Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 20, 2024

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: CCN: 245361
Cycle Start Date: March 6, 2024

Dear Administrator:

On March 6, 2024, a survey was completed at your facility by the Minnesota Department 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 isolated deficiencies that constituted immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On March 1, 2024, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

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 location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's

administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Meeker Manor Rehabilitation Center, Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 6, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@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://forms.web.health.state.mn.us/form/NHDisputeResolution

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/5/24 and 3/6/24, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaints were reviewed: H53611403C (MN00101329, MN001262, MN00101330) and H53611408C (MN00100912 and MN00101354) with a deficiency was cited at F689 for PAST NON-COMPLIANCE IJ. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. NO plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify heat register as safety hazard for 1 of 1 resident's (R1) bed that was too close to the heat who had a history of sleeping with his legs off the bed. This deficient	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 03/21/2024

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 689	Continued From page 1 practice resulted in an immediate jeopardy (IJ) for R1. The IJ began on 3/1/24, when the facility failed to ensure R1's bed was a safe distance from the heat source, R1 was found with is left foot on top of the heater which resulted in multiple second degree burns to the foot and required admission to hospital burn unit for treatment. The administrator and director of nursing (DON) were notified of the IJ on 3/6/24 at 4:51 p.m. The facility implemented corrective action and the deficient practice was corrected on 3/1/24, prior to the survey and was issued at past non-compliance. Findings include: Second degree burn: is also called partial thickness burn. These burns involve the outer layer of skin (epidermis). They can extend to the middle skin layer (dermis). Second degree burns can be very painful and often take several weeks to heal. Facility reported incident (FRI) submitted on 3/1/24 at 1:45 a.m., indicated facility staff noted R1's legs were dangling over the side of the bed and touching the top of the heat register. Also indicated R1's bed was pushed close to the wall that had the heat register mounted. Facility staff initially noted R1 to have new blisters on the bottom of his left toes. R1's diagnoses list last updated 3/5/24, indicated R1's diagnoses included diabetes, muscle weakness, non-pressure chronic ulcer of the right foot, autonomic neuropathy (damage to the nerves that control automatic body functions),	F 689		

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F 689	Continued From page 2 meralgia paresthetica (compression of the nerve to the thigh which affects sensation but doesn't impact the ability to move the leg), and second degree burn of left foot. R1's quarterly minimum data set (MDS) dated 12/8/23, identified R1 to have moderate cognitive impairment and no behaviors. R1's care plan dated 7/10/23, indicated R1 is a fall risk and staff are directed to keep the bed in low position. R1's areas of vulnerability included mobility impairment, hard of hearing, diabetes, and refusal to walk. R1 requires staff assist of two to transfer with mechanical lift and for turning and repositioning. Staff were directed to encourage R1 to assist by using bed rails. Further identifies R1 has "extremely fragile skin that is highly susceptible to skin tears". Care plan update on 3/1/24 indicated R1 had a burn to left foot from heat source in room. As a result of R1's burn and complications of diabeties identiifed an increased risk for infections. R1's March 2024 treatment administration record (TAR) informed and directed staff to keep R1's bed a good distance away from the heat register by the window. Tosses and turns at noc (night) especially, laying sideways with LE (lower extremity) on heat register if too close to it. Always have Rooke Boots [offloading boots] in place. Start date was 2/25/24 at 6:30 p.m. R1's progress notes on 3/1/24 at 3:17 a.m., indicated at 12:15 a.m., nursing assistant (NA) noted R1 lying on his bed with feet hanging by the bed, the bed was close to the heater. The right foot had an offloading boot on but the offloading boot for the left foot was off and R1's left foot was	F 689		

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F 689	Continued From page 3 laying on the heater. R1 was not in pain and was confused. R1's left forefoot was noted to have blisters with the size of two (2) centimeters (cm) x three (3) cm; big toe had a skin tear of 0.5 cm x 0.5 cm, and every single toe had a blister with the same size. R1's progress notes on 3/1/24 at 5:31 p.m., indicated R1 was being transferred from wound clinic to hospital Burn Unit. R1's progress notes on 3/5/24 at 5:09 a.m., indicated R1 returned from the hospital at 7:30 p.m. on 3/4/24. R1's Wound Progress Note by certified nurse practitioner (CNP)-A on 3/1/24 at 5:04 p.m., indicated R1 had kicked off his offloading boot and foot went off the side of the bed onto the heat register. Uncertain how long the foot was on the register but had developed significant blisters. Identifies extensive blistering on the plantar (sole of the foot) of the left foot covering all metatarsal heads and great toe through the 5th toes. All blisters on toes and metatarsal heads were debrided (remove dead tissue from the skin) using forceps and scissors. Toenails of the 2nd-5th toes are removed. Measurements provided of the left foot burns as follows: (length x width x depth) plantar was 5.5 cm x 6.2 cm x. 0.1 cm; plantar metatarsal head under great toe 1.2cm x 1.4 cm x 0.1cm; 5th toe plantar 2.8 cm x 2.4 cm x 0.1 cm; 4th toe plantar 3.3cm x 3.5 cm x 0.1 cm; great toe plantar 5/2 cm x 5 cm x 0.1 cm; 3rd toe plantar 4.1cm x 3.6 cm x 0.1 cm. Further noted due to the extent of the burns and R1's underlying co morbidities it was advised to transfer to a burn unit.	F 689		

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F 689	Continued From page 4 R1's hospital Interagency Transfer Form dated 3/4/24, indicated R1 had presented with 2% TBSA (total body surface area) partial superficial and partial deep 2nd degree burns to left foot and toe. R1 had discharge orders for daily dressing changes to the left foot and appointments to follow up. During an observation and interview on 3/5/24 at 4:45 p.m., R1 was in his bed with family sitting bedside. Bed position was turned perpendicular to the wall with the heating register. Head of bed was approximately 2 feet away from the wall. R1 had protective boots on both feet and lower legs. R1 stated he had just returned from the hospital after burning his foot on the heat register. R1 explained he moved around in bed on his own and favored laying on his right side facing the wall towards the window (the wall also holds the heat register). Family member (FM)-A indicated R1's bed had been up against that wall since he was admitted a couple of years prior, and he liked laying on his side and looking out the window. FM-A indicated that a note was taped to the windowsill for a week or two prior to R1's burn that warned staff to keep the bed away from the wall because the heater was too hot. FM-A did not know why the note had been taped there or where it was at the time of this interview (there was no note taped to the windowsill). FM-A further indicated R1 had poor circulation in his legs and had wounds on his right foot that weren't healing but that prior to the burn, his left foot was without any wounds. FM-A reported that R1 had required surgery on his leg a few weeks prior to increase the blood flow to help heal the wounds on the right leg. FM-A was afraid of R1's ability to heal the left foot burns because of his poor circulation.	F 689		

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F 689	Continued From page 5 During observation and interview on 3/6/24 at 10:04 a.m., the maintenance director indicated the surface temperature of baseboard heat registers were not routinely checked. If a resident complains of the temperature in their room, they used a heat gun to check the general room air temperature but clarified, they did not check the surface temp of the heat registers. Observation of heat register temperatures included: Room 301's heat register was 109 degrees Fahrenheit (F) on the side and was 169 degrees(F) over the actual air vent. Room 407's heat register was 73 degrees (F) on the side of and 120 degrees (F) over the air vent. During an interview on 3/6/24 at 9:55 a.m., nursing assistant (NA)-A indicated the heat registers get "pretty hot" and have heard some staff complaints about how hot it gets on their pant legs when they are by them but was not aware of any resident injuries until R1's. NA-A stated R1 moved in bed a lot, often would find R1's legs hanging over the side of the mattress, and would put them back into bed. R1 usually wore the protective boots on his lower legs but the left one had fallen off. NA-A explained there had been a note dated 2/25/24, hanging on the windowsill telling staff to keep the bed away from the heater but had been taken down after the incident. During an interview on 3/6/24 at 10:45 a.m., NA-B stated. R1 "swung his legs off the bed towards the window all the time" and R1 "constantly kicked off the boot protectors, he hated those". During an interview on 3/7/24 at 8:20 a.m., RN-A indicated R1 was known to be "restless" at night	F 689		

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F 689	Continued From page 6 and a few weeks prior, she observed R1 laying sideways in bed and feet were on the heater. R1 was wearing the protective boots at that time but the boots were warm to touch. RN-A moved the bed away from the heat register and locked the brakes. RN-A stated she could not remember the exact day but did indicate that she made a progress note in his record, put instructions in the TAR, placed a note on R1's windowsill, and told other nurses to pass it on. RN-A was not sure what happened after that. During an interview on 3/6/24 at 12:15 p.m., the director of nursing (DON) indicated she was not aware of any potential safety risks related to R1 and the heat registers until after the incident on 3/1/24. DON expected stafff notify her of any safety concerns and brought forward to the interdisciplinary team for review. During an interview on 3/6/24 at 12:00 p.m., the administrator indicated during their investigation of R1's burns, it was discovered that registered nurse (RN)-A had recognized a potential risk of R1 getting burned by the heat register, put a sign up on the windowsill in his room and put "something" in the treatment record but did not notify the nurse manager or administration for proper follow through to protect R1. Administrator stated the expectation was to have all potential safety risks addressed immediately for safety and then passed through the proper channels for follow-up. During an interview on 3/11/24 at 4:11 p.m., CNP-A reported being notified of the incident late morning on 3/1/24 and evaluated R1 later that afternoon. R1 was noted to have "very significant blisters that had been partially unroofed [blister	F 689		

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F 689	Continued From page 7 popped] already so had to debride them". Further indicated, because of the significance of the blisters and the complexity of R1 medical conditions, consulted with the burn unit and they advised to have him transferred for further evaluation. The facility Safety Policy dated 3/09 indicates their objective to develop and implement a system that will address the following components: management commitment and resident/employee involvement; environment and worksite analysis, hazard prevention and control, and safety and health training. The facility implemented the following corrective actions on 3/1/24: R1's bed moved away from wall; perimeter mattress applied to R1's bed, and therapy screen for input regarding room arrangement and bed mobility. Resident skin checks were completed. All high-risk residents were identified, and rooms rearranged for safety. Staff education on how to identify and report potential behaviors or resident' changes to ensure they're evaluated to reduce safety hazards within the environment and associated resident harm Audits of bed placement implemented. On 3/5/24 and 3/6/24 staff were able to articulate appropriate bed placement and the safety risk heaters pose to residents.	F 689		

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{E 000}	Initial Comments On 2/1/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. 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 On 3/5/24, an offsite revisit was conducted to follow up on deficiencies issued related to a standard recertification survey exited on 2/1/24. Your facility was IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/08/2024

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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	00775	A. BUILDING: _____ B. WING _____	R-C 03/05/2024

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MEEKER MANOR REHABILITATION CENTER, I	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/5/24, an offsite revisit was conducted to follow up on licensing orders issued related to a licensing survey exited on 2/1/24, by the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure.	{2 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775	A. BUILDING: _____ B. WING _____	R-C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 000}	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	{2 000}		

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{2 000}	Continued From page 2 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.	{2 000}		