DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 8, 2023

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

RE: CCN: 245361
Cycle Start Date: March 17, 2023

Dear Administrator:

On May 8, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 8, 2023

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

Re: Reinspection Results
Event ID: UN7K12

Dear Administrator:

On May 8, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 17, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 6, 2023

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

RE: CCN: 245361
Cycle Start Date: March 17, 2023

Dear Administrator:

On March 17, 2023, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 17, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 17, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

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,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 03/17/2023

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 Surveyor: 34083 On 3/16/23 through 3/17/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53619615C (MN91952), with a deficiency issued at F585. The following complaints were reviewed: H53619228C (MN91846), H53619595C (MN91946), H53619498C (MN91959) and H53619499C (MN91957) with a deficiency issued at F580. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		5/4/23

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

Electronically Signed | 04/13/2023

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 580	Continued From page 1 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various	F 580		

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F 580	Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Surveyor: 34083 Based on interview and document review, the facility failed to appropriately notify the physician when 1 of 1 resident fell, sustained injuries to his right leg and hip that caused pain with observed changes in limb size to the right leg. Findings include: R1's, 3/9/23, discharge with return anticipated, Minimum Data Set (MDS) assessment, identified R1 had moderate cognitive impairment and behaviors of rejection of cares. R1 required extensive assistance of 2 staff for activities of daily living, (ADLs). R1 was always incontinent of bladder and frequently incontinent of bowel and was not identified as being on a toileting program. R1 had diagnosis of non-traumatic brain dysfunction, schizoaffective disorder-bipolar type, cancer, anxiety disorder, dementia, psychotic disorder other than schizophrenia, weakness, and was noted to have repeated falls. R1's 3/5/23 at 11:10 a.m., fall report R1 experience a fall resulting in a bruise on his scalp, 2 scratches on his right forearm, and a painful, swollen right knee and leg. R1 was noted to have had increased bruising on his right side and hip and the underside of his right forearm. Staff noted R1 "States his buttocks hurt" and also "resident denies pain at the time of assessment."	F 580	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F580 S/S D -The process for satisfying this requirement has been reviewed and	

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F 580	Continued From page 3 R1's progress notes identified on: 1) 3/5/23 at 1:40 p.m., R1 had fallen. Staff noted R1 "complained of leg pain" and noted his right knee/leg was swollen and much bigger than the left.Staff documented a "decision was made" to monitor for increased pain and abnormalities. There was no indication how the nurse came to that decision nor if she called R1's physician or called the local hopsital emergency department to identify immediate assessment could be postponed. 2) 3/5/23 at 2:42 p.m., staff noted R1 was found on the floor sitting on his buttocks. Staff stated there was no injuries. 3) 3/5/23 at 6:00 p.m., staff noted they had faxed R1's physician. There was no mention any provider had been notified by phone of the pain and/or abnormality to R1's right leg. 4) 3/6/23 at 3:12 p.m., R1 had a bruise on his right hip the size of staff's hand. R1's physician was notified via fax on 3/5/23, R1 had fallen 2x that day. R1's right leg was "larger than the left" and his right knee and leg was painful and swollen. There was no indication R1's physician was called, nor the local emergency department notified of R1's significant change in physical condition after a fall requiring emergency medical assessment and treatment. R1's physician nurse practitioner (NP)-A replied back 3 days later on 3/8/23 at 10:00 a.m., through an electronic physician order, advising staff "Okay for X-ray Left Pelvis/Femur". There was no indication staff had called the physician to clarify the right leg was the leg to be xrayed. R1's 3/8/23 at 5:02 p.m., portable X-Ray report identified staff had xrayed R1's left leg. Their	F 580	revised as needed, to ensure physicians are appropriately notified of significant changes. -All residents have the potential to be affected if this regulation is not met. -R1's medical record was reviewed to ensure the physician was notified. -All resident falls and/or significant health events have been reviewed and investigated to ensure appropriate physician notifications are made. -All necessary Meeker Manor staff received education on 4/12/23 regarding the requirement to notify a physician with any significant change(s) in condition. -Compliance audits will be completed three (3) times weekly for two (2) weeks, two (2) times weekly for two (2) weeks, one (1) time weekly for two (2) weeks, and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator or designee is responsible party. -Corrective action will be completed on or before 05/04/2023.	

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F 580	Continued From page 4 report identified there was no fracture or dislocation and the joints appeared normal. Further review of R1's progress notes identified on: 1) 3/9/23 at 11:10 a.m., staff documented they learned the wrong hip had been xrayed. R1 was experiencing "more pain" and his leg was turned outward. Staff had updated NP-A through the electronc portal. The NP replied back "if he is having increased pain and swelling, it may be best to send him to the ER for imaging". 2) 3/9/23 at 1:41 p.m., staff noted the ambulance was at the facility to transport R1 to the ER. R1's physcian order dated 3/9/23, identified NP-A ordered staff to send R1 to the emergency department for evaluation related to "increased pain." R1's emergency department progress notes dated 3/9/23, identified R1 presented with right leg pain from a fall on 3/5/23. "Staff noted adduction [abnormal inward rotation of a limb] the to the right leg." The physician noted R1 had imaging to the left side and not the right. R1 was not an accurate historian and could point to the pain but vocalized pain in his right extremety. R1 was given Fentanyl (strong narcotic pain medication). R1 had imaging on his right leg and was found to have an acute minimally displaced. Orthopedics was consulted with a plan to perform surgery the next day on the fractured site. Interview on 3/16/23 at 2:25 p.m., with registered nurse (RN)-A identified she was not working 3/5/23 or 3/6/23 but had been updated through shift report on her return on 3/8/23 that R1 had pain and bruising relieved with Tylenol and rest	F 580		

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F 580	Continued From page 5 following 2 falls on 3/5/23. RN-A had assessed R1 on 3/8/23 and noted he had signs of pain without verbalizing a specific location but would "grab his right leg" when NAs were attempting to provide cares and refused to get out of bed. RN-A had updated the nurse manager and reported R1 should have x-rays done of his right hip. The nurse manager had contacted the doctor and orders were received for an xray. A portable x-ray provider was called, but had been delayed to provide the xray until about 5:00 p.m. due to weather. RN-A assisted the unidentified x-ray technician to perform the x-ray, which was performed on R1's left side. RN-A had questioned why R1's left side was being xrayed and the xray technician referenced the order identified to xray R1's left hip. At that time, there was no administration in the faciity, and physician clinic staff had left for the day. She left a message for the nurse manager who returned the call about 6:30 p.m. and was updated that x-ray had been completed on the wrong side (left). Since his medical provider was gone for the day and the xray tech had left, she would update the provider the following morning of the incorrect hip being x-rayed. On 3/9/23, R1 was noted to have increased pain in his right leg, and had inward rotation of his right leg. NP-A was updated and a new order was received to transfer R1 to the hospital emergency department (ED) for evaluation. Interview on 3/16/23 at 3:53 p.m., licensed practical nurse (care coordinator)-A reported following R1's falls he had "minimal pain" and indicated both his range of motion (ROM) and neurological signs were within normal limits. LPN-A stated the provider was updated via fax. LPN-A added R1 had "increased pain" and	F 580		

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F 580	Continued From page 6 refused to allow staff to transfer him from his bed on 3/8/23. Staff obtained orders to x-ray his left hip. LPN-A stated there was an "error in transcription" with the orders received and the order identified the left hip was to be x-rayed instead of the right. When R1's pain increased and he had inward rotation of his right leg, the MD was notified and an order was obtained to transfer to the ED for further evaluation. Upon arrival at the ED on 3/9/23, R1's right hip was x-rayed, and fracture of his right hip was discovered. Interview on 3/16/23 at 5:06 p.m., with MD-A who was both R1's primary medical provider and the facility medical director identified R1 was a "difficult resident to manage", because he frequently self-transferred without help and failed to understand his limited abilities and lack of safety awareness. MD-A expected nursing staff to have called to the on-call provider to obtain a corrected order to complete an x-ray of R1's right hip, rather than wait until the next day. She did not feel the delay caused R1 increased pain. MD-A reported she was not certain if the delay caused a change in R1's treatment or R1 experienced increased discomfort due to the error. Interview on 3/17/23 at 10:23 a.m., with the director of nursing (DON) identified she expected staff to notify the physician for an error in a physician order. If an error was discovered, the provider or on-call provider should be contacted for clarification before continuing. Interview on 3/17/23 at 10:29 a.m., with the facility administrator reported the ADON had sent the fax request for R1's right hip x-ray to the NP	F 580		

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F 580	Continued From page 7 via the online portal reporting R1's increased pain with rotation of his right leg. he NP sent the order for x-ray of R1's left hip and pelvis. As a result, the incorrect side (left) had been x-rayed. The administrator reported the error should have been caught and corrected by nursing staff immediately. The administrator reported changes had been made to the facility policy and procedure to have nurse managers receive a verbal report to ensure orders were not missed and errors or issues were caught. Review of the 2/24/23 Trauma Informed Care policy identified the facility supported safety for both staff, residents, and visitors. The IDT team was to monitor approaches to ensure implementation and achievement of the goals of care. Care Plans were to be updated as needed. Review of the 2/2021 Fall Prevention and Management policy identified staff were to monitor and document vital signs every shift for 24 hours following the fall and continue to monitor and document intervention effectiveness for 72 hours after the fall occurred. Nursing staff were to observe a resident for delayed complications following a fall and document findings in the resident's medical record in addition to updating the medical provider.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		5/4/23

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F 585	Continued From page 8 respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman	F 585		

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 03/17/2023

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F 585	Continued From page 9 program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement	F 585		

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F 585	Continued From page 10 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Surveyor: 47497 Based on interview and document review, the facility failed to complete an appropriate root cause analysis and make efforts to resolve identified grievances related to long call light wait times for 1 of 2 residents (R3) reviewed for grievances. R3's 2/17/23, quarterly Minimum Data Set (MDS) identified R3 had diagnoses including: Bipolar disorder, hypertension, seizure disorder, anxiety, depression, post traumatic stress disorder, chronic obstructive pulmonary disease (COPD), personality disorder, obesity, and difficulty walking. The MDS identified R3's cognition was intact, required extensive assist of 1 staff with bed mobility, extensive assist of 2 staff with transfers, and limited assist of one staff with hygiene and dressing. R3's undated, current care plan identified she was at risk for falls with interventions that included to keep the bed in the lowest position, ensure proper footwear on when transferring, to place signs to call for help, use a soft touch call light, and ensure their wheelchair was kept at their bedside with the breaks locked. Review of the undated, current facility grievance	F 585	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F585 S/S D -The process for satisfying this	

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F 585	Continued From page 11 log identified R3 had reported a grievance on 1/20/23, the report details identified R3's complaint had been that the call light wait times ranged from a half hour to an hour on a daily basis. The Summary of Findings identified the facility had reviewed the call light log and found that call lights had been on greater than 30 minutes six times from 1/9/23 through 1/20/23, usually in the evenings. The Summary of Action Taken identified that R3 had been told that call lights are answered in the order they are turned on. Interview on 3/16/23 at 11:09 a.m., with R3 identified "they take forever to answer call lights around here"and that while she understood that she needed assistance from staff to safely transfer from her wheel chair to bed or to the bathroom, she often transfers herself because her body had becomes sore from sitting in the wheel chair and she had been unable to wait any longer than that to use the bathroom. R3 explained that when she had fallen in the past it had been because she could not wait any longer for staff to answer her call light so she had transferred herself. R3 identified that she had put in grievances and requested to be placed on an every 2 hour toileting schedule but that the facility had not done that. R3 also stated that following the grievances the nurse manager had told her they would speak with the staff about it but that the call light wait time had not improved. Interview on 3/16/23 at 1:44 p.m., with trained medication aid (TMA)-A identified that there had been no place to see how long a call light had been on. TMA-A further identified that staff had carried walkie's and the walkie's alert staff if a call light had been on for an "extended wait time",	F 585	requirement has been reviewed and revised as needed, to ensure Meeker Manor completes root cause analyses and makes efforts to resolve identified grievances related to long call light wait times. -All residents have the potential to be affected if this regulation is not met. -R3's electronic medical record, to include the plan of care, was reviewed and revised as needed to ensure there was no harm or lasting effects. -R3's grievance was resolved via follow up with R3, necessary staff education, & review of Monarch Healthcare Policy & Procedure regarding grievance resolution. -All necessary Meeker Manor staff received education in accordance with Monarch Healthcare Policy and Procedure on 4/12/23 and 4/19/23 to ensure grievances are appropriately resolved. -The facility completed QAPI on 3/24/23 and discussed the shared concern of call lights and the expectations for answering them; ensuring residents are provided care and services in a timely manner. -Compliance audits will be completed weekly for four (4) weeks, and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator or designee is responsible party. -Corrective action will be completed on or before 05/04/2023.	

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F 585	Continued From page 12 however, TMA-A revealed she had not known how long the call light had been on before the alert would have been sent out. TMA-A revealed she had not received any training on the call light system and she has had residents complain about the wait time for call lights to be answered and that if residents had been "really upset" she notified the nurse. Interview on 3/16/23 at 2:49 p.m., administrator identified that it is her expectation that grievances be investigated and that the person resolving the grievance should review the resolution with the resident. administrator further identified that she had reviewed the call light log but had not completed any call light audits or training since receiving the complaints regarding the long call light wait times. The adminsitrator agreed that they should have followed up with R3 to ensure the call light wait times had improved. Interview on 3/17/23 at 10:22 a.m., director of nursing identified that it would be her expectation that grievances should have been passed on to the unit nurse managers to complete a root cause analysis to determine an effective resolution, then that resolution should have been reviewed with the resident for satisfaction. Documentation of a root cause analysis was requested, none was provided. Review of the undated facility policy titled Complaint and Grievance Procedure identifies grievances should be given to the direct supervisor, then to the director of nursing, and if unresolved given to the adminsitrator. The administrator or designee will conduct an investigation and resolution within 5 business	F 585		

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F 585	Continued From page 13 days and will notify complainant of the proposed action for satisfaction.	F 585		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 6, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: UN7K11

Dear Administrator:

The above facility was surveyed on March 16, 2023 through March 17, 2023 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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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: Surveyor: 34083 On 3/16/23 through 3/17/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic	2 000		

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2 000	Continued From page 1 plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H53619615C (MN91952), with a deficiency issued at F585. The following complaints were reviewed: H53619228C (MN91846), H53619595C (MN91946), H53619498C (MN91959) and H53619499C (MN91957) with a deficiency issued at F580. 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 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 surveyor ' s 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 14-01, available at <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	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been	21830		5/4/23

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21830	Continued From page 3 admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact,	21830		

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21830	Continued From page 4 the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Surveyor: 34083 Based on interview and document review, the facility failed to appropriately notify the physician when 1 of 1 resident fell, sustained injuries to his right leg and hip that caused pain with observed changes in limb size to the right leg. Findings include: R1's, 3/9/23, discharge with return anticipated, Minimum Data Set (MDS) assessment, identified	21830	Corrected.	

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21830	Continued From page 5 R1 had moderate cognitive impairment and behaviors of rejection of cares. R1 required extensive assistance of 2 staff for activities of daily living, (ADLs). R1 was always incontinent of bladder and frequently incontinent of bowel and was not identified as being on a toileting program. R1 had diagnosis of non-traumatic brain dysfunction, schizoaffective disorder-bipolar type, cancer, anxiety disorder, dementia, psychotic disorder other than schizophrenia, weakness, and was noted to have repeated falls. R1's 3/5/23 at 11:10 a.m., fall report R1 experience a fall resulting in a bruise on his scalp, 2 scratches on his right forearm, and a painful, swollen right knee and leg. R1 was noted to have had increased bruising on his right side and hip and the underside of his right forearm. Staff noted R1 "States his buttocks hurt" and also "resident denies pain at the time of assessment." R1's progress notes identified on: 1) 3/5/23 at 1:40 p.m., R1 had fallen. Staff noted R1 "complained of leg pain" and noted his right knee/leg was swollen and much bigger than the left.Staff documented a "decision was made" to monitor for increased pain and abnormalities. There was no indication how the nurse came to that decision nor if she called R1's physician or called the local hopsital emergency department to identify immediate assessment could be postponed. 2) 3/5/23 at 2:42 p.m., staff noted R1 was found on the floor sitting on his buttocks. Staff stated there was no injuries. 3) 3/5/23 at 6:00 p.m., staff noted they had faxed R1's physician. There was no mention any provider had been notified by phone of the pain and/or abnormality to R1's right leg. 4) 3/6/23 at 3:12 p.m., R1 had a bruise on his	21830		

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	00775	A. BUILDING: _____ B. WING _____	C 03/17/2023

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21830	Continued From page 6 right hip the size of staff's hand. R1's physician was notified via fax on 3/5/23, R1 had fallen 2x that day. R1's right leg was "larger than the left" and his right knee and leg was painful and swollen. There was no indication R1's physician was called, nor the local emergency department notified of R1's significant change in physical condition after a fall requiring emergency medical assessment and treatment. R1's physician nurse practitioner (NP)-A replied back 3 days later on 3/8/23 at 10:00 a.m., through an electronic physician order, advising staff "Okay for X-ray Left Pelvis/Femur". There was no indication staff had called the physician to clarify the right leg was the leg to be xrayed. R1's 3/8/23 at 5:02 p.m., portable X-Ray report identified staff had xrayed R1's left leg. Their report identified there was no fracture or dislocation and the joints appeared normal. Further review of R1's progress notes identified on: 1) 3/9/23 at 11:10 a.m., staff documented they learned the wrong hip had been xrayed. R1 was experiencing "more pain" and his leg was turned outward. Staff had updated NP-A through the electronc portal. The NP replied back "if he is having increased pain and swelling, it may be best to send him to the ER for imaging". 2) 3/9/23 at 1:41 p.m., staff noted the ambulance was at the facility to transport R1 to the ER. R1's physcian order dated 3/9/23, identified NP-A ordered staff to send R1 to the emergency department for evaluation related to "increased pain."	21830		

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21830	Continued From page 7 R1's emergency department progress notes dated 3/9/23, identified R1 presented with right leg pain from a fall on 3/5/23. "Staff noted adduction [abnormal inward rotation of a limb] the to the right leg." The physician noted R1 had imaging to the left side and not the right. R1 was not an accurate historian and could point to the pain but vocalized pain in his right extremety. R1 was given Fentanyl (strong narcotic pain medication). R1 had imaging on his right leg and was found to have an acute minimally displaced. Orthopedics was consulted with a plan to perform surgery the next day on the fractured site. Interview on 3/16/23 at 2:25 p.m., with registered nurse (RN)-A identified she was not working 3/5/23 or 3/6/23 but had been updated through shift report on her return on 3/8/23 that R1 had pain and bruising relieved with Tylenol and rest following 2 falls on 3/5/23. RN-A had assessed R1 on 3/8/23 and noted he had signs of pain without verbalizing a specific location but would "grab his right leg" when NAs were attempting to provide cares and refused to get out of bed. RN-A had updated the nurse manager and reported R1 should have x-rays done of his right hip. The nurse manager had contacted the doctor and orders were received for an xray. A portable x-ray provider was called, but had been delayed to provide the xray until about 5:00 p.m. due to weather. RN-A assisted the unidentified x-ray technician to perform the x-ray, which was performed on R1's left side. RN-A had questioned why R1's left side was being xrayed and the xray technician referenced the order identified to xray R1's left hip. At that time, there was no administration in the faciity, and physician clinic staff had left for the day. She left a message for the nurse manager who returned the call about 6:30 p.m. and was updated that x-ray had	21830		

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21830	Continued From page 8 been completed on the wrong side (left). Since his medical provider was gone for the day and the xray tech had left, she would update the provider the following morning of the incorrect hip being x-rayed. On 3/9/23, R1 was noted to have increased pain in his right leg, and had inward rotation of his right leg. NP-A was updated and a new order was received to transfer R1 to the hospital emergency department (ED) for evaluation. Interview on 3/16/23 at 3:53 p.m., licensed practical nurse (care coordinator)-A reported following R1's falls he had "minimal pain" and indicated both his range of motion (ROM) and neurological signs were within normal limits. LPN-A stated the provider was updated via fax. LPN-A added R1 had "increased pain" and refused to allow staff to transfer him from his bed on 3/8/23. Staff obtained orders to x-ray his left hip. LPN-A stated there was an "error in transcription" with the orders received and the order identified the left hip was to be x-rayed instead of the right. When R1's pain increased and he had inward rotation of his right leg, the MD was notified and an order was obtained to transfer to the ED for further evaluation. Upon arrival at the ED on 3/9/23, R1's right hip was x-rayed, and fracture of his right hip was discovered. Interview on 3/16/23 at 5:06 p.m., with MD-A who was both R1's primary medical provider and the facility medical director identified R1 was a "difficult resident to manage", because he frequently self-transferred without help and failed to understand his limited abilities and lack of safety awareness. MD-A expected nursing staff to have called to the on-call provider to obtain a corrected order to complete an x-ray of R1's right	21830		

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21830	Continued From page 9 hip, rather than wait until the next day. She did not feel the delay caused R1 increased pain. MD-A reported she was not certain if the delay caused a change in R1's treatment or R1 experienced increased discomfort due to the error. Interview on 3/17/23 at 10:23 a.m., with the director of nursing (DON) identified she expected staff to notify the physician for an error in a physician order. If an error was discovered, the provider or on-call provider should be contacted for clarification before continuing. Interview on 3/17/23 at 10:29 a.m., with the facility administrator reported the ADON had sent the fax request for R1's right hip x-ray to the NP via the online portal reporting R1's increased pain with rotation of his right leg. he NP sent the order for x-ray of R1's left hip and pelvis. As a result, the incorrect side (left) had been x-rayed. The administrator reported the error should have been caught and corrected by nursing staff immediately. The administrator reported changes had been made to the facility policy and procedure to have nurse managers receive a verbal report to ensure orders were not missed and errors or issues were caught. Review of the 2/24/23 Trauma Informed Care policy identified the facility supported safety for both staff, residents, and visitors. The IDT team was to monitor approaches to ensure implementation and achievement of the goals of care. Care Plans were to be updated as needed. Review of the 2/2021 Fall Prevention and Management policy identified staff were to monitor and document vital signs every shift for 24 hours following the fall and continue to monitor	21830		

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21830	Continued From page 10 and document intervention effectiveness for 72 hours after the fall occurred. Nursing staff were to observe a resident for delayed complications following a fall and document findings in the resident's medical record in addition to updating the medical provider. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement measure to ensure timely notification to the physician. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The facility should perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the	21880		5/4/23

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21880	Continued From page 11 Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Surveyor: 34083	21880	Corrected.	

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21880	Continued From page 12	21880		

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could review policies and procedures regarding grievances to ensure feedback is communicated, then inservice staff regarding the process and audit to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.