onset, a marked change in relation to the resident's usual signs and symptoms or a symptom that is unrelieved by current measures already prescribed. (See attached guidelines for immediate, non-immediate and routine notifications).
Non-immediate and routine notifications are to be

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F 309	Continued From page 19 made same day during normal business hours or the next day when after hours. The tool is to be used for all changes that require physician/Nurse Practitioner notification unless there are other specific physician/Nurse Practitioner directed orders. Immediate Notification: (Unless otherwise specified by Nurse Practitioner or MD orders) Any symptom, sign or apparent discomfort that is: 1. Sudden in onset 2. A marked change (i.e. more severe) in relation to usual symptoms and signs 3. Unrelieved by measures already prescribed Immediate notification also included, Weight gain associated with respiratory symptoms, weight gain greater that 3 lb in one day or 5 lb in one week.	F 309		
F 354 SS=F	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 354	1. With respect to Registered Nursing	6/11/17

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F 354	Continued From page 20 facility failed to consistently provide registered nurse (RN) coverage of eight hours daily for 7 days a week. This had the potential to affect all 23 residents residing at the facility. Findings include: On review of facility nursing staffing documents, dated from 1/2017 to 4/2017, documents were reviewed and was found to not have a minimum of 8 hours RN coverage for the following days: 1/14/17 a Saturday; 1/15/17 a Sunday; 2/11/17 a Saturday; 2/12/17 a Sunday; 3/35/17 a Saturday and 3/26/17 a Sunday. During an interview on 4/26/17, at 4:43 p.m. the Director of Nursing (DON) states that she sometimes has to work on the floor for RN coverage during her scheduled director of nursing hours when there are call in's ..."Have worked it plenty of times." During an interview on 4/26/17, at 12:37 p.m. nurse consultant (NC)-A states for the month of 1/2017 there is no daily schedule for this month (out of white book labeled, DAILY SCHEDULE),just have the daily nursing hours posted. During an interview on 4/26/17 at 4:29 p.m. with the executive director (ED) he confirmed missing RN coverage for 1/14/17 a Saturday; 1/15/17 a Sunday; 2/11/17 a Saturday; 2/12/17 a Sunday; 3/35/17 a Saturday and 3/26/17 a Sunday. A policy for RN coverage was requested and none received.	F 354	hours: the schedule was reviewed for potential gaps in RN hours no other gaps in coverage were identified. 2. The Staffing Coordinator received education regarding the requirement for registered nursing coverage 7 days a week. 3. Nursing schedules have been reviewed to assure 7 day/week registered nurse coverage and schedules adjusted. 4. The Director of Nursing and/or designee will audit the nursing schedule weekly for assuring sufficient quantity and quality of staff. 5. The data collected will be presented to the QAPI committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QAPI committee will make the decision/recommendation regarding any necessary follow-up studies.	
F 441	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL,	F 441		6/11/17

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F 441 SS=F	Continued From page 21 PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 441		

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F 441	Continued From page 22 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control practices had been used during pericare for 1 of 1 resident (R1) and failed to to operationalize there overall infection program in the areas of tracking, analyze, and timely taking corrective action to prevent ongoing infections. Findings include: R1 had been observed on 4/25/17 at 1:49 p.m.	F 441	1. With respect to R1 staff re-educated on infection prevention and proper glove use. 2. All nursing staff received re-education on proper hand washing and glove use on 5/15/17 by Medical Director. 3. In regards to R27, R31, R10, R7, R28 facility revised infection monitoring tool to include location, classification, organism and analysis. Staff re-educated on completion of resident specific infection	

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F 441	Continued From page 23 transferred onto a commode in her room with the use of an EZ-stand. After R1 had finished using the commode Licensed practical nurse (LPN)-A was observed to do pericare for R1. It was noted that R1 had a bowel movement and LPN-A put gloves on, wiped perineal area with wipe, then continued to wear the soiled gloves by assiting with a clean incontinent brief, pulled up R1's pants and assisted back into her wheel chair. LPN-A took her gloves off, moved the lift out of the room and halfway down the hall, then stopped and washed her hands at the sink. During an interview on 4/25/17, at 2:09 p.m. LPN-A verified her gloves remained on after cleansing stool from peri area and also verified she washed her hands after everything was done out of the residents room halfway down the hallway. LPN-A stated, "I realized that, I'm not used to doing cares." During an interview on 4/26/17, at 2:02 p.m. the director of nursing (DON) stated staff should remove soiled gloves and wash their hands immediately after providing peri-cares. The facility policy titled Hand Hygiene dated 1/2010, includes: 1. Hand hygiene must be performed after touching blood, body fluids, secretions, excretions, and contaminated items. Whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other resident's, personnel, equipment and/or environment. 2. Specific examples include: e. before and after providing personal cares to a resident. F. after removing gloves. LACK OF OPERATIONALIZING FACILITY WIDE	F 441	data collection. 4. All staff re-educated on proper glove use and hand washing on 5/24/17. 5. DNS/designee will audit 3 x a week x 4, then 2 x a week x 4 regarding infection control. 6. The data collected will be presented to the QAPI committee by the Director of Nursing and/or designee. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At this time the QAPI committee will make the decision/recommendation regarding any necessary follow-up studies. 7. DNS/designee is responsible.	

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F 441	Continued From page 24 INFECTION PROGRAM: On asking the facility for it's overall facility infection program copy of the Monthly Infecton Control Date Collection was given for reveiw. Document titled Monthly Infection Control Date Collection reviewed included the following residents to have frequent urinary tract infections (UTI): R27 had UTIs in 03/2017, two in 11/2016, 10/2016 and 6/2016. R31 had UTIs in 3/2016, 1/2017, and 2/2017. R10 had UTIs in 3/2017, 2/2017, 11/2016, 9/2016 and 3/2016. R7 had UTIs in 2/2017, 1/2017, 11/2016 and 10/2016. R28 had UTIs in 3/2017,two in 2/2017 and two in 1/2017. R4 had UTIs two in 2/2017, 1/2017, two in 10/2016 and 6/2016. R21 had UTIs in 2/2017, 1/2017, 9/2016, 7/2016, 6/2016, 3/2016. The Monthly Infection Control Data Collection document provided by the facility included the culture date listing, organism as well clinical data and precautions used. The logs given for tracking infections did not include any information regarding the UTIs for R27, R31, R10, R7, R28, R4 or for R21. During an interview with the DON on 4/27/17 at 9:20 a.m. regarding infections that occur in house and when residents are admitted with infections. The DON indicated that staff are to complete the infection logs when a resident is started on an antibiotic and then she will review the information at the end of the month to look for trends and will	F 441		

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F 441	Continued From page 25 re-educate staff if it looks like lack of proper handwashing. DON stated that the infection logs have not been completed since she started in 1/2017. The DON was asked about the facility policy regarding infections, she stated implementation of actions taken to resolve infection concerns/when trends identified in infection such as UTI will reeducate her staff and complete audits. Review of facility policy title Infection Control Surveillance Policy and Procedure reads the purpose: Prompt identification of individual infections and trends of infection within the facility to prevent the spread of infectious diseases and provide needed treatment to resident and staff.	F 441		

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. At the time of this survey, Meadow Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/25/2017

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 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. Meadow Manor is a 1-story building . The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction, with a partial basement. In 1990, an addition was added to the South and was determined to be Type II (111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 24 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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	245367	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/25/2017**

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K 222	Continued From page 2	K 222		
K 222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be	K 222		6/2/17

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K 222	Continued From page 3 permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K 222	1. Maintenance Director/designee will check egress doors weekly for timed 30 second egress. 2. Maintenance Director included egress locking arrangements into preventive maintenance program.	

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K 222	Continued From page 4 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.	K 222		

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K 222	Continued From page 5 18.2.2.2.4, 19.2.2.2.4 Findings Include: On facility tour between 11:00 AM and 03:00 PM on 4/25/2017, based on observation and interview revealed that the following include: The delay egress locks are not operating properly when tested at front door and west wing. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 222		
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no	K 511	Maintenance Director will re-education staff using supplies to keep items off the red marked area.	6/2/17

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K 511	Continued From page 6 hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Findings Include: On facility tour between 11:00 AM and 03:00 PM on 4/25/2017, based on observation and interview revealed the following include: Items are being stored in front of the electrical panels in lower level storage room. This deficient practice could affect the safety of all the residents, staff and visitors within the lower level. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511		