DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 12, 2022

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

RE: CCN: 245367
Cycle Start Date: November 1, 2022

Dear Administrator:

On December 8, 2022, the Minnesota Department(s) 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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 12, 2022

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

Re: Reinspection Results
Event ID: V8I812

Dear Administrator:

On December 8, 2022 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 November 1, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Electronically delivered
November 8, 2022

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

RE: CCN: 245367
Cycle Start Date: November 1, 2022

Dear Administrator:

On November 1, 2022, 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:

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

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 February 1, 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 May 1, 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

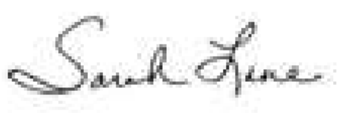
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/31/22-11/1/22 a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H53675161C (MN00087660), with no citations due to the actions taken by the facility prior to the survey. H53675111C (MN 00087620), with a deficiency cited at (F684). 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		11/23/22

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

Electronically Signed | 11/18/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an appropriate wheelchair (WC) for 1 of 3 residents (R1) reviewed for wheelchair positioning. Findings include: During an interview on 11/1/22, at 12:52 p.m. family member (FM)-A indicated R1 had a leg fracture in June. She had recently became aware R1 had not used his wheelchair since that happened. FM-A stated the facility had not notified her of any issues with the wheelchair or R1 could no longer use it. FM-A indicated it broke her heart when she found out R1 had to remain in bed. FM-A reported she told the facility they needed to get things going to get R1 a new chair. R1's Quarterly Minimum Data Set (MDS) assessment dated 9/20/22, indicated R1 was severely cognitively impaired and required total assistance of two in all activities of daily living (ADL)'s. R1's diagnoses included heart failure, hypertension, hip fracture, cerebral palsy, and seizure disorder or epilepsy. R1's care plan (CP) dated 6/30/18, with revision on 11/27/21 indicated R1 required a tilt and space wheelchair and R1 was to remain tilted up when in the chair. R1's PN dated 6/14/22, at 12:12 p.m. indicated R1 was readmitted to the facility after being	F 684	1. In continuing compliance with F 684, Quality of Care Grand Meadow Senior Living corrected the deficiency by placing resident R1 in an appropriate wheelchair on 11/11/2022 as well as assessed audited all current residents for appropriate wheelchairs per their care plan on 11/23/2022. 2. To correct the deficiency and to ensure the problem does not recur all nursing staff were educated by 11/18/2022 on utilizing the cares sheet for appropriate wheelchairs and to notify the nurse in charge if there are concerns with the wheelchair or if it is unavailable by DON. The DON and/or designee will audit 3 residents per week on all shifts for four weeks, then 3 residents per week on random shifts for 8 weeks and then randomly for appropriate wheelchairs. 3. As part of Grand Meadow Senior Living ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2 hospitalized on 6/10/22 for left femur fracture. R1 required two staff for assistance with all ADL's, was not able to walk, and required wheelchair/scooter for mobility. On 7/14/22 the care plan revision directed staff to not sit resident up past 45 degree angle. R1's PN dated 8/11/22, at 7:28 p.m. indicated R1 was a high risk for skin alterations and unable to perform physical activity due to being confined to a bed/bedfast and was completely immobile. R1's medical record reviewed between 6/14/22 to 10/20/22 did not include physician orders for change in weight bearing status or range of motion restrictions. Further the record did not identify an order for new wheelchair or a change in wheelchair positioning. Additionally, a physician order for bedrest was not evident. R1's therapy records also did not identify a recommendation for wheelchair positioning, nor restrict R1's ability to sit in a wheelchair or had certain angle restrictions when sitting. R1's PN dated 10/20/22, at 1:11 p.m. indicated R1 unable to sit up past 45-degree angle and his personal chair was no longer able to be used. R1 had been currently using facility chair and therapy department was assisting facility to obtain R1 with his own chair. Review of R1's records between 10/20/22 to 10/31/22, continued to lack a comprehensive wheelchair or positioning assessment by nursing or therapy to determine appropriate positioning and wheelchair. During observation and interview on 10/31/22, at	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3 10:48 a.m. R1 was seated in the facility Broda wheelchair (brand of wheelchair that promotes safety, pressure relief, and correct posture) in his room. During interview on 10/31/22, at 1:31 p.m. nursing assistant (NA)-A stated R1 had used his personal wheelchair previous to his leg fracture but since has not used it because he did not sit in it properly. NA-A explained after the fracture she had only transferred R1 to the shower chair on Tuesdays and Saturdays. That was the only time R1 was out of bed for months unless he was going to the hospital. NA-A indicated she noticed about a month ago, R1 started using the facility's Broda chair after another resident no longer needed it. During an interview on 10/31/22 at 1:43 p.m. trained medication administrator (TMA)-A stated R1 had used his wheelchair daily before the fracture but after the fracture she could not remember the last time he had used it. TMA-A stated R1 had gone to therapy for positioning but did not remember what happened after that. TMA-A stated R1 was to be seated at a certain angle and his chair was unable to accommodate that. TMA-A reported even after the fracture healed R1's wheelchair appeared to cause him pain, however no other wheelchair was attempted or available. TMA-A stated R1 stayed in bed, staff would reposition him every 1-2 hours. TMA-A stated about a month ago they started putting R1 in a facility Broda chair after another resident no longer needed it. During an interview on 11/1/22, at 9:25 a.m. medical records receptionist (MR)-A stated she had not heard that R1 was unable to be up out of	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4 bed, but had heard R1 could not be at a 90-degree angle. MR-A stated R1's wheelchair was set at a permanent 90-degree angle. MR-A stated the facility was able to start using the Broda chair for R1 that could be adjusted to accommodate R1 positioning needs after another resident no longer needed it. During an interview on 11/1/22, at 11:33 a.m. with licensed practical nurse (LPN)-A stated R1 used his personal wheelchair daily before his leg fracture in June. LPN-A indicated R1 was put in his wheelchair until staff were told not to put R1 at more than a 45-degree angle because of the risk of another fracture. LPN-A stated the direction of not using the wheelchair had come through a interdisciplinary team meeting. The intervention of not using the wheelchair was added to R1's care plan on 7/14/22. LPN-A indicated R1 may have used another resident's wheelchair that would accommodate the angle when the other resident was laid down. However, LPN-A could not articulate how often that occurred or specific dates as LPN-A only worked on Tuesdays. LPN-A stated she had taken a call from R1's family member around October 11th; family had wanted to pick up R1's wheelchair to use for transport back to the facility from the hospital. LPN-A stated family had not been aware R1 had not used his wheelchair in months and had to inform them. During an interview on 11/1/22 at 1:52 p.m. director of nursing (DON) stated R1 had used his wheelchair daily before the fracture on June 8th, 2022. She stated she was aware R1 had changed after the fracture and had therapy work with him. DON remembered the doctor saying that putting R1 forward at 90 degrees could have	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5 possibly been the cause of the fracture. DON indicated there was not a physician order for R1 to remain in bed or not to put R1 in a wheelchair. The decision not to put R1 in the chair was nursing judgment. DON stated she knew staff were afraid to position and transfer R1 after the fracture. DON indicated she had instructed staff to use the other resident's wheelchair when not used; she did not know this was not completed. DON indicated around 9/27/22, the facility Broda chair was no longer needed by the other resident and was given to R1 to use. DON stated she had called other facilities in attempt to find another Broda for R1 but was not successful. DON was not aware if a positioning assessment for Broda chair had been completed by therapy or nursing for appropriateness. DON indicated therapy had tried to get him on caseload for Medicare B services as he did not have any skilled days left. DON stated she had not informed family of R1 not being able to use his personal wheelchair but thought that therapy had. During an interview at 3:12 p.m. MD stated R1's weight bearing status had not changed since the incident in June. MD stated he believed that he did not know any reason why he would not be able to sit in the wheelchair. MD stated he did not recall putting any angle restrictions on R1. During an interview at 3:30 p.m. NP stated R1 has never been weight bearing and is not aware of any changes of ROM (range of motion) or weightbearing status. NP stated there had been some discussion of getting occupational therapy for proper wheelchair positioning. NP stated if R1 did not have a wheelchair, she would given an order for one.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6 A facility policy regarding accommodation of needs was requested but not provided.	F 684		

Electronically delivered
November 8, 2022

Administrator
Meadow Manor
210 East Grand Avenue
Grand Meadow, MN 55936

Re: State Nursing Home Licensing Orders
Event ID: V8I811

Dear Administrator:

The above facility was surveyed on October 31, 2022 through November 1, 2022 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:

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

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,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 10/31/22-11/1/22, 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 plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53675161C (MNMN00087660), with no licensing order issued. The following complaint was found to be SUBSTANTIATED: H53675111C (MN00087620), with a licensing order issued at (0830). 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 available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an appropriate wheelchair (WC) for 1 of 3 residents (R1) reviewed for wheelchair positioning. Findings include:	2 830	Corrected	11/23/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 During an interview on 11/1/22, at 12:52 p.m. family member (FM)-A indicated R1 had a leg fracture in June. She had recently became aware R1 had not used his wheelchair since that happened. FM-A stated the facility had not notified her of any issues with the wheelchair or R1 could no longer use it. FM-A indicated it broke her heart when she found out R1 had to remain in bed. FM-A reported she told the facility they needed to get things going to get R1 a new chair. R1's Quarterly Minimum Data Set (MDS) assessment dated 9/20/22, indicated R1 was severely cognitively impaired and required total assistance of two in all activities of daily living (ADL)'s. R1's diagnoses included heart failure, hypertension, hip fracture, cerebral palsy, and seizure disorder or epilepsy. R1's care plan (CP) dated 6/30/18, with revision on 11/27/21 indicated R1 required a tilt and space wheelchair and R1 was to remain tilted up when in the chair. R1's PN dated 6/14/22, at 12:12 p.m. indicated R1 was readmitted to the facility after being hospitalized on 6/10/22 for left femur fracture. R1 required two staff for assistance with all ADL's, was not able to walk, and required wheelchair/scooter for mobility. On 7/14/22 the care plan revision directed staff to not sit resident up past 45 degree angle. R1's PN dated 8/11/22, at 7:28 p.m. indicated R1 was a high risk for skin alterations and unable to perform physical activity due to being confined to a bed/bedfast and was completely immobile. R1's medical record reviewed between 6/14/22 to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 10/20/22 did not include physician orders for change in weight bearing status or range of motion restrictions. Further the record did not identify an order for new wheelchair or a change in wheelchair positioning. Additionally, a physician order for bedrest was not evident. R1's therapy records also did not identify a recommendation for wheelchair positioning, nor restrict R1's ability to sit in a wheelchair or had certain angle restrictions when sitting. R1's PN dated 10/20/22, at 1:11 p.m. indicated R1 unable to sit up past 45-degree angle and his personal chair was no longer able to be used. R1 had been currently using facility chair and therapy department was assisting facility to obtain R1 with his own chair. Review of R1's records between 10/20/22 to 10/31/22, continued to lack a comprehensive wheelchair or positioning assessment by nursing or therapy to determine appropriate positioning and wheelchair. During observation and interview on 10/31/22, at 10:48 a.m. R1 was seated in the facility Broda wheelchair (brand of wheelchair that promotes safety, pressure relief, and correct posture) in his room. During interview on 10/31/22, at 1:31 p.m. nursing assistant (NA)-A stated R1 had used his personal wheelchair previous to his leg fracture but since has not used it because he did not sit in it properly. NA-A explained after the fracture she had only transferred R1 to the shower chair on Tuesdays and Saturdays. That was the only time R1 was out of bed for months unless he was going to the hospital. NA-A indicated she noticed about a month ago, R1 started using the facility's	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 Broda chair after another resident no longer needed it. During an interview on 10/31/22 at 1:43 p.m. trained medication administrator (TMA)-A stated R1 had used his wheelchair daily before the fracture but after the fracture she could not remember the last time he had used it. TMA-A stated R1 had gone to therapy for positioning but did not remember what happened after that. TMA-A stated R1 was to be seated at a certain angle and his chair was unable to accommodate that. TMA-A reported even after the fracture healed R1's wheelchair appeared to cause him pain, however no other wheelchair was attempted or available. TMA-A stated R1 stayed in bed, staff would reposition him every 1-2 hours. TMA-A stated about a month ago they started putting R1 in a facility Broda chair after another resident no longer needed it. During an interview on 11/1/22, at 9:25 a.m. medical records receptionist (MR)-A stated she had not heard that R1 was unable to be up out of bed, but had heard R1 could not be at a 90-degree angle. MR-A stated R1's wheelchair was set at a permanent 90-degree angle. MR-A stated the facility was able to start using the Broda chair for R1 that could be adjusted to accommodate R1 positioning needs after another resident no longer needed it. During an interview on 11/1/22, at 11:33 a.m. with licensed practical nurse (LPN)-A stated R1 used his personal wheelchair daily before his leg fracture in June. LPN-A indicated R1 was put in his wheelchair until staff were told not to put R1 at more than a 45-degree angle because of the risk of another fracture. LPN-A stated the direction of not using the wheelchair had come through a	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 interdisciplinary team meeting. The intervention of not using the wheelchair was added to R1's care plan on 7/14/22. LPN-A indicated R1 may have used another resident's wheelchair that would accommodate the angle when the other resident was laid down. However, LPN-A could not articulate how often that occurred or specific dates as LPN-A only worked on Tuesdays. LPN-A stated she had taken a call from R1's family member around October 11th; family had wanted to pick up R1's wheelchair to use for transport back to the facility from the hospital. LPN-A stated family had not been aware R1 had not used his wheelchair in months and had to inform them. During an interview on 11/1/22 at 1:52 p.m. director of nursing (DON) stated R1 had used his wheelchair daily before the fracture on June 8th, 2022. She stated she was aware R1 had changed after the fracture and had therapy work with him. DON remembered the doctor saying that putting R1 forward at 90 degrees could have possibly been the cause of the fracture. DON indicated there was not a physician order for R1 to remain in bed or not to put R1 in a wheelchair. The decision not to put R1 in the chair was nursing judgment. DON stated she knew staff were afraid to position and transfer R1 after the fracture. DON indicated she had instructed staff to use the other resident's wheelchair when not used; she did not know this was not completed. DON indicated around 9/27/22, the facility Broda chair was no longer needed by the other resident and was given to R1 to use. DON stated she had called other facilities in attempt to find another Broda for R1 but was not successful. DON was not aware if a positioning assessment for Broda chair had been completed by therapy or nursing for appropriateness. DON indicated therapy had	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 tried to get him on caseload for Medicare B services as he did not have any skilled days left. DON stated she had not informed family of R1 not being able to use his personal wheelchair but thought that therapy had. During an interview at 3:12 p.m. MD stated R1's weight bearing status had not changed since the incident in June. MD stated he believed that he did not know any reason why he would not be able to sit in the wheelchair. MD stated he did not recall putting any angle restrictions on R1. During an interview at 3:30 p.m. NP stated R1 has never been weight bearing and is not aware of any changes of ROM (range of motion) or weightbearing status. NP stated there had been some discussion of getting occupational therapy for proper wheelchair positioning. NP stated if R1 did not have a wheelchair, she would given an order for one. A facility policy regarding accommodation of needs was requested but not provided. SUGGESTED METHOD OF CORRECTION: Director of nursing (DON)/designee could review facility protocals for wheelchair assessments and positioning. The DON could re-educate staff pertaining to the policy's. The DON/designee could develop and implement an auditing system to ensure all residents are in the appropriate	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00390	A. BUILDING: _____ B. WING _____	C 11/01/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 wheelchiar. DON/designee could then develop an auditing system as part of their quality assurance program ot ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		