



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
December 23, 2020

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

RE: CCN: 245361
Cycle Start Date: December 1, 2020

Dear Administrator:

On December 1, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On November 16, 2020, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department is recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at

Meeker Manor Rehabilitation Center, LLC

December 23, 2020

Page 2

§488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Meeker Manor Rehabilitation Center, Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 1, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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/lrc_idr.cfm

Meeker Manor Rehabilitation Center, LLC

December 23, 2020

Page 4

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 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,

A handwritten signature in black ink, appearing to read "Douglas Larson", with a horizontal line extending to the right.

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

cc: Licensing and Certification File

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments	E 000			
F 000	<p>A COVID-19 Focused Infection Control survey was conducted on 11/30/20 through 12/1/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance.</p> <p>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p> <p>INITIAL COMMENTS</p> <p>On 11/30/20 through 12/1/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p> <p>The following complaint was found to be SUBSTANTIATED with a deficiency cited at F689, past non-compliance:</p> <p>H5361046C/MN67354</p> <p>The survey resulted in findings of immediate jeopardy (IJ). An IJ began on 11/15/20, when Housekeeper (HK)-A mistakenly disarmed an exit door resulting in R1 eloping from the facility unwitnessed, in a wheelchair, crossed a city street, an active railroad track, and a major highway before being located at a local gas station by police. The Administrator, Director of Nursing (DON), and Regional Director of Operations were notified of the immediate jeopardy at 12:10 p.m. on 12/1/20. However, the facility had implemented several actions which</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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.

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Continued From page 1 included conducting a thorough investigation, identifying the root cause, placing R1 on 1:1 supervision, checking all residents with a wanderguard and its functionality, auditing of doors that have safety alarms, educating all facility staff on the elopement and door alarm activation/deactivation policies and procedures. As a result, the IJ was removed and the identified non-compliance was corrected as of 11/16/20. The above findings constituted substandard quality of care, and an extended survey was also conducted. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to provide adequate supervision for 1 of 6 residents (R1) who required 24 hour care/supervision resulting in R1 eloping from the facility when the door safety alarm did not sound. This failure resulted in an immediate jeopardy (IJ)	F 689	Past noncompliance: no plan of correction required.		

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 2</p> <p>when R1 propelled self 0.2 miles away from the facility, alone.</p> <p>The IJ began on 11/15/20, when housekeeper (HK)-A mistakenly disarmed the alarmed door and R1 eloped from facility in a wheelchair crossing a city street, a railroad track, and a major highway before being located at a local gas station by police. The administrator, director of nursing (DON), and regional director of operations were notified of the immediate jeopardy at 12:10 p.m. on 12/1/20. However, the facility had implemented several action plans including conducting a thorough investigation, placing R1 on 1:1 supervision, checking all residents with a wanderguard and its functionality, auditing of doors that have alarms, educating all staff on the elopement policy and door alarm activation/deactivation. The IJ was corrected as of 11/16/20, and issued at past non-compliance.</p> <p>Findings include:</p> <p>R1's Minimum Data Set (MDS) dated 10/26/20, indicated R1 had severe cognitive impairment and required extensive assistance with transfers and activities of daily living.</p> <p>R1's care plan revised 11/17/20, indicated R1's diagnoses included encephalopathy (damage or disease that affects brain function) unspecified, altered mental status and alcohol dependence. The care plan also indicated R1 was at risk for falls, had a self-care deficit and was at risk for elopement due to a history of attempts to exit the building.</p> <p>R1's elopement risk evaluation dated 11/15/20, indicated R1 was at risk for elopement.</p>	F 689			

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 3</p> <p>R1's brief interview for mental status dated 11/5/20, rated R1 as having severe cognitive impairment.</p> <p>The facility investigation report dated 11/20/20, indicated on 11/15/20, at approximately 5:55 p.m. R1 left the building out of an unarmed door at the end of lane 1. A missing person code was called and staff swept the facility and the outside perimeter with no sign of R1. Registered nurse (RN)-A called 911 at which time the police informed RN-A that at 6:09 p.m., R1 was at the gas station across the street, 0.2 miles away from the facility. R1 was wearing a jacket, footwear, and sweat pants. R1 was returned to the facility and placed on 1:1 monitoring. Skin check performed with no new concerns. MD and R1's spouse were notified. Staff education initiated. All code alerts checked for placement and function. Door arming verification.</p> <p>A written facility interview with HK-A dated 11/16/20, read: "I did see hear [R1] set the alarm off on Sunday. I went over to the door and saw it wasn't locked. I used my key and turned the red sign over. I locked it and left. I have a key on my chain all housekeeping employee's do." Following this interview, staff were educated that when HK-A turned the key, it did not lock the door rather disarmed the safety alarm. Turning the key does not lock the door from the inside out rather locked the door from the outside in. HK-A was educated and directed to alert a nurse if a door setting needed to be changed.</p> <p>R1's progress noted dated 11/15/20, at 1:51 p.m. indicated R1 had made two attempts to exit the building through the north and south exit doors</p>	F 689			

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 4</p> <p>earlier in the day. The alarms did sound and R1 was returned to the facility day area. Staff attempted to sit with R1, offered activities and attempted to call R1's wife. However, R1 was still agitated and was administered as needed Zyprexa (antipsychotic).</p> <p>During interview on 11/30/20, at 12:32 p.m. nursing assistant-B stated R1's safety was at risk if he eloped from the facility due to the potential for tipping over in his wheelchair and getting hurt. NA-B verified R1 had attempted to exit the facility doors in the past, but he had never actually gotten out of the facility until the event on 11/15/20.</p> <p>During interview on 11/30/20, at 12:46 p.m. the environmental service director (ESD) verified he was aware of R1's elopement and stated one of his staff had unintentionally disarmed the exit door when she thought she had locked it. The ESD was unsure as to what time of the day HK-A had disarmed the door.</p> <p>During interview on 11/30/20, at 1:12 p.m. HK-A verified R1 had attempted to elope from the facility earlier in the day, and stated, "I made a big mistake" when she had mistakenly turned off the safety alarm to the exit door on lane 1 when she thought she had locked it. HK-A stated following this discovery, she had received education on the door's safety alarm mechanism and how it works and also directed to inform a nurse whenever an alarm needs to be turned off or to ensure activation. HK-A verbalized the importance of maintaining the safety alarm's functionality in order to ensure resident safety.</p> <p>During interview on 11/30/20, at 1:47 p.m. family</p>	F 689			

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 5</p> <p>member (FM)-A stated the facility staff had notified her that R1 had eloped from facility through an unlocked door and was found at a gas station, without any injuries. FM-A stated she had called the facility back to find out more information about the incident and was told R1 was receiving 1:1 supervision. FM-A added, R1 was at risk when out of the facility on his own, therefore she had been in the process of getting R1 into a more secured facility.</p> <p>During interview on 11/30/20, at 2:29 p.m. with the administrator and DON, the administrator stated she had reviewed camera footage and was able to develop a time line of the incident. The administrator stated R1 exited facility at 5:48 p.m. and just prior to exiting the building, R1 had been at the nurse's cart with RN-A. When RN-A entered a room, R1 wheeled himself to the end of the hall and exited the building without the alarm sounding. The administrator stated about three minutes later, RN-A exited the room she had been in and began looking for R1. When R1 was unable to be found, RN-A called the police and was informed R1 was located at a local gas station. The administrator stated in order for R1 to get to the gas station, he had to have first crossed St. Paul Avenue and then highway 12. The DON stated R1 often looked for his previous boss. The administrator verified R1 was at risk when out in the community, alone. The administrator and DON stated following the incident, R1 was placed on 1:1 supervision for a week followed by every 15 minute checks, then every 30 minutes checks and all the staff were immediately trained on the functionality of the door safety alarms and elopements. In addition, all residents at risk for elopement were checked for wanderguard placement and functionality and</p>	F 689			

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 6</p> <p>all door alarms were also audited for proper functioning. The administrator verified it was important for the door alarms to be functioning properly in order to alert the staff of any elopement attempts. The DON and administrator stated since the incident, R1 had made no further attempts to elope from the facility.</p> <p>During interview on 11/30/20, at 3:04 p.m. RN-A stated R1 often roamed throughout the facility and in/out of other resident rooms. RN-A stated on 11/15/20, prior to R1 eloping, he had been agitated and attempted to leave the facility earlier in the day and was administered Zyprexa for the agitation. Just before the elopement, RN-A stated R1 was by her side as she passed medications and when she went into a room at approximately 5:50 p.m., and exited the room about five minutes later, R1 was gone. RN-A stated no alarms had sounded. RN-A immediately alerted the staff and all began searching for him inside the facility as well as facility grounds, but were unable to locate R1. RN-A called 911 to report R1 missing and was informed 6:09 p.m. that R1 was at a local gas station. RN-A stated R1 had cognitive impairment and was at risk when out in the community, alone. RN-A stated that earlier in the day when R1 attempted to elope, the alarm had sounded therefore the door alarm was not rechecked for functionality, prior to R1's actual elopement.</p> <p>During interview on 11/30/20, at 4:19 p.m. the ESD verified HK-A had not been educated on the door alarms functionality prior to R1's elopement, but was educated following the incident. The ESD stated he was not sure why housekeeping staff even had key access to the alarms.</p>	F 689			

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 7</p> <p>During interview on 12/1/20, at 10:10 a.m. the administrator stated as of 11/16/20, all employees were educated on elopement and the alarming/disarming of the exit doors. When asked, the administered verified the railroad tracks that R1 had crossed are still active tracks for the railroad.</p> <p>During interview on 12/1/20, at 11:02 a.m. licensed practical nurse (LPN)-A verified that after R1 had eloped from the facility, she had received training on resident elopements door alarms. LPN-A stated nurses are now the only staff that can disarm a door alarm.</p> <p>During interview on 12/1/20, at 11:03 a.m. health unit coordinator verified she had received education regarding elopement protocol and how to check door alarms to ensure they are activated/turned on and that the night shift nurse checks the alarms every night to make sure they are working.</p> <p>During interview on 12/1/20, at 11:05 a.m. nursing assistant (NA)-A verified the facility had provided education on the proper elopement procedure and how to make sure the door safety alarms remained activated.</p> <p>During interview on 12/1/20, at 11:10 a.m. HK-B verified the facility retrained all staff on elopement procedures and door alarm functionality. HK-B stated she was responsible to clean the exit doors therefore she had a key to the doors/alarms and was trained about 18 years ago on how to properly activate and deactivate the door alarms. HK-B stated it was important to make sure the alarms remained activated in order to prevent the at risk residents from eloping from</p>	F 689			

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	<p>Continued From page 8 the facility.</p> <p>During interview on 12/1/20, at 11:15 a.m. dietary aide (DA)-A verified she was recently trained on facility elopement procedures and the door alarms. DA-AD stated if the dietary staff witnessed a resident attempting to leave the facility, they were to stay with the resident and summon for a nurse.</p> <p>During interview on 12/1/20, at 11:35 a.m. the certified occupational therapy assistant (COTA) stated about 1-2 weeks ago, the facility had trained all staff about elopements and the functionality of exit door alarms.</p> <p>During interview on 12/1/20, at 2:20 p.m. the medical director stated R1 had dementia, but was able to accurately answer some questions and at times, knew right from wrong. However, the medical director stated R1 was not safe to be out in the community alone and especially now with the cold weather.</p> <p>The facility's Elopement Guideline policy dated 11/17 indicated a specific system had been developed to notify staff that an external door had been opened in an area accessible to residents. Only the Administrator (or designee) may authorize the disabling of the alarm system and was responsible for the method of monitoring for residents' safety and resetting the alarm and the charge nurse or designee would test resident personal alarms/devices according to the manufacturer's recommendations.</p> <p>The past non-compliance IJ which began on 11/15/20, was removed prior to the abbreviated survey due to multiple action(s) taken by the</p>	F 689			

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

PRINTED: 12/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245361	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER MEEKER MANOR REHABILITATION CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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 689	Continued From page 9 facility to correct the identified non-compliance. These actions included conducting a thorough investigation, identifying the root cause, placing R1 on 1:1 supervision, checking all residents with a wanderguard and its functioning, auditing all doors with alarms, educating all staff on the elopement policy and procedures and door alarm activation/deactivation. As a result, the IJ was removed and the identified non-compliance was corrected as of 11/16/20.	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 23, 2020

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

Re: Event ID: CQOO11

Dear Administrator:

The above facility survey was completed on December 1, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Douglas Larson'.

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

cc: Licensing and Certification File