Electronically delivered
January 27, 2021

Administrator
Meadow Lane Restorative Care Center
2209 Utah Avenue
Benson, MN 56215

RE: CCN: 245313
Cycle Start Date: January 5, 2021

Dear Administrator:

On January 5, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

## REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 26, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 26, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 26, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 26, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Meadow Lane Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 26, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 July 5, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
January 27, 2021

Administrator
Meadow Lane Restorative Care Center
2209 Utah Avenue
Benson, MN 56215

Re: State Nursing Home Licensing Orders
Event ID: MN6T11

Dear Administrator:

The above facility was surveyed on December 30, 2020 through January 5, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@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 |
|---|---|---|---|
| | 00930 | A. BUILDING: _____ B. WING _____ | C 01/05/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MEADOW LANE RESTORATIVE CARE CENTEI | 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) COMPLETE DATE |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 12/30/20, to 1/5/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>The following complaints were found to be SUBSTANTIATED: H5313044C, H5313046C, H5313045C with licensing orders issued.<br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. | 2 000 | | |
| 2 905 | MN Rule 4658.0525 Subp. 4 Rehab - Positioning<br><br>Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide timely repositioning for 2 of 3 residents (R3, R4) who were identified at risk for pressure ulcers and required staff assitance to reposition.<br><br>Findings include:<br><br>R4's quarterly Minimum Data Set (MDS) dated 12/21/20, indicated cognitively intact, extensive assist of 2 needed with bed mobility, transfers, dressing, toileting, personal hygiene, and balance with transferring and standing. R4's MDS indicated always incontinent of bowel and bladder. Medical diagnoses identified diabetes mellitus, peripheral vascular disease (PVD), | 2 905 | corrected | 2/12/21 |

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| 2 905 | Continued From page 2 | 2 905 | | |

hypertension (HTN), paraplegia, obesity, and at risk for pressure ulcers.

Review of R4's quarterly Braden Scale dated 12/1/20, identified R4 is chair fast and his ability to walk severely limited or nonexistent, cannot bear own weight and or must be assisted into chair or wheelchair. Mobility is very limited, makes occasionally slight changes in body or extremity position but unable to make frequent or significant changes indecently. R4 required moderate to maximum assistance in moving. Frequently slides down in bed or chair required frequent repositioning with maximum assistance. R4's Braden score was 15 out of 23 and placed him at a mild risk for a pressure sore.

R4's current care plan revised on 5/6/20, R4 requires observation/assistance to turn/reposition at least every 2 hours, more often as needed or requested. Follow facility policies/protocols for the prevention/treatment of skin breakdown.

R4's progress notes on 12/1/2020, at 5:00 p.m. confirmed he had a Braden assessment completed with a score of 15 and identified R4 at a risk for skin breakdown.

R4's physician orders dated 12/29/20, directed staff to stand resident in standing lift for 5 minutes one time a day.

During observations on 12/30/20, at 9:00 a.m., 10:00 a.m., 11:00 a.m., 1:00 p.m., and 2:00 p.m. R4 sat in wheelchair (w/c) in his room in front of television (TV), dressed in street clothes, feet on foot peddles, and hair combed and shaven.

During observation on 12/30/20, at 9:30 a.m. R4 sat in w/c, dressed, watching TV, feet on foot

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| 2 905 | Continued From page 3<br>pedals.<br><br>During observation on 12/30/20, at 9:42 a.m. R4 was in room dressed in street clothes in w/c in front of TV, feet on foot peddles, and hair combed and shaven.<br><br>During observation on 12/30/20, at 10:16 a.m. physical therapist (PT)-A, entered R4's room, said "going to work with R4 with a sit to stand lift." R4 sat in w/c. At 10:17 a.m. PT-A placed R4's feet on PAL lift and buckled strap around R4's waist and around lower legs. PT-A instructed R4 to hang on to handle, then stated "ok, we will stand." At 10:23 a.m. lifted him up with stand lift, helped him move his left (L) leg and pulled pants up. PT-A said "going to have him stand, last time was 5 minutes." While R4 stood, PT-A asked how he was doing, R4 stated "ok." PT-A said "almost 2 minutes now, will try for 5 minutes." R4 stated "getting sore." PT-A stated "we will go down now" and lowered him down onto w/c. At 10:29 PT-A assisted R4 to lift his L leg off PAL lift, and R4 moved his right (R) leg. At 10:35 a.m. PT-A returned back to R4's room to complete leg stretches.<br><br>During an interview on 12/30/30, at 12:48 a.m. R4 identified the staff completed cares, dressed him, and then transferred him from the bed to the wc with a stand lift at 7 a.m. R4 also stated he stood up for a few minutes at 10:30 a.m. with staff and assistance. R4 indicated he needed staff help to be repositioned in the w/c. They have not stood me up or repositioned me since 10:30 am today.<br><br>During an interview on 12/30/20, at 1:38 p.m. NA-B identified R4 should had been repositioned every 2 hours. NA-B identified she was unsure when R4 had been repositioned last. NA-B | 2 905 | | |

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| 2 905 | Continued From page 4 | 2 905 | | |

indicated a soaker pad underneath R4 or his pants are used by staff to pull him up in the w/c. NA-B identified R4 stood up with the stand lift when he requested to be repositioned but this is only completed when he requests it.

During an interview on 12/30/20, at 1:55 p.m. NA-A indicated very limited interaction with R4 for the day. NA-A indicated NA-C had completed cares for R4 at 10:00 a.m. and placed him in his w/c early in the morning. NA-C indicated R5 had not been checked, changed, or repositioned since 8 a.m. NA-A confirmed he had not checked on R4 since 8 a.m. NA-A stated "I can not assure he has been repositioned every two hours today, besides sitting in the w/c and lying in bed. NA-A stated, "the repositioning really does not really happen."

During observation on 12/30/20, at 2:12 p.m. a nursing assistant (NA)-D lifted R4 with a stand lift to a standing position. NA-D wheeled R4 into bathroom, removed incontinence product, and lowered him onto the toilet. NA-D verified the incontinent product was saturated with urine and very heavy.

During an interview on 12/31/20, at 11:35 a.m. the director of nursing (DON) identified the meaning of "off loading" is when a resident is repositioned every two hours. DON indicated the resident must be lifted off the bed or chair for at least 5 minutes to relieve the pressure to prevent pressure ulcers. DON indicated tugging on a soaker pad underneath them would not be considered repositioning. DON indicated all CNA's are expected to document cares on the ADL sheet and pass it on from one shift to another to help coordinate care. DON also identified the cares included are: repositioned,

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| 2 905 | Continued From page 5 | 2 905 | | |

toileted, check and changed, and offload. DON indicated staff are expected to list their name at the top of the document. DON identified she assumed the CNAs were repositioning R4 every 2 hours and they should have written it down when they completed repositioning on their care sheets. DON also indicated the document lacked clarification as she was uncertain as to which CNA completed the cares.

During an interview on 12/31/20, at 11:47 a.m. NA-C indicated the staff pretty much did everything for him. NA-C indicated staff asked R4 at least every two hours if he needed toileting cares. NA-C also indicated R4 probably would not ask staff for assistance. NA-C indicated all staff are expected to signed off the cares on the activities of daily living (ADLs) sheet so staff are informed as to what had been completed. NA-C also identified on 12/30/20, at 7:00 a.m. R4 was incontinent of urine. NA-C indicated she completed incontinent cares for R5, and transferred him from the bed to the wheel chair.

During observation on 12/31/20, at 12:00 p.m. R4 sat in w/c, dressed, ate lunch with TV on, feet on foot pedals, dressed in street clothes, and hair combed and shaven.

Review of NA activities of daily living (ADL) sheet dated 12/23/20, identified R5 should have been turned and repositioned every two hours and stood in standing lift for for 8 minutes two times a day. The ADL document did not identify which NA completed cares.

R3's Significant Change Minimum Data Set (MDS) dated 10/20/20, identified R3 had severe cognitive impairment and diagnoses which included; arthritis, depression, chronic peripheral

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| 2 905 | Continued From page 6 | 2 905 | | |

venous insufficiency (persistent condition of difficulty for blood to return to the heart from the legs) and constipation. R3's MDS further identified she required extensive assistance with transfers, personal hygiene and toileting and was at risk of developing pressure ulcers.

R3's Care Area Assessment (CAA) dated 11/17/20, identified R3 was at risk of developing pressure ulcer/injury due to limited mobility and frequent incontinence. R2's CAA identified R3 required extensive assistance to change positions and was frequently incontinent of bowel and bladder as well as was confused to time and situation and identified staff were to assist R3 with repositioning every 2 hours.

R3's Braden Scale For Predicting Pressure Sore Risk assessment dated 10/20/20, identified R3 at mild risk of pressure sore with a score of 16 of 23.

R3's care plan revised 6/30/20, identified R3 had a physical functioning deficit related to mobility impairment. R3's interventions identified R3 required toileting, personal hygiene assistance and required the use of a standing lift for transfers. R3's care plan identified R3 was at risk of pressure ulcers with intervention to assist R3 with repositioning every 2 hours while in wheelchair, to encourage R3 to have a 1 hour rest period in bed 2 times a day and to assist R3 while in bed if position had not changed every 2 hours.

On 12/30/20, at 9:40 a.m. R3 was in her wheelchair in her room, with a blanket over her lap. At 10:12 a.m. R3 was sitting in her wheelchair while activity assistant (AA)-A sat next to her while reading and visiting with R3. At

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MEADOW LANE RESTORATIVE CARE CENTEI | 2209 UTAH AVENUE BENSON, MN 56215 |

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| 2 905 | Continued From page 7<br><br>10:14 a.m. AA-A left R3's room, while R3 remained in her wheelchair. At 10:32 a.m. R3 remained sitting in her wheelchair, in her room while she appeared to be watching television.<br><br>On 12/30/20, at 11:21 a.m. R3 was sitting in her wheelchair and nursing assistant (NA)-A and NA-B were in R3's room applying the sling to the mechanical lift. NA-A ran the controls of the lift, while NA-B held onto R3 while in the sling and they transferred assisted R3 to her bed, then provided incontinence cares. NA-B cleansed R3's buttocks of yellow loose incontinence stool while R3 laid on her right side. R3's buttocks had wrinkles across the skin, pale in color and her skin was reddened 4-5 inches around her rectal area. NA-B applied Nutrashield skin protectant cream to her rectal area and buttocks. At 11:41 a.m. NA-A and NA-B assisted R3 to transfer from her bed back into her wheelchair with the mechanical lift. At 12:20 p.m. R3 was in room in wheelchair. At 1:30 p.m. R3 continued to sit in her wheelchair in her room. At 1:45 p.m. R3 continued to sit in her wheelchair in her room, appeared to be watching television.<br><br>On 12/30/20, at 1:23 p.m. NA-A indicated R3 required repositioning every 2 hours. NA-A indicated her skin was not normally red like it was today during cares, but indicated she had just had a bowel movement. Later, at 2:20 p.m. NA-A indicated he had assisted R3 three times that day, at 5:15 a.m., then NA-A indicated he checked on R3 around 8:45 a.m. and changed her clothing protector, because she had spilt yogurt on it, then around 11:30 a.m. when surveyor observed cares. NA-A indicated R3 required 2 staff with repositioning with the mechanical lift when she was in her wheelchair. NA-A indicated he had not done any further cares | 2 905 | | |

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| 2 905 | Continued From page 8 | 2 905 | | |

after 11:41 a.m. when they assisted R3 back into her wheelchair (2 hours and 41 minutes ago). NA-A indicated R3 should have been repositioned every 2 hours. Their usual practice was to get R3 up around 6:00 a.m. then lay her down before breakfast, assist R3 back to her wheelchair, then she would lay down before or after lunch.

On 12/30/20, at 1:53 p.m. NA-B indicated she assisted R3 with morning cares around 6:30 a.m. NA-B indicated she had not repositioned R3 until 11:21 when surveyor was in R3's room with them (4 hours and 51 minutes). NA-B indicated she had not completed any further repositioning of R3 since 11:41 a.m. when they put R3 back into her wheelchair. NA-B indicated she was not sure if NA-A had assisted her and indicated they had worked as a team today, and NA-B was not sure which residents she was responsible for. NA-B indicated R3 required 2 staff with the mechanical lift for repositioning. NA-B indicated she did not think anyone else had repositioned R3 that shift. NA-B indicated she had not repositioned R3 for nearly 5 hours that morning and she was not repositioned her after 11:41 a.m. NA-B indicated that was not her usual practice which was to check on R3 every hour and R3 should of been repositioned every 2 hours.

On 12/31/20, at 10:49 a.m. licensed practical nurse (LPN)-A indicated R3 required total assitance with cares and was at risk for skin breakdown. LPN-A indicated R3 was to be repositioned every 2 hours, but at times refused. LPN-A indicated the nursing assistants knew what cares were to be done with each resident, and if R3 refused to be repositioned, the nursing assistants should have informed her and she would have talked to R3 and encourage her, which she indicated was usually effective. LPN-A

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| 2 905 | Continued From page 9 | 2 905 | | |

indicated she assumed the nursing assistants were repositioning R3 every 2 hours and she was never quite sure, but they should have written it down when they completed repositioning on their care sheets.

On 12/31/20, at 11:45 a.m. NA-C indicated R3 required assistance with all activities of daily living, except she could feed herself, but at times required encouragement and assistance. NA-C indicated R3 required the use of the mechanical lift for transfers. NA-C indicated they were to check on R3, and do a check and change for incontinence cares and repositioning every 2 hours. NA-C indicated she had not assisted R3 with any cares on 12/30/20.

On 12/31/20, at 12:11 p.m. NA-B indicated they had gotten R3 up at 6:00 a.m. and repositioned her at 11:30 a.m. then she assisted the next shift to transfer R3 around 2:15 p.m. on 12/30/21. NA-B indicated she had asked R3 if she wanted to lay down after lunch yesterday, but had not repositioned her other than when at 6:00 when she woke up, 11:30, then again at 2:15 p.m. with the next shift. NA-B reviewed the care sheets with surveyor and indicated she had written down each care performed, but this did not indicated the times the cares were performed. NA-B indicated the form confused her and she had been documenting on the form incorrectly.

Review of facility policy Prevention of Pressure Ulcers updated 2/1/20, identified pressure ulcers are usually formed when a resident remains in the same position for an extended period of time, causing increased pressure or decreased circulation (blood flow) to that area. Change positions every two hours or more frequently if needed.

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| 2 905 | Continued From page 10<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee could review and revise policies and procedures related to repositioning 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 repositioning.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 2 905 | | |
| 2 910 | MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence<br><br>Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and<br>B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents | 2 910 | corrected | 2/12/21 |

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| 2 910 | Continued From page 11<br>(R4) who was identified as incontinent of bowel and bladder received the necessary care and services to manage incontinence.<br><br>Findings include:<br><br>R4's quarterly Minimum Data Set (MDS) dated 12/21/20, identified cognitively intact, extensive assist of 2 needed with bed mobility, transfers, dressing, toileting, personal hygiene, and balance with transferring and standing. R4's MDS indicated always incontinent of bowel and bladder. Medical diagnoses identified diabetes mellitus, peripheral vascular disease (PVD), hypertension (HTN), paraplegia, obesity, and at risk for pressure ulcers.<br><br>R4's bowel and bladder program screener document dated 4/21/20, identified R4 sometimes aware of need to toilet and incontinent of bowel and bladder. R4's predisposing factors included diabetes, multiple sclerosis (MS), cardio vascular disease (CVA), bladder or prostate disease, frequent urinary tract infections (UTI), and spinal cord injury. R5 required assistance of 1 person to transfer to toilet, adjust clothing, and wipe.<br><br>R4's care plan identified bladder incontinence related to impaired mobility and neurogenic disorder. R4's care plan identified voiding routine and directed staff to toilet upon rising, lay down mid a.m. and mid p.m. and HS (hour of sleep). R4's care plan also identified limited mobility and muscular impairment and does not ambulate.<br><br>R4's progress notes on 12/1/2020, at 5:00 p.m. identified Resident had a Braden Assessment completed with a score of 15 and placed R5 at a risk for skin breakdown. | 2 910 | | |

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| 2 910 | Continued From page 12<br><br>During observations on 12/30/20, at 9:00 a.m., 10:00 a.m., 11:00 a.m., 12:00 p.m., 1:00 p.m., and 2:00 p.m. R4 sat in wheelchair (w/c) in his room and watched television.<br>.<br>During observation on 12/30/20, at 2:12 p.m. nursing assistant (NA)-D lifted R4 with a sit to stand lift to a standing position. NA-D wheeled R4 into bathroom, removed incontinence product, and lowered him onto the toilet. NA-D verified the incontinent product was saturated with urine and very heavy.<br><br>During an interview on 12/30/20, at 12:48 p.m. R4 stated, the staff take me to the bathroom only once a shift and assist me when I need help. R4 indicated it maybe ok but not always aware when he needed to go to the bathroom.<br><br>During an interview on 12/31/20, at 11:58 a.m. NA-C identified personal cares were completed for R4 on 12/30/20, at 7:00 a.m. R4 was incontinent of urine and was transferred from the bed to his wheel chair. NA-C also indicated NA-A and NA-B were verbally informed of the tasks completed prior to her leaving that morning on 12/30/20, around 10:00 a.m.<br><br>During an interview on 12/30/20, at 1:38 p.m. NA-B identified R4 is usually incontinent of bowel and bladder and check and change should had been done every 2 hours. NA-B indicated her usual practice was to check R4 every hour for incontinence. NA-B also indicated R4 verbalized his needs but not sure he knows when the brief was wet. R4 verbalized to staff when it had been a long time since the check and change if he was uncomfortable. NA-B identified she was unsure when R4 had been checked and changed last. | 2 910 | | |

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| 2 910 | Continued From page 13<br><br>During an interview on 12/30/20, at 1:55 p.m. NA-A indicated NA-C had completed cares for R4 early in the morning and placed him in his w/c. NA-A identified a check and change was done at 8 a.m. before R4 got out of bed and NA-A had not checked him since then.<br><br>During an interview on 12/31/20, at 11:35 a.m. the director of nursing (DON) indicated all CNA's are expected to document check and change and toileting on the ADL sheet and pass it on from one shift to another to help coordinate care. DON indicated staff are expected to list their name at the top of the document. DON identified she assumed the CNAs completed a check and change on R4 according to his Careplan and the staff should have written it down when it was completed on their care sheets. DON also indicated the document lacked clarification as she was uncertain as to which CNA completed the cares.<br><br>Facility policy titled Urinary Continence and Incontinence - Assessment and Management updated last 2/1/20, indicated relevant information related to urinary continence includes diabetes mellitus, obesity, and neurological disorders (MS), functional and/or cognitive function impaired mobility, and decreased upper and lower extremity muscle strength. A "check and change" strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related | 2 910 | | |

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| 2 910 | Continued From page 14<br>to the necessary care and services to manage incontinence 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 the necessary care and services to manage incontinence.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 2 910 | | |

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| E 000 | Initial Comments<br><br>A COVID-19 Focused Infection Control survey was conducted on 12/30/20 to 1/05/21, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance.<br><br>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 12/30/20, to 1/5/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be SUBSTANTIATED:<br>H5313044C with deficiencies cited at F686 and F690<br>H5313046C with deficiencies cited at F686 and F690<br>H5313045C with deficiencies cited at F686 and F690<br><br>A COVID-19 Focused Infection Control survey was also conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the | F 000 | | |

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

Electronically Signed | 02/06/2021

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 000 | Continued From page 1<br>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. | F 000 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide timely repositioning for 2 of 3 residents (R3, R4) who were identified at risk for pressure ulcers and required staff assitance to reposition.<br><br>Findings include:<br><br>R4's quarterly Minimum Data Set (MDS) dated 12/21/20, indicated cognitively intact, extensive assist of 2 needed with bed mobility, transfers, dressing, toileting, personal hygiene, and balance with transferring and standing. R4's MDS indicated always incontinent of bowel and | F 686 | It is the policy of Meadow Lane Restorative Care Center that the facility ensures that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered plan of care and resident□s choices. It was identified that the facility failed to provide timely repositioning for 2 of 3 residents (R3, R4) who were identified at risk for pressure ulcers and required staff assistance to reposition. At the time of the survey, the DON assessed, reviewed, and updated R3 and R4s NA care sheets, care plan, | 2/12/21 |

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| F 686 | Continued From page 2<br>bladder. Medical diagnoses identified diabetes mellitus, peripheral vascular disease (PVD), hypertension (HTN), paraplegia, obesity, and at risk for pressure ulcers.<br><br>Review of R4's quarterly Braden Scale dated 12/1/20, identified R4 is chair fast and his ability to walk severely limited or nonexistent, cannot bear own weight and or must be assisted into chair or wheelchair. Mobility is very limited, makes occasionally slight changes in body or extremity position but unable to make frequent or significant changes indecently. R4 required moderate to maximum assistance in moving. Frequently slides down in bed or chair required frequent repositioning with maximum assistance. R4's Braden score was 15 out of 23 and placed him at a mild risk for a pressure sore.<br><br>R4's current care plan revised on 5/6/20, R4 requires observation/assistance to turn/reposition at least every 2 hours, more often as needed or requested. Follow facility policies/protocols for the prevention/treatment of skin breakdown.<br><br>R4's progress notes on 12/1/2020, at 5:00 p.m. confirmed he had a Braden assessment completed with a score of 15 and identified R4 at a risk for skin breakdown.<br><br>R4's physician orders dated 12/29/20, directed staff to stand resident in standing lift for 5 minutes one time a day.<br><br>During observations on 12/30/20, at 9:00 a.m., 10:00 a.m., 11:00 a.m., 1:00 p.m., and 2:00 p.m. R4 sat in wheelchair (w/c) in his room in front of television (TV), dressed in street clothes, feet on foot peddles, and hair combed and shaven. | F 686 | interventions and provided education to all direct care staff to ensure compliance.<br><br>At like residents identified to require assistance with turning and repositioning or at risk or have pressure ulcers have the potential to be affected. Audits were completed and residents were assessed, reviewed, and care sheets, care plans and interventions updated.<br><br>Policies titled Prevention of Pressure Ulcers and Repositioning were reviewed and revised. All direct care nursing staff were provided education on 1-6-2021 immediately and ongoing by the DON/Designee which included in person training, handouts, return demonstrations and also provided via mail. Education included the above policies, proper use of care sheets, training with staff and audits implemented. All staff in-service to provide updates with plan of correction will be provided on 2/10, 2/11, 2/12 by DON/Clinical Manager.<br><br>The DON/Designee will complete random weekly audits, for 6 weeks, checking that appropriate assessments, documentation, and interventions in place and any deficient practices corrected immediately. All findings will be brought to and monitored through QAPI for further review and recommendations.<br><br>Director of Nursing is responsible for compliance. | |

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During observation on 12/30/20, at 9:30 a.m. R4 sat in w/c, dressed, watching TV, feet on foot pedals.

During observation on 12/30/20, at 9:42 a.m. R4 was in room dressed in street clothes in w/c in front of TV, feet on foot peddles, and hair combed and shaven.

During observation on 12/30/20, at 10:16 a.m. physical therapist (PT)-A, entered R4's room, said "going to work with R4 with a sit to stand lift." R4 sat in w/c. At 10:17 a.m. PT-A placed R4's feet on PAL lift and buckled strap around R4's waist and around lower legs. PT-A instructed R4 to hang on to handle, then stated "ok, we will stand." At 10:23 a.m. lifted him up with stand lift, helped him move his left (L) leg and pulled pants up. PT-A said "going to have him stand, last time was 5 minutes." While R4 stood, PT-A asked how he was doing, R4 stated "ok." PT-A said "almost 2 minutes now, will try for 5 minutes." R4 stated "getting sore." PT-A stated "we will go down now" and lowered him down onto w/c. At 10:29 PT-A assisted R4 to lift his L leg off PAL lift, and R4 moved his right (R) leg. At 10:35 a.m. PT-A returned back to R4's room to complete leg stretches.

During an interview on 12/30/30, at 12:48 a.m. R4 identified the staff completed cares, dressed him, and then transferred him from the bed to the wc with a stand lift at 7 a.m. R4 also stated he stood up for a few minutes at 10:30 a.m. with staff and assistance. R4 indicated he needed staff help to be repositioned in the w/c. They have not stood me up or repositioned me since 10:30 am today.

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During an interview on 12/30/20, at 1:38 p.m. NA-B identified R4 should had been repositioned every 2 hours. NA-B identified she was unsure when R4 had been repositioned last. NA-B indicated a soaker pad underneath R4 or his pants are used by staff to pull him up in the w/c. NA-B identified R4 stood up with the stand lift when he requested to be repositioned but this is only completed when he requests it.

During an interview on 12/30/20, at 1:55 p.m. NA-A indicated very limited interaction with R4 for the day. NA-A indicated NA-C had completed cares for R4 at 10:00 a.m. and placed him in his w/c early in the morning. NA-C indicated R5 had not been checked, changed, or repositioned since 8 a.m. NA-A confirmed he had not checked on R4 since 8 a.m. NA-A stated "I can not assure he has been repositioned every two hours today, besides sitting in the w/c and lying in bed. NA-A stated, "the repositioning really does not really happen."

During observation on 12/30/20, at 2:12 p.m. a nursing assistant (NA)-D lifted R4 with a stand lift to a standing position. NA-D wheeled R4 into bathroom, removed incontinence product, and lowered him onto the toilet. NA-D verified the incontinent product was saturated with urine and very heavy.

During an interview on 12/31/20, at 11:35 a.m. the director of nursing (DON) identified the meaning of "off loading" is when a resident is repositioned every two hours. DON indicated the resident must be lifted off the bed or chair for at least 5 minutes to relieve the pressure to prevent pressure ulcers. DON indicated tugging on a soaker pad underneath them would not be

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considered repositioning. DON indicated all CNA's are expected to document cares on the ADL sheet and pass it on from one shift to another to help coordinate care. DON also identified the cares included are: repositioned, toileted, check and changed, and offload. DON indicated staff are expected to list their name at the top of the document. DON identified she assumed the CNAs were repositioning R4 every 2 hours and they should have written it down when they completed repositioning on their care sheets. DON also indicated the document lacked clarification as she was uncertain as to which CNA completed the cares.

During an interview on 12/31/20, at 11:47 a.m. NA-C indicated the staff pretty much did everything for him. NA-C indicated staff asked R4 at least every two hours if he needed toileting cares. NA-C also indicated R4 probably would not ask staff for assistance. NA-C indicated all staff are expected to signed off the cares on the activities of daily living (ADLs) sheet so staff are informed as to what had been completed. NA-C also identified on 12/30/20, at 7:00 a.m. R4 was incontinent of urine. NA-C indicated she completed incontinent cares for R5, and transferred him from the bed to the wheel chair.

During observation on 12/31/20, at 12:00 p.m. R4 sat in w/c, dressed, ate lunch with TV on, feet on foot pedals, dressed in street clothes, and hair combed and shaven.

Review of NA activities of daily living (ADL) sheet dated 12/23/20, identified R5 should have been turned and repositioned every two hours and stood in standing lift for for 8 minutes two times a day. The ADL document did not identify which NA

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completed cares.

R3's Significant Change Minimum Data Set (MDS) dated 10/20/20, identified R3 had severe cognitive impairment and diagnoses which included; arthritis, depression, chronic peripheral venous insufficiency (persistent condition of difficulty for blood to return to the heart from the legs) and constipation. R3's MDS further identified she required extensive assistance with transfers, personal hygiene and toileting and was at risk of developing pressure ulcers.

R3's Care Area Assessment (CAA) dated 11/17/20, identified R3 was at risk of developing pressure ulcer/injury due to limited mobility and frequent incontinence. R2's CAA identified R3 required extensive assistance to change positions and was frequently incontinent of bowel and bladder as well as was confused to time and situation and identified staff were to assist R3 with repositioning every 2 hours.

R3's Braden Scale For Predicting Pressure Sore Risk assessment dated 10/20/20, identified R3 at mild risk of pressure sore with a score of 16 of 23.

R3's care plan revised 6/30/20, identified R3 had a physical functioning deficit related to mobility impairment. R3's interventions identified R3 required toileting, personal hygiene assistance and required the use of a standing lift for transfers. R3's care plan identified R3 was at risk of pressure ulcers with intervention to assist R3 with repositioning every 2 hours while in wheelchair, to encourage R3 to have a 1 hour rest period in bed 2 times a day and to assist R3

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while in bed if position had not changed every 2 hours.

On 12/30/20, at 9:40 a.m. R3 was in her wheelchair in her room, with a blanket over her lap. At 10:12 a.m. R3 was sitting in her wheelchair while activity assistant (AA)-A sat next to her while reading and visiting with R3. At 10:14 a.m. AA-A left R3's room, while R3 remained in her wheelchair. At 10:32 a.m. R3 remained sitting in her wheelchair, in her room while she appeared to be watching television.

On 12/30/20, at 11:21 a.m. R3 was sitting in her wheelchair and nursing assistant (NA)-A and NA-B were in R3's room applying the sling to the mechanical lift. NA-A ran the controls of the lift, while NA-B held onto R3 while in the sling and they transferred assisted R3 to her bed, then provided incontinence cares. NA-B cleansed R3's buttocks of yellow loose incontinence stool while R3 laid on her right side. R3's buttocks had wrinkles across the skin, pale in color and her skin was reddened 4-5 inches around her rectal area. NA-B applied Nutrashield skin protectant cream to her rectal area and buttocks. At 11:41 a.m. NA-A and NA-B assisted R3 to transfer from her bed back into her wheelchair with the mechanical lift. At 12:20 p.m. R3 was in room in wheelchair. At 1:30 p.m. R3 continued to sit in her wheelchair in her room. At 1:45 p.m. R3 continued to sit in her wheelchair in her room, appeared to be watching television.

On 12/30/20, at 1:23 p.m. NA-A indicated R3 required repositioning every 2 hours. NA-A indicated her skin was not normally red like it was today during cares, but indicated she had just had a bowel movement. Later, at 2:20 p.m. NA-A

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indicated he had assisted R3 three times that day, at 5:15 a.m., then NA-A indicated he checked on R3 around 8:45 a.m. and changed her clothing protector, because she had spilt yogurt on it, then around 11:30 a.m. when surveyor observed cares. NA-A indicated R3 required 2 staff with repositioning with the mechanical lift when she was in her wheelchair. NA-A indicated he had not done any further cares after 11:41 a.m. when they assisted R3 back into her wheelchair (2 hours and 41 minutes ago). NA-A indicated R3 should have been repositioned every 2 hours. Their usual practice was to get R3 up around 6:00 a.m. then lay her down before breakfast, assist R3 back to her wheelchair, then she would lay down before or after lunch.

On 12/30/20, at 1:53 p.m. NA-B indicated she assisted R3 with morning cares around 6:30 a.m. NA-B indicated she had not repositioned R3 until 11:21 when surveyor was in R3's room with them (4 hours and 51 minutes). NA-B indicated she had not completed any further repositioning of R3 since 11:41 a.m. when they put R3 back into her wheelchair. NA-B indicated she was not sure if NA-A had assisted her and indicated they had worked as a team today, and NA-B was not sure which residents she was responsible for. NA-B indicated R3 required 2 staff with the mechanical lift for repositioning. NA-B indicated she did not think anyone else had repositioned R3 that shift. NA-B indicated she had not repositioned R3 for nearly 5 hours that morning and she was not repositioned her after 11:41 a.m. NA-B indicated that was not her usual practice which was to check on R3 every hour and R3 should of been repositioned every 2 hours.

On 12/31/20, at 10:49 a.m. licensed practical

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nurse (LPN)-A indicated R3 required total assitance with cares and was at risk for skin breakdown. LPN-A indicated R3 was to be repositioned every 2 hours, but at times refused. LPN-A indicated the nursing assistants knew what cares were to be done with each resident, and if R3 refused to be repositioned, the nursing assistants should have informed her and she would have talked to R3 and encourage her, which she indicated was usually effective. LPN-A indicated she assumed the nursing assistants were repositioning R3 every 2 hours and she was never quite sure, but they should have written it down when they completed repositioning on their care sheets.

On 12/31/20, at 11:45 a.m. NA-C indicated R3 required assistance with all activities of daily living, except she could feed herself, but at times required encouragement and assistance. NA-C indicated R3 required the use of the mechanical lift for transfers. NA-C indicated they were to check on R3, and do a check and change for incontinence cares and repositioning every 2 hours. NA-C indicated she had not assisted R3 with any cares on 12/30/20.

On 12/31/20, at 12:11 p.m. NA-B indicated they had gotten R3 up at 6:00 a.m. and repositioned her at 11:30 a.m. then she assisted the next shift to transfer R3 around 2:15 p.m. on 12/30/21. NA-B indicated she had asked R3 if she wanted to lay down after lunch yesterday, but had not repositioned her other than when at 6:00 when she woke up, 11:30, then again at 2:15 p.m. with the next shift. NA-B reviewed the care sheets with surveyor and indicated she had written down each care performed, but this did not indicated the times the cares were performed. NA-B

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| F 686 | Continued From page 10<br>indicated the form confused her and she had been documenting on the form incorrectly.<br><br>Review of facility policy Prevention of Pressure Ulcers updated 2/1/20, identified pressure ulcers are usually formed when a resident remains in the same position for an extended period of time, causing increased pressure or decreased circulation (blood flow) to that area. Change positions every two hours or more frequently if needed. | F 686 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to | F 690 | | 2/12/21 |

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| F 690 | Continued From page 11<br>prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R4) who was identified as incontinent of bowel and bladder received the necessary care and services to manage incontinence.<br><br>Findings include:<br><br>R4's quarterly Minimum Data Set (MDS) dated 12/21/20, identified cognitively intact, extensive assist of 2 needed with bed mobility, transfers, dressing, toileting, personal hygiene, and balance with transferring and standing. R4's MDS indicated always incontinent of bowel and bladder. Medical diagnoses identified diabetes mellitus, peripheral vascular disease (PVD), hypertension (HTN), paraplegia, obesity, and at risk for pressure ulcers.<br><br>R4's bowel and bladder program screener document dated 4/21/20, identified R4 sometimes aware of need to toilet and incontinent of bowel and bladder. R4's predisposing factors included diabetes, multiple sclerosis (MS), cardio vascular disease (CVA), bladder or prostate disease, frequent urinary tract infections (UTI), and spinal cord injury. R5 required assistance of 1 person to | F 690 | It is the policy of Meadow Lane Rehabilitation and Healthcare Center to ensure that residents who are incontinent of bladder receive the appropriate treatment and services to prevent urinary tract infections and to restore as much continence to the extent possible, within a timely fashion as to not contribute to have any adverse effects. At the time of the survey, the DON assessed, reviewed, and updated R4s NA care sheets, care plan, interventions and provided education to all direct care staff to ensure compliance.<br><br>At like residents identified as incontinent of bowel and bladder have the potential to be affected. Audits were completed and residents assessed, reviewed, and care sheets, care plans and interventions updated.<br><br>Policies titled Urinary Continence and Incontinence □ Assessment and Management reviewed and revised. All direct care nursing staff were provided education on 1-6-2021 immediately and ongoing by the DON/Designee which | |

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| F 690 | Continued From page 12<br>transfer to toilet, adjust clothing, and wipe.<br><br>R4's care plan identified bladder incontinence related to impaired mobility and neurogenic disorder. R4's care plan identified voiding routine and directed staff to toilet upon rising, lay down mid a.m. and mid p.m. and HS (hour of sleep). R4's care plan also identified limited mobility and muscular impairment and does not ambulate.<br><br>R4's progress notes on 12/1/2020, at 5:00 p.m. identified Resident had a Braden Assessment completed with a score of 15 and placed R5 at a risk for skin breakdown.<br><br>During observations on 12/30/20, at 9:00 a.m., 10:00 a.m., 11:00 a.m., 12:00 p.m., 1:00 p.m., and 2:00 p.m. R4 sat in wheelchair (w/c) in his room and watched television.<br>.<br>During observation on 12/30/20, at 2:12 p.m. nursing assistant (NA)-D lifted R4 with a sit to stand lift to a standing position. NA-D wheeled R4 into bathroom, removed incontinence product, and lowered him onto the toilet. NA-D verified the incontinent product was saturated with urine and very heavy.<br><br>During an interview on 12/30/20, at 12:48 p.m. R4 stated, the staff take me to the bathroom only once a shift and assist me when I need help. R4 indicated it maybe ok but not always aware when he needed to go to the bathroom.<br><br>During an interview on 12/31/20, at 11:58 a.m. NA-C identified personal cares were completed for R4 on 12/30/20, at 7:00 a.m. R4 was incontinent of urine and was transferred from the bed to his wheel chair. NA-C also indicated NA-A | F 690 | included in person training, handouts, return demonstrations and also provided via mail. Education included the above policies, proper use of care sheets, training with staff and audits implemented. All staff in-service to provide updates with plan of correction will be provided on 2/10, 2/11, 2/12 by DON/Clinical Manager.<br><br>The DON/Designee will complete random weekly audits, for 6 weeks, checking that appropriate assessments, documentation, and interventions in place and any deficient practices corrected immediately. All findings will be brought to and monitored through QAPI for further review and recommendations.<br><br>Director of Nursing is responsible for compliance. | |

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and NA-B were verbally informed of the tasks completed prior to her leaving that morning on 12/30/20, around 10:00 a.m.

During an interview on 12/30/20, at 1:38 p.m. NA-B identified R4 is usually incontinent of bowel and bladder and check and change should had been done every 2 hours. NA-B indicated her usual practice was to check R4 every hour for incontinence. NA-B also indicated R4 verbalized his needs but not sure he knows when the brief was wet. R4 verbalized to staff when it had been a long time since the check and change if he was uncomfortable. NA-B identified she was unsure when R4 had been checked and changed last.

During an interview on 12/30/20, at 1:55 p.m. NA-A indicated NA-C had completed cares for R4 early in the morning and placed him in his w/c. NA-A identified a check and change was done at 8 a.m. before R4 got out of bed and NA-A had not checked him since then.

During an interview on 12/31/20, at 11:35 a.m. the director of nursing (DON) indicated all CNA's are expected to document check and change and toileting on the ADL sheet and pass it on from one shift to another to help coordinate care. DON indicated staff are expected to list their name at the top of the document. DON identified she assumed the CNAs completed a check and change on R4 according to his Careplan and the staff should have written it down when it was completed on their care sheets. DON also indicated the document lacked clarification as she was uncertain as to which CNA completed the cares.

Facility policy titled Urinary Continence and

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| F 690 | Continued From page 14<br>Incontinence - Assessment and Management updated last 2/1/20, indicated relevant information related to urinary continence includes diabetes mellitus, obesity, and neurological disorders (MS), functional and/or cognitive function impaired mobility, and decreased upper and lower extremity muscle strength. A "check and change" strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin. | F 690 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(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; | F 880 | | 2/19/21 |

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| F 880 | Continued From page 15<br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review. | F 880 | | |

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| F 880 | Continued From page 16<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene and personal protective equipment (PPE) practices were performed while providing medical treatments and personal cares to 9 of 9 residents (R3,R4, R6, R8, R9, R10, R11, R12, R13) reviewed for provisions of care. These failed facility practices had the potential to affect all 23 residents who currently reside in the facility.<br><br>Findings include:<br><br>R3's significant change MDS dated 12/28/20, indicated medical diagnosis atrial fibrillation, hypertension (HTN) and<br><br>R4's quarterly Minimum Data Set (MDS) dated 12/1/20, identified medical diagnoses paraplegia, diabetes mellitus, and peripheral vascular disease.<br><br>R6's quarterly MDS dated 9/24/20, identified medical diagnoses of anemia, atrial fibrillation, coronary artery disease (CAD), congestive heart failure (CHF), (HTN), and diabetes mellitus.<br><br>R8' s quarterly MDS dated 12/23/20, identified medical diagnoses of CHF, HTH, and cardiovascular accident (CVA).<br><br>R9's admission MDS dated 12/8/20, identified medical diagnoses of traumatic brain injury (TBI) and HTN.<br><br>R10's discharge MDS dated 10/26/20 identified | F 880 | It is the expectation of the facility to ensure appropriate hand hygiene and personal protective equipment (PPE) practices were performed while providing medical treatments and personal cares to R3, R4, R6, R8, R9, R10, R11, R12, R13. Upon identification of the deficient practice, the DON provided reeducation to licensed and non-licensed nursing staff on proper handwashing and PPE practices while providing medication treatments and personal cares.<br><br>All residents have the potential to be affected by improper infection control practices. Upon identification of deficient practices, all policies, procedures and systems were reviewed to ensure system compliance. Re-education was provided by DON to staff on proper handwashing and PPE practices being performed while providing medication treatments and personal cares to ensure no other residents were adversely impacted.<br><br>Policies titled Handwashing/Hand Hygiene, Personal Protective Equipment  Using Gloves were reviewed with all staff. All staff education began on 1-6-2021 immediately and ongoing by the DON/Designee which included in person training, handouts and competencies with return demonstration on both PPE and handwashing. All staff in-service to provide updates with plan of correction will | |

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| F 880 | Continued From page 17<br>CAD, CHF, and HTN.<br><br>R11's admission MDS dated 12/28/20, identified medical diagnoses of atrial fibrillation, HTN, diabetes mellitus, and chronic obstructive disease (COPD).<br><br>R12's quarterly MDS dated 12/15/20, identified medical diagnoses of viral hepatitis, CVA, and COPD.<br><br>R13's quarterly MDS dated 11/20/20, identified medical diagnoses of stroke, HTN, neurogenic bladder, and CVA.<br><br>During continued observation starting on 12/30/20, at 10:20 a.m. a trained medication aide (TMA)-B walked down the hallway with disposable gloves on and entered R3's room. TMA-B checked R3'S temperature and oxygen levels, then wiped off oximeter with an alcohol wipe. TMA-B documented, did not sanitize hands and exited room with gloves on. At 10:25 a.m. TMA-B entered R8's room with the gloves on and did not sanitize her hands. TMA-B touched resident's hand, applied oximeter, checked temperature, and documented. TMA-B wiped off oximeter with an alcohol wipe. At 10:30 a.m. TMA-B exited R8's room without removing the gloves and did not sanitize her hands. TMA-B entered R6's room with the same gloves on and did not sanitize her hands. TMA-B touched residents hand and adjusted the bedside table, checked R6's temperature and oxygen saturation levels, and documented. TMA-B then wiped off oximeter with an alcohol wipe. TMA-B exited R6's room without sanitizing her hands and with the same gloves on. At 10:35 a.m., TMA-B walked into R9's room without sanitizing her hands and | F 880 | be provided on 2/10, 2/11, 2/12 by DON/Clinical Manager.<br><br>Effective 1-6-2021 a quality assurance program was initiated under the direction of the Director of Nursing for ensuring proper handwashing and appropriate PPE is used for all residents residing at the facility in accordance with their plan of care and facility□s policies and procedures. On 2-9-21 the increased monitoring was determined and audits initiated on all shifts every day, with 100 percent compliance for one week, then frequency decreased pending ongoing results. Any deficient practices corrected immediately. All findings will be brought to and monitored through QAPI for further review and recommendations.<br><br>Director of Nursing is responsible for compliance. | |

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with same gloves on, checked temperature and oxygen levels. TMA-B documented, exited R9's room did not remove her gloves and applied hand sanitizer to gloved hands then walked down the hallway to the next room. TMA-B then entered R10's room did not sanitize her hands and with the same gloves on TMA-B touched resident's hand, applied the oximeter, adjusted the bedside table, checked temperature, and documented. TMA-B exited R10's room without sanitizing hands and with same gloves on. TMA-B removed her gloves at medication cart, did not sanitize her hands, and documented on computer.

During the same continuous obseravton TMA then got from the computer and, without washing nor sanitizing her hands, at 11:20 a.m. TMA-B applied gloves and entered R4's room. TMA-B wiped off R4's finger with alcohol wipe, pricked his finger with lancet, placed a drop of blood onto test strip, and then placed test strip into the machine. TMA-B took dirty test strip, placed it in the garbage, and placed dirty lancet in sharps container, checked temp 99.7 Fahrenheit (F), and oxygen level. TMA-B informed R4 she would need to monitor his elevated temperature. R4's roommate sat in the wheelchair by the door. TMA-B adjusted here goggles, placed her gloved hand on R12's wheel chair handle, and patted his shoulder. TMA-B exited room with the same gloves on and without sanitizing her hands. TMA-B walked to medication cart and removed gloves, did not sanitize her hands, and documented on the computer.

On 11/30/20 at 11:50 a.m. TMA-B entered R13's room with meal tray and assisted her with meal set up. Staff exited room at 11:55 a.m. and did not sanitize her hands. TMA-B then entered

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R11's room and did not sanitize her hands. TMA-B lifted R11's head and adjusted the pillow, took a hold of draw sheet, repositioned R11 on his back, and elevated head of bed. TMA-B washed her hands with soap and water prior to exiting R11's room.

On 12/30/20 at 2:52 p.m. nursing assistant (NA) -D entered R4's room and applied gloves. R4 sat on toilet. NA-D lifted R4 off of toilet with a stand lift and a large bowel movement (BM) fell onto toilet seat. NA-D cleansed R5's rectal area with a wipe. NA-D then attached brief, and used stand lift to push resident over to the bed and lowered him down.NA-D lifted R5's legs onto bed, pulled up his pants, adjusted the resident's pillow, removed shoes, covered him up with blanket, and then washed hands with soap and water.

During an interview on 12/30/20, at 11:51 am with TMA-B indicated if she wore gloves, her usual practice was to remove her gloves and sanitize her hands prior to leaving a resident's room. TMA-B stated she usually performed hand hygiene prior to entering and exiting a resident's room. TMA-B indicted she did not remove her gloves and wore them from one resident's room to another and did not sanitize her hands prior to entering and exiting a resident's room or after she removed her gloves. TMA-B also indicated she should have not sanitized her gloves prior to leaving the resident's room and instead should have removed the gloves and then sanitized her hands.

R3's Significant Change Minimum Data Set (MDS) dated 10/20/20, identified R3 had severe cognitive impairment and diagnoses which included; arthritis, depression, chronic peripheral

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venous insufficiency (persistent condition of difficulty for blood to return to the heart from the legs) and constipation. R3's MDS further identified she required extensive assistance with dressing, personal hygiene and toileting.

R3's care plan revised 6/30/20, identified R3 had a physical functioning deficit related to mobility impairment. R3's interventions identified R3 required toileting assistance, assistance to manage incontinent products and personal hygiene assistance.

On 12/30/20, at 11:21 a.m. R3 was sitting in her wheelchair in her room, dressed in a skirt and blouse. Nursing assistant (NA)-A and NA-B transferred R3 from her wheelchair to her bed using a mechanical sling lift. NA-A and NA-B were both wearing gloves. NA-B on R3's left side of bed began to remove R3's skirt while NA-A got a garbage bag out, placed it in the garbage can, then removed his gloves, sanitized his hands, then left the room. At 11:25 a.m. NA-A returned to the room with wipes, washed his hands, then warmed up the wipes under the warm running water. NA-A informed R3 what he was doing, then rolled R3 towards him then towards NA-B while removing her sling from under her,then they both lowered R3's brief in the front. R3 was incontinent of a large amount of loose yellow stool, which had gotten on her sweater and the incontinence pad under her. NA-B used a wipe to begin to clean R3's perineal area while she laid on her back, then NA-A completed the front perineal cares with multiple wipes. They then rolled R3 towards her right side, NA-B completed the incontinence cares with the wipes on her buttocks and rectal area. At 11:32 a.m. NA-A and NA-B applied the new brief to R3. NA-A

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removed R3's shirt, covered her with the blanket, then went to the closet, opened the closet door, then removed a sweater, while he was still wearing the gloves used during incontinence cares. NA-A and NA-B assisted R3 with putting on her sweater, NA-A continued to wear the gloves worn during incontinence cares. NA-A then applied a compression bandage wrap to R3's lower left leg then applied a slipper sock, while still wearing the gloves worn during incontinence cares. At 11:40 a.m. NA-A removed his gloves and washed his hands. NA-B and NA-A then transferred R3 into her wheelchair.

On 12/30/20, at 1:23 p.m. NA-A indicated the usual facility practice was to sanitize hands prior to going into a resident's room, before applying gloves, and when done with cares. NA-A indicated if gloves were soiled, then he would change gloves and wash hands, then put on new gloves to prevent spread of possible infection. NA-A indicated he had not removed or changed his gloves after incontinence care when R3 had been incontinent of bowel. NA-A indicated he had worn the same gloves while getting R3's clean sweater from the closet and when he assisted R3 to put on the sweater. NA-A indicated he had been nervous while being watched and it was not his usual practice. NA-A indicated he should have taken off his gloves after providing incontinence cares, washed his hands then went to the closet and apply new gloves before he continued with cares. NA-A indicated everything could have been contaminated when he did not remove his gloves.

During an Interview on 12/31/20, at 11:35 a.m. DON indicated she would expect hand hygiene to

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be performed before and after glove use and gloves to be changed in between residents. DON also indicated staff are expected to remove their gloves and sanitize their hands when hands or gloves are visibly soiled and after completing peri cares with a bowel movement (BM) or urine. DON identified good hand hygiene would be necessary to help prevent the spread of infection to other residents.

During interview on 1/4/21, at 2:18 p.m. the infection preventionist (IFP)-B identified gloves are expected to be removed after completing cares and prior to exiting the resident's room followed by good hand hygiene. IFP-B also identified staff are expected to use good hand hygiene when entering a residents' room, after completing cares, and prior to exiting the room. IFP-B also indicated good hand hygiene would be necessary to help prevent transmission of infection.

Review of facility policy titled Persona Protective Equipment - Using Gloves updated 2/1/20, indicated the purpose of wearing gloves is to prevent the spread of infection. Wash hands after removing gloves (Note: Gloves do not replace handwashing).

Review of facility policy titled Handwashing/Hand Hygiene updated 10/29/19, indicated hand hygiene is the primary means to prevent the spread of infection. Use alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after coming in direct contact with residents, before preparing medications, after contact with a resident's intact skin, and after removing gloves.

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| F 880 | Continued From page 23<br>The use of gloves does not replace hand washing/hygiene. Integration of gloves use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infection | F 880 | | |
| F 885 SS=D | Reporting-Residents,Representatives&Families<br>CFR(s): 483.80(g)(3)(i)-(iii)<br><br>§483.80(g) COVID-19 reporting. The facility must—<br><br>§483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—<br><br>(i) Not include personally identifiable information;<br>(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and<br>(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to appropriately inform 2 of 2 residents (R6, R7) by 5:00 p.m. the next calendar | F 885 | It is the expectation of the facility to ensure all residents are informed within 24 hours of a single confirmed COVID-19 | 2/12/21 |

| 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 _____ | C 01/05/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MEADOW LANE RESTORATIVE CARE CENTER** | **2209 UTAH AVENUE BENSON, MN 56215** |

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| F 885 | Continued From page 24<br>day following the occurrence of a single confirmed COVID-19 infection, or when 3 or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other during the facility's outbreak. This had potential to affect all 23 residents residing in the facility.<br><br>Findings include:<br><br>R6's quarterly MDS dated 6/25/20, indicated cognitively intact.<br><br>R7's quarterly MDS dated 10/22/20, indicated cognitively intact.<br><br>During an interview on 12/31/20, at 9:51 a.m. F6 identified the facility did not update or notify resident in a timely manner on the facility's COVID status. F6 stated "I asked staff and no information was provided."<br><br>During an interview on 12/31/20, at 10:54 a.m. R7 confirmed the facility did not update or notify the resident in a timely manner on the COVID status within the facility. R7 stated, "No they don't ever do that."<br><br>During an Interview on 1/4/21, at 2:18 p.m. the infection preventionist (IFP)-B indicated all residents were expected to be notified verbally by staff. IFP-B indicated the charge nurse is expected to inform residents during the testing of each resident. IFP-B expected the documentation to be located in the nurse's notes in the resident's chart.<br><br>During an interview on 12/31/20, at 1:25 p.m. activities assistant (A)-A indicated all residents | F 885 | case, within 72 hours when 3 or more residents or staff have new onset of symptoms during outbreak, and weekly ongoing of status of cases of COVID-19 and the facilities preventative actions in place. Upon identification of the deficient practice, the facility notified all residents of the current status and documented the information in their medical record.<br><br>All residents have the potential to be affected if not informed properly of the COVID-19 notifications required to be completed by the facility within appropriate timeframes. Upon identification of deficient practices, all policies, procedures and systems were reviewed to ensure system compliance. The facility notified all residents of the status and documented the information in their medical record. Re-education was provided by DON to ensure activities staff/designees assigned for notification of cases are being completed and within appropriate timeframes, while ensuring documented is completed in the medical record for all residents.<br>Policies titled COVID-19 Facility Guidelines and CMS Pathway titled Infection Prevention, Control and Immunizations Pathway were reviewed with Activities Assistant and all Department Heads on 1-6-2021 by the DON/Designee. All staff in-service to provide updates with plan of correction will be provided on 2/10, 2/11, 2/12 by DON/Clinical Manager. | |

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| F 885 | Continued From page 25<br>were notified weekly about new COVID cases in the facility. A-A also indicated she had stopped in each resident room, verbally informed them, and documented in their progress notes. A-A was unable to locate documentation in the resident charts.<br><br>During an interview on 12/31/20, at 11:35 a.m. DON indicated the updates provided to each resident was completed by the A-A weekly. DON indicated A-A notified each resident and documented in each residents' chart. DON also indicated the activities director was currently on leave and A-A was expected to cover for her.<br><br>Review of facility document Midnight Census Report received on 12/31/20, identified a hand written note "told residents about covid cases" signed on these dates 9/11/20, 11/3/20, 11/6/20, 11/10/20, 11/12/20, 11/16/20, 11/17/20, 11/18/20, 11/20/20, 11/24/20, 11/28/20, 12/1/20, 12/4/20, 12/5/20, 12/6/20, 12/11/20, 12/12/20, 12/14/20, and 12/16/20.<br><br>The facility failed to document each resident was informed appropriately of new resident or staff onset of COVID-19 infection.<br><br>Review of Centers for Medicare and Medicaid Services (CMS) document titled Infection Prevention, Control and Immunizations (pathway) dated 11/2020, indicated the facility is required to inform all residents, their representatives, and family by 5 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other. | F 885 | The DON/Designee will complete random weekly audits, for 6 weeks, checking that appropriate assessments, documentation, and interventions in place and any deficient practices corrected immediately. All findings will be brought to and monitored through QAPI for further review and recommendations.<br><br>Director of Nursing is responsible for compliance. | |