STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	03/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW LANE REHABILITATION & HEALTHCARE CTR	2209 UTAH AVENUE BENSON, MN 56215

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess, and implement interventions for 1 of 1 residents (R1) who developed moisture associated skin damage and was incontinent of bowel and bladder. Findings include: R1's annual Minimum Data Set ((MDS) dated [DATE], identified R1 was cognitively intact and had [DIAGNOSES REDACTED]. R1's MDS identified R1 required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, dressing, toilet care and personal hygiene. R1's care plan identified R1 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS revealed R1 had no moisture associated skin damage (MASD) or any other skin impairments. R1's annual Care Area Assessment (CAA) signed 1/15/20, identified R1 had a progressive neuromuscular condition and gradual decline over time. The CAA revealed R1 was alert, oriented and required extensive assistance with ADL's of bed mobility and toileting. The CAA identified R1 had no pressure ulcers or other skin alterations or impairments. The CAA revealed R1 was frequently incontinent of both bowel and bladder, required routine assistance with toileting and was not on a toileting plan. Review of R1's care plan revised 3/19/20, identified R1 required assistance with ADL's of bed mobility and toileting The care plan revealed R1 was incontinence of bowel, bladder, wore an incontinent product and required assistance with a mechanical lift to toilet. The care plan indicated R1 was at risk for pressure ulcer development and required assistance with repositioning every two hours. R1's care plan lacked identification of any non-pressure skin wounds (MASD) interventions for prevention or an indication of a toileting program. Review R1's East Aide Sheet (nursing assistant (NA) care guide), revised 3/9/20, indicated R1 used a maxi pad,and used urinal at bedside. The NA care guide incorrectly listed R1 was continent of urine and did not identify a toileting schedule for R1. R1's care guide did not identify R1's MASD or any skin care needs. Review of R1's medical records revealed R1 had not had a comprehensive bowel and bladder assessment completed in last 11 months. A request was made for any skin breakdown risk assessments for R1, one was not provided. On 3/19/20, at 9:53 a.m. R1 was lying in bed on his back, at that time, nursing assistant (NA)-A proceeded to assist R1 with incontinence cares. NA-A removed R1's pants and incontinent brief. NA-A confirmed R1's pants and incontinent pad were saturated with urine and had loose bowel. R1's buttocks skin was wet, puckered with wrinkled skin grooves where his incontinent brief had rested. R1 remained on his left side, held onto the assist bar of his bed, while NA-A completed incontinence cares. R1's peri-rectal area was dark pink in color and his left buttocks had a red open area with areas of excoriation (skin that had been scraped or abraded) noted near his rectum and right buttocks. R1 had a duoderm dressing (gel forming flexible dressing with adhesive compound) slightly attached to his buttocks, folded in multiple areas and covered in bowel. NA-A removed the duoderm dressing the rest of the way, and cleansed the area with disposable wipes. NA-A then assisted R1 onto his back, covered him with an incontinent brief and sheet and left R1's room. At 10:04 a.m. NA-A stated the last time she had assisted R1 with incontinence care was at 6:45 a.m, three hours (3) and eight (8) minutes prior to observation. At 11:04 a.m. R1 remained lying on his back in his room, at that time LPN-B indicated R1 had another bowel movement and she had just provided incontinence cares. LPN-B stated she had used a skin prep wipe (protective barrier wipe) on R1's skin to aid in the adherence of the dressing. Registered nurse (RN)-A entered R1's room to complete the wound assessment with LPN-B. The following was confirmed; R1's had a red open area on his left buttocks which measured 3.2 cm by 2 cm, by 0.1 cm. RN-A confirmed R1 had a second open area presented as a slit on his left buttocks underneath the coccyx (tailbone) measured 3.0 cm by 0.5 cm by 0.1 cm. RN-A confirmed R1 had a reddened area on his right buttocks with excoriation near his peri-rectal area. RN-A stated she felt R1's wounds were from shearing while he was in bed. LPN-B then applied the new duoderm dressing to the open wounds, and [MEDICATION NAME] (protective skin ointment) to the rest of the buttocks, peri- rectal area and scrotum. RN-A indicated the above assessment was R1's first skin assessment since his return from the hospital the day prior. R1's weekly wound assessment dated [DATE], identified R1 had moisture excoriation (abraded skin) of the peri area/left buttock identified on 3/13/20. R1's wound assessment identified two sites with open areas. Left buttocks open area measured 3 cm (centimeters) length, 0.5 cm width and 0.1 cm in depth. R1's second left buttocks open area measured 2.5 cm by 0.5 cm by 0.1 cm. The assessment revealed both open area wound beds were pink, moist and had a scant amount serous (thin watery) drainage. The assessment revealed R1 had a little pain and indicated a border foam dressing was applied and was to be changed daily and as needed. The form failed to identify if physician, family or dietary notification was completed and not applicable was documented for care plan review or update. The wound assessment failed to identify possible cause of wounds and interventions to prevent further wounds or impede healing. Review of R1's hospital Transfer and Referral form dated 3/18/20, identified R1 was hospitalized from [DATE], to 3/18/20, and returned to the facility with [DIAGNOSES REDACTED]. The referral form revealed R1 had open areas (shear) on both buttocks with orders to apply duoderm and change PRN (as needed). The referral form revealed R1 had redness of his scrotum with small open areas with orders to apply [MEDICATION NAME] frequently. Review of R1's progress notes from 3/13/20, to 3/20/20, identified the following: -3/13/20, weekly wound assessment identified peri area/left buttocks with length 3 cm, width 0.5 cm and depth 0.1 cm. -3/15/20, change of condition noted which included; elevated blood sugar, slurred speech and confusion. R1 was seen by physician, urine specimen obtained, insulin ordered and R1 was diagnosed with [REDACTED]. -3/16/20, charge nurse reported R1 had a slit on his coccyx due to moisture. R1's physician was notified and interventions were in place. R1 was admitted to the hospital for urospesis and was referred to hospice. -3/18/20, R1 returned to facilty from the hospital, with new orders which included Duoderm (is a [MEDICATION NAME], moisture-retentive wound dressing, used for partial- and full-thickness wounds with exudate,) to open areas on buttocks and apply [MEDICATION NAME] (drying cream) to groin area frequently. On 3/19/20, at 2:54 p.m. R1 indicated he had sores on his bottom and was incontinent of both bowel and bladder. R1 indicated he would call for assistance and nursing staff would assist him with incontinence and toileting cares. On 3/19/20, at 2:04 p.m. NA-A indicated she had assisted R1 with morning cares at 6:45 a.m. and R1 had been incontinent of bowel and bladder at that time. NA-A indicated at that time R1's dressing to his buttocks was in place and firmly affixed to his buttocks at that time. NA-A stated R1 was not on a toileting schedule and indicated he was not assisted to check and change his brief at regular intervals. On 3/19/20, at 4:10 p.m. LPN-B indicated she observed R1's wounds on his buttocks on 3/13/20, had applied a border foam dressing and then notified R1's primary care physician (PCP)-A. LPN-B indicated when R1 returned from the hospital, a day ago, R1's dressing was changed to the Duoderm dressing. LPN-B indicated R1 had a history of [REDACTED]. LPN-B indicated she thought R1 had been recently changed to an every 2 hour repositioning and incontinence care schedule. LPN-B indicated she would expect staff to assist R1 with repositioning, checking and changing him for incontinence every 2 hours. On 3/20/20, at 8:28 a.m. family member (FM)-A indicated they visited R1 frequently and had found R1 in a dirty state, saturated with urine to the point the urine had overflowed into his chair and bed. FM-A stated R1 had informed them the nursing staff were not taking him to the bathroom,

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

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 IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	03/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW LANE REHABILITATION & HEALTHCARE CTR	2209 UTAH AVENUE BENSON, MN 56215

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) and indicated he would just go in his brief. FM-A stated R1 had incontinence for the past few years, and they felt R1 was able to maintain some continence if he was on a toileting schedule. FM-A indicated they were made aware that R1 now had skin breakdown but were unsure of what the facility was doing to heal and/or prevent further skin breakdown. On 3/20/20, at 11:09 a.m. during a telephone interview with R1's primary care physician (PCP)-A, she indicated upon R1's arrival to the hospital he had required immediate incontinence cares and indicated the hospital nurses voiced concern regarding R1's incontinence and skin condition. PCP-A confirmed he felt R1 should not go three hours without being checked for incontinence. PCP-A stated he felt R1's skin breakdown could be caused from bowel and bladder incontinence. PCP-A indicated her expectation was for R1 to be checked and changed routinely by staff and to be assisted to the toilet as he was able. On 3/20/20, at 12:36 p.m. director of nursing (DON) stated R1's MASD was likely caused by incontinence and confirmed she would have expected a comprehensive bowel and bladder assessment to have been completed to determine appropriate interventions to manage continence and prevent skin breakdown. The DON confirmed R1's medical record lacked a comprehensive bowel and bladder assessment. The DON indicated she expected R1 to receive incontinence cares every 2 hours and stated R1's skin should be kept clean and dry and indicated prolonged exposure to moisture could cause R1's skin to breakdown. The DON stated at that time she had updated R1's NA care guide to reflect every 2 hour check and change. A facility policy for non-pressure related skin wounds was not provided.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to comprehensively assess 1 of 1 resident (R1) who was incontinent of urine. In addition, the facility failed to provide timely incontinence cares for 1 of 1 resident who was dependent on staff for incontinence care and had moisture associated skin damage (MASD.) Findings include: R1's annual Minimum Data Set ((MDS) dated [DATE], identified R1 was cognitively intact and had [DIAGNOSES REDACTED]. R1's MDS identified R1 required extensive assistance with activities of daily living (ADL's) of bed mobility, transfers, dressing, toilet care and personal hygiene. R1's care plan identified R1 was frequently incontinent of bowel and bladder and was not on a toileting program. The MDS revealed R1 had no moisture associated skin damage (MASD) or any other skin impairments. Review or R1's annual Care Area Assessment (CAA) signed 1/15/20, identified R1 had a progressive neuromuscular condition and gradual decliner over time. The CAA revealed R1 was alert, oriented and required extensive assistance with ADL's of transfers and toileting. The CAA revealed R1 was frequently incontinent of both bowel and bladder and was not on a toileting program. Review of R1's care plan revised 3/19/20, identified R1 required assistance ADL's of bed mobility, transfers and toileting. The care plan revealed R1 was incontinence of bowel, bladder, wore an incontinent product and required assistance with toileting. R1's care plan lacked identification of any non-pressure skin wounds (MASD) interventions for prevention or an indication of a toileting program. Review R1's East Aide Sheet (nursing assistant care guide), revised 3/9/20, indicated R1 used a maxi pad and used a urinal at bedside. R1's NA care guide incorrectly listed R1 was continent of urine. R1's nursing assistant care guide did not identify R1's toileting or incontinence needs. Review of R1's medical records lacked documentation of any bladder and bowel assessments within the last 11 months. On 3/19/20, at 9:53 a.m. R1 was lying in bed on his back, at that time, nursing assistant (NA)-A proceeded to assist R1 with incontinence cares. NA-A removed R1's pants and incontinent brief. NA-A confirmed R1's pants and incontinent pad were saturated with urine and had loose bowel. R1's buttocks skin was wet, puckered with wrinkled skin grooves where his incontinent brief had rested. R1 remained on his left side, held onto the assist bar of his bed, while NA-A completed incontinence cares. R1's peri-rectal area was dark pink in color and his left buttocks had a red open area with areas of excoriation (skin that had been scraped or abraded) noted near his rectum and right buttocks. R1 had a duoderm dressing (gel forming flexible dressing with adhesive compound) slightly attached to his buttocks, folded in multiple areas and covered in bowel. NA-A removed the duoderm dressing the rest of the way, and cleansed the area with disposable wipes. NA-A then assisted R1 onto his back, covered him with an incontinent brief and sheet and left R1's room. At 10:04 a.m. NA-A confirmed the last time she had assisted R1 with incontinence care was at 6:45 a.m, three (3) hours and eight (8) minutes prior to observation. At 11:04 a.m. R1 remained lying on his back in his room, at that time LPN-B indicated R1 had another bowel movement and she had just provided incontinence cares. LPN-B stated she had used a skin prep wipe (protective barrier wipe) on R1's skin to aid in the adherence of the dressing. At that time registered nurse (RN)-A entered R1's room to complete the wound assessment with LPN-B. The following was confirmed; R1's had a red open area on his left buttocks which measured 3.2 cm by 2 cm, by 0.1 cm. RN-A confirmed R1 had a second open area presented as a slit on his left buttocks underneath the coccyx (tailbone) measured 3.0 cm by 0.5 cm by 0.1 cm. RN-A confirmed R1 had a reddened area on his right buttocks with excoriation near his peri-rectal area. RN-A stated she felt R1's wounds were from shearing while he was in bed. LPN-B then applied the new duoderm dressing to the open wounds, and [MEDICATION NAME] (protective skin ointment) to the rest of the buttocks, peri-rectal area and scrotum. RN-A indicated the above assessment was R1's first skin assessment since his return from the hospital. Review of R1's emergency room Report dated 3/15/20, identified R1 presented to the emergency department with a urinary tract infection (UTI,) [MEDICAL CONDITION] (elevated blood sugar) and dysphagia (difficulty swallowing.) The emergency room report revealed R1 had soiled underwear with feces and had a partially dissolved tablet underneath his chin when he presented to the emergency room . The report revealed R1 was close to dying, and was admitted to the hospital for observation. On 3/19/20, at 2:54 p.m. R1 indicated he had sores on his bottom and was incontinent of both bowel and bladder. R1 indicated he would call for assistance and nursing staff would assist him with incontinence and toileting cares. On 3/19/20, at 2:04 p.m. during a follow up interview, NA-A indicated she had assisted R1 with morning cares at 6:45 a.m. and R1 had been incontinent of bowel and bladder at that time. NA-A indicated at that time R1's dressing to his buttocks was in place and firmly affixed to his buttocks at that time. NA-A stated R1 was not on a toileting schedule and indicated he was not assisted to check and change his brief at regular intervals. On 3/19/20, at 4:10 p.m. LPN-B indicated she observed R1's wounds on his buttocks on 3/13/20, had applied a border foam dressing and then notified R1's primary care physician (PCP)-A. LPN-B indicated when R1 returned from the hospital, a day ago, R1's dressing was changed to the Duoderm dressing. LPN-B indicated R1 had a history of [REDACTED]. LPN-B indicated she thought R1 had been recently changed to an every 2 hour repositioning and incontinence care schedule. LPN-B indicated she would expect staff to assist R1 with repositioning, checking and changing him for incontinence every 2 hours. On 3/20/20, at 8:28 a.m. family member (FM)-A indicated they visited R1 frequently and had found R1 in a dirty state, saturated with urine to the point the urine had overflowed into his chair and bed. FM-A stated R1 had informed them the nursing staff were not taking him to the bathroom, and indicated he would just go in his brief. FM-A stated R1 had incontinence for the past few years, and they felt R1 was able to maintain some continence if he was on a toileting schedule.) FM-A indicated they were made aware that R1 now had skin breakdown but were unsure of what the facility was doing to heal and/or prevent further skin breakdown. On 3/20/20, at 11:09 a.m. during a telephone interview with R1's primary care physician (PCP)-A, she indicated upon R1's arrival to the hospital he had required immediate incontinence cares and indicated the hospital nurses voiced concern regarding R1's incontinence and skin condition. PCP-A confirmed he felt R1 should not go three hours without being checked for incontinence. PCP-A stated he felt R1's skin breakdown could be caused from bowel and bladder incontinence. PCP-A indicated her expectation was for R1 to be checked and changed routinely by staff and to be assisted to the toilet as he was able. On 3/20/20, at 12:16 p.m. NA-E stated R1 had been frequently incontinent of bowel more recently and was always incontinent of urine. NA-E indicated R1 was not on a toileting schedule at that time. On 3/20/20, at 12:36 p.m. director of nursing (DON) stated R1's MASD was likely caused by incontinence and confirmed she would have expected a comprehensive bowel and bladder assessment to have been completed to determine appropriate interventions to manage continence and prevent skin breakdown. The DON confirmed R1's medical record lacked a comprehensive bowel and bladder assessment. The DON indicated she expected R1 to receive incontinence cares every 2 hours and stated R1's skin should be kept clean and dry and indicated prolonged exposure to moisture could cause R1's skin to breakdown. The DON stated at that time she had updated R1's NA care guide to reflect every 2 hour check and change. Review of the facility policy titled Urinary Incontinence-Clinical Protocol revised 2/1/18, identified as part of the initial assessment the physician would help identify individuals with impaired urinary incontinence. In addition the policy identified the nurse would assess and document as part of the assessment. For incontinent individuals, the nurse would identify and document circumstances related to the incontinence. The policy futher identified the staff would identify environmental interventions and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	**03/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEADOW LANE REHABILITATION & HEALTHCARE CTR	**2209 UTAH AVENUE BENSON, MN 56215**

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 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) assistive devises that facilitate toileting. Based on the assessment the staff would provide toileting or other interventions to try to improve the individuals continence status. The staff and physician would review the progress of the individual with impaired continence. The policy identified the review should be documented of the individuals responses to interventions to treat incontinence.