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	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Manor	210 East Grand Avenue Grand Meadow, MN 55936

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379 Based on observation, interview and document review, the facility failed to ensure three years of survey results were readily accessible for residents or visitors to view without having to ask. This had the potential to affect all 21 residents who resided in the facility and visitors. Findings include: R8's significant change minimum data set (MDS) dated [DATE], indicated mild cognitive impairment. During an interview on 1/22/25 at 2:17 p.m., R8 who is the resident council president stated the survey binder containing the previous surveys was removed from the common area a long time ago. During observation on 1/22/25 at 3:30 p.m., the survey binder was not present in the common area in the main entrance. During interview on 1/22/25 at 3:31 p.m., the director of nursing (DON) and the activities director (A)-A confirmed the survey binder was removed from all common areas and was only available to residents or visitors if they ask for it. No policy regarding posting of survey results was provided.

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379 Based on observation, interview, and document review, the facility failed to ensure personal privacy when providing cares for 1 of 1 resident (R17) reviewed for personal privacy. Findings include: R17's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated R17 had mild cognitive impairment, required substantial assistance for activities of daily living (ADL), and was dependent on facility staff for transfers, bathing, and personal hygiene. During an interview on 1/21/25 at 9:30 a.m., R17 stated she has been at the facility for 7 months; the blinds in her room have been broken the entire time. R17 states this bothers her because she has her bed baths in her room, and lacks the privacy she wants. The facility has told her the blinds are coming but it has been 7 months since she initially voiced her concern. During observation on 1/21/25 at 9:30 a.m., R17's vertical blinds were missing slats, and the remaining slats were broken in half. During observation on 1/22/25 at 8:42 a.m., R17's vertical blinds remained broken, R17 stated she does not expect new blinds any time soon since it has already been so long. During an interview and observation on 1/22/25 03:05 p.m., nurse manager (NM) verified R17's shade was broken, NM stated this is the first she is hearing about it. NM tried to move the vertical blinds, and another slat fell to the floor. NM acknowledges resident privacy is paramount and they will get this fixed as soon as possible. During an interview on 1/22/25 03:28 p.m., maintenance (M)-A stated he knew about the broken shades in R17's room [ROOM NUMBER] weeks ago. He stated he ordered the new blinds; it hasn't arrived yet. He also provided the last 3 months of work orders; R17's blinds were not on the work order report. Facility policy dated 10/1/24 included: all repair and maintenance requests must be properly documented to ensure timely and efficient resolution.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379 Based on observation and interview, the facility failed to identify a grievance official to oversee, process, and track grievances presented by residents, resident representatives and visitors. The facility failed to provide information on how to file a grievance or complaint. This had the potential to affect all 21 residents, resident representatives, and visitors Findings include: R8's significant change minimum data set (MDS) dated [DATE], indicated mild cognitive impairment. R8 is the resident council president and gave permission to review the last 3 months of resident council meeting minutes. During interview with R8 on 1/22/25 at 2:17 p.m., R8 stated the social services director left in November 2024. R8 stated the social services director was the grievance official and residents knew who they could report any grievances to. R8 stated grievances were followed up on frequently prior to the social services director leaving. R8 stated the facility has not designated a new grievance official and residents do not know who they can report grievances to. R8 stated is has been difficult to get grievances reported and followed up on since the social services director left. R8 stated a formal grievance form or policy is not readily available to residents, resident representatives, or visitors. During observation on 1/22/25 at 2:45 p.m., a grievance form or grievance policy was not available in the front lobby. During an interview on 1/22/25 at 3:05 p.m., nurse manager (NM) confirmed the facility does not have an appointed grievance official since the social services director left in November 2024. NM confirmed the front lobby did not have a resident grievance or complaint form, and the grievance policy was not available in the front lobby. During interview on 1/22/25 at 3:31 p.m., the director of nursing (DON) and the activities director (A)-A confirmed the social services director left in November 2024. The A-A confirmed the facility does not have a designated grievance official to oversee the grievance process. DON confirmed the facility does not have a grievance form available to residents, resident representatives, or visitors. An undated facility policy titled, Grievances/Complaints-Staff Responsibility included: a grievance form and policy is available to residents or person acting on resident's behalf in the front lobby.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49893 Based on observation, interview, and record review, the facility failed to secure dispensed medications in a manner to prevent diversion and/or consumption by others by leaving dispensed medications on top of medication cart. This has the potential to affect residents, staff, and visitors. Findings include: R20's admission Minimum Data Set (MDS), dated [DATE], indicated intact cognition. R20's diagnoses list included nausea with vomiting and hypomagnesemia (low magnesium level in the blood). R20's physician orders included: -ondasetron (medication used to treat nausea) 4 mg 1 tablet three times a day for nausea and vomiting. -Slo-mag delayed release (magnesium supplement) 71.5-119 mg give 2 tablets by mouth four times a day for hypomagnesemia -Magic cup (high calorie frozen nutritional supplement) three times a day between meals as supplemental snack R172 R172's admission MDS, dated [DATE], indicated severe cognitive impairment, wandering significantly intrudes on the privacy of activities of others, and independence with transfers and ambulation. R172's diagnoses list included dementia and wandering R172's care plans indicated elopement risk/wandering related to disorientation to place, impaired safety awareness, and wandering aimlessly. It also indicated R172 wears a wanderguard and had impaired cognitive function. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation of medication administration on 1/21/25 at 12:14 p.m., trained medication aide (TMA)-A was standing at medication cart with back toward the common area. A second medication cart was located to the TMA-A's right. R172 walked up behind TMA-A and asked about calling her husband. TMA-A turned, spoke to R172, and then returned toward the medication cart. TMA-A opened medication cart and dispensed R20's medications (2 slo-mag tablets and 1 ondasetron tablet) into medication cup and placed cup on the top of the medication cart. R172 remained standing next to the 2nd medication cart. TMA-A stated he needed to retrieve magic cup from the kitchen. TMA-A closed computer screen, locked the medication cart, and walked passed R172. The medication cup remained on top of the cart. While TMA-A retrieved the magic cup, R172 walked to the medication cart and figeted with a pen that was located on the cart. The cup containing R20's medications was immediately to the left of R172, within reach. R172 looked in the direction of the medication cup however did not pick it up. TMA-A returned with magic cup, grabbed medication cup, and walked to R20's room to administer the medications. During an interview on 1/21/25 at 12:24 p.m., TMA-A confirmed medications were left unattended on top of the cart. TMA-A stated for resident safety, medications should be locked in the top drawer of the medication cart and not be left unattended. During an interview on 1/22/25 at 11:56 a.m., registered nurse (RN)-A stated medications should be locked up in the medication cart to prevent other residents and staff from taking them. During an interview on 1/23/25 at 11:17 a.m., the director of nursing (DON) stated staff are expected to lock up medications in the cart if they need to walk away. This is important to prevent diversion or another residents taking them. A policy titled Administering Medications, revised 2019 indicated medications are administered in a safe and timely manner, and as prescribed. Paragraph 19 indicated .during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide . No medications are kept on top of the cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49893 Based on observation, interview, and record review, the facility failed to ensure use of proper personal protective equipment (PPE) during catheter care for 1 of 1 residents (R174) reviewed for enhanced barrier precautions (EBP). Findings include: R174's annual Minimum Data Set (MDS) dated [DATE], indicated R174 was cognitively intact and had an indwelling urinary catheter. R174's provider orders included indwelling urinary catheter for urinary retention (a condition that causes difficulty emptying bladder). R174's care plan indicated R174 had an indwelling urinary catheter. During observation and interview on 1/21/25 at 3:04 p.m., R174 confirmed long term catheter use due to history of difficulty with urination. A urinary catheter bag was observed hanging on the left side of R174's recliner. No PPE noted in or around R174's room. A large set of drawers containing disposable PPE gowns was noted down the hall just outside the soiled utility room. During observation and interview on 1/22/25 at 1:37 p.m., nursing assistant (NA)-B entered R174's room without donning PPE. NA-B washed hands and applied gloves. Without applying a gown, NA-B emptied R174's urinary catheter bag in graduated cylinder, measured output, and emptied cylinder in the toilet. NA-B washed hands and placed cylinder in a plastic bag in the closet. NA-B stated EBP should be used for residents who have catheters or wounds. NA-B stated an EBP sign should have been placed on the door. During interview on 1/22/25 at 2:45 p.m., the infection preventionist (IP) stated admission paperwork and 24-hour progress notes are reviewed to determine if residents are appropriate for transmission-based precautions. Residents placed on EBP have a star placed on the nameplate outside their room and are placed on a list located in the nurses' station. PPE bins for EBP are kept near the soiled utility room to keep the facility as home-like as possible. EBP is implemented for residents who have chronic wounds requiring daily dressing changes, pressure ulcers, catheters, MDRO's (antibiotic resistant bacteria), and feeding tubes. Staff are expected to wear proper PPE when changing a resident's catheter, providing cares, ambulating, and emptying catheter bags. During observation on 1/22/25 at 3:09 p.m., it was confirmed R174's name plate does contain a star. During interview on 1/22/25 at 3:52 p.m., NA-A did not know what the stars next to the resident's name indicated. When asked how staff know if a resident is on EBP, NA-A stated there is a book in the nurses' station or she would ask another nursing assistant or nurse. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 1/22/25 at 4:01 p.m., NA-C stated there is a usually a list of residents in the nurses' station who have a star next to their name indicating EBP. NA-C confirmed no list was found in the nurses' station. During interview on 1/23/25 at 11:24 a.m., the director of nursing (DON) stated EBP is implemented for residents with urinary catheters, wounds, colonized bacteria, or any kind of tubing. EBP is implemented immediately upon admission or when precautions are deemed appropriate. PPE bins are stored near the soiled utility room. Staff are expected to wear appropriate PPE when dressing, bathing, transferring, emptying catheters, or providing any other type of care. The DON stated the facility places stars outside resident's rooms as a way of communicating EBP to staff in addition to verbal report. The DON did state however, there have been issues with follow-through in this communication. A policy titled Enhanced Barrier Precautions (EBP) Policy and Procedure revised 11/6/24 indicated EBP is used during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of the MDRO status . Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. The Indications for Use section indicated EBP is required when performing the following high-contact resident care activities .device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. The Procedure section instructed staff to gather supplies, clean hands, apply PPE (gown and gloves) prior to providing care. Staff notification for resident who require EBP section indicated resident's requiring use of EBP will have a star symbol placed by their name on their room plate outside of the resident's room.