DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 22, 2023

Administrator
Meadow Lane Restorative Care Center
2209 Utah Avenue
Benson, MN 56215

RE: CCN: 245313
Cycle Start Date: December 14, 2022

Dear Administrator:

On January 25, 2023, the Minnesota Department(s) of Health and Public Safety, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2022

Administrator
Meadow Lane Restorative Care Center
2209 Utah Avenue
Benson, MN 56215

RE: CCN: 245313
Cycle Start Date: December 14, 2022

Dear Administrator:

On December 14, 2022, a survey was completed at your facility by the Minnesota Departments 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.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us

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 March 14, 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 June 14, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	2209 UTAH AVENUE BENSON, MN 56215

(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 On 12/12/22, to 12/14/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/12/22, to 12/14/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H53136587C (MN00087042), and H53136588C (MN00084101). 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	F 000		

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

Electronically Signed | 01/09/2023

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

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F 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F 578		1/20/23

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F 578	Continued From page 2 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident advanced directives were accurately documented in the resident's paper and electronic medical record (EMR) to reflect the residents current wishes for 2 of 2 residents (R8 and R19) reviewed for advanced directives. Findings include: R19 R19's quarterly Minimum Data Set (MDS) dated 10/22/22, identified R19 had diagnosis which included cardiovascular vascular accident (stroke), and hemiplegia (paralysis of one side of the body). Identified R 19 had intact cognition. Review of R19's Order Summary Report signed 11/3/22, revealed an order dated 2/25/22, which identified R19 was a DNR (do not resuscitate). Review of R19's care plan revised 7/8/22, identified R19 had decided to remain DNR. Review of R 19's POLST (physician orders for life sustaining treatment) form signed 7/1/21, indicated R19 wanted CPR (cardiopulmonary resuscitation). During an interview on 12/13/22, at 8:47 a.m. R19	F 578	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. It is the Meadow Lane Restorative Care Center to ensure that residents advanced directives will be honored. To ensure this, the facility should maintain accurate medical records both paper and EHR. During the survey it was identified that R8 and R 19□s advanced directives did not match the EHR. Upon identification of this, both were reviewed, and records updated to reflect resident□s wishes. 2. The deficient practice has potential to impact all residents. An audit was completed of all resident□s POLST against the EHR, any discrepancies were clarified and updated to EHR as needed. To prevent recurrence, upon admission, significant change and during each care conference the POLST form will be reviewed, and preferences honored; and	

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F 578	Continued From page 3 stated she did not want any life saving measures implemented. R19 indicated she had informed the facility of her wishes. R19's medical record (MR) did not accurately reflect R19's current wishes for advance directives. R8 R8's annual Minimum Data Set (MDS) dated 11/30/22, indicated R8 had diagnoses which included depression, renal insufficiency, peripheral vascular disease and R8 was cognitively intact. R8 required supervision from staff with locomotion off the unit, dressing, toileting and was independent with all other activities of daily living (ADL'S). Review of R8's Order Summary Report dated and signed by the physician on 10/20/22, identified R8 had changed her code status to Do Not Resuscitate/Do Not Intubate (DNR/DNI) meaning if R8's (heart stopped beating or if she stopped breathing, no medical procedure to restart breathing or heart functioning would be instituted or continued. R8 would be allowed to die naturally). The report indicated staff were to update R8's POLST form in her MR. Review of R8's Order Summary Report dated 12/13/22, indicated R8's wishes were to be a DNR/DNI. R8's Advance Directive tab located under the cover of R8's MR in a plastic sleeve dated 7/12/21, identified R8 wanted resuscitation/cardiopulmonary resuscitation	F 578	then checked against the EHR for accuracy. 3. The Advanced Directives policy was updated to reflect review of the EHR and the signed POLST with each care conference including baseline care plan meeting. Licensed Nurses will be educated in advanced directives with a focus on accurate transcription from documents to EHR. 4. Audits will be completed weekly for 6 weeks, then monthly for 3 months. Audits will be brought to and monitored through the QAPI (Quality Assurance and Performance Improvement) meetings or further recommendations and ongoing monitoring. 5. Director of Nursing or designee responsible for compliance.	

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F 578	Continued From page 4 (CPR). Review of R8's Admission Record dated 12/13/22, indicated under code status: R8 was to be a full code meaning if R8's (heart stopped beating and/or she stopped breathing, all resuscitation procedures would be provided to keep her alive). Review of R8's care plan revised 7/12/21, indicated R8's advanced directives would be honored and her code status would be reviewed on a quarterly basis and as needed. R8's care plan identified R8 had decided to remain a full code. Review of the facility's Resident Listing Report dated 11/21/22, located on top of a cart behind the nursing station indicated R8's code status was a full code. R8's MR did not accurately reflect R8's advance directive wishes. During an interview on 12/12/22, at 5:16 p.m. R8 indicated her wishes were to be DNR/DNI. During an interview on 12/13/22, at 11:45 a.m. clinical manager (CM) confirmed R8 and R19's code status were not accurately identified in their MR's. CM verified R8's and R19's POLST had not been updated when they decided to become DNR. CM indicated her usual practice was to verify a resident's current advance directive was to review the POLST in the front of the chart. CM further indicated if the physician orders and the POLST did not match she would follow the POLST.	F 578		

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F 578	Continued From page 5 During an interview on 12/14/22, at 11:25 p.m. director of nursing (DON) indicated upon admission the social worker (SW) and nursing staff were expected to complete a POLST with each resident and send it to the doctor for a signature. DON indicated the MR was then immediately updated and the POLST was added. DON stated if a resident requested to revise their advance directive, the nursing staff were expected to immediately complete a new POLST with the resident, update the MR and replace the POLST in the front of the resident's paper MR. DON confirmed R8's and R19's code status were not accurately identified in their MR's. The DON stated she would have expected each resident's POLST to accurately reflect the resident's wishes. Review of a facility policy titled, Advanced Directives revised December 2016, identified advanced directives would have been respected in accordance with state law and facility policy. The policy revealed upon admission, residents would have been provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chose to do so. The policy further revealed the plan for each resident would be consistent with his or her documented treatment preferences and/ or advance directive.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		1/20/23

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F 584	Continued From page 6 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hot water was available in 6 of 6 resident rooms (RR), (RR146,	F 584	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission	

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F 584	Continued From page 7 RR147, RR148, RR154, RR155 and RR156) tested for comfortable water temperatures. Findings Include: During the environmental tour on 12/14/22, at 11:57 a.m. with maintenance supervisor (MS) the water temperatures were checked in various RR with the facility's thermometer. The following temperatures were observed: - RR 147 was 75.6 degrees Fahrenheit (F) after the water had run for 10 minutes. - RR 146 was 82.2 degrees (F) - RR 148 was 83.6 degrees (F) - RR 154 was 70.0 degrees (F) - RR 155 was 79.2 degrees (F) - RR 156 was 83.2 degrees (F) Review of the facility weekly water temperature audits revealed, the audits were completed for the last 3 weeks during the day hours, with the last audit completed on 12/13/22. Further review of the logs revealed water temperatures were not checked randomly on other shifts or various times. During an interview on 12/12/22, at 2:33 p.m. R26 indicated the water in his bed room at the sink area did not ever get hot. During an interview on 12/12/22, at 2:37 p.m. R25 indicated the water in her room at the sink area continued to be cold even after it ran for several minutes. R25 stated it took at least 15 minutes or longer for the water to reach a warm temperature. R25 indicated the lack of hot water had been an issue for a long time and she had staff about her concerns regarding the lack of hot water in the	F 584	of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. It is the expectation of this facility to ensure that a safe, clean, comfortable and homelike environment is provided to all residents who reside at Meadow Lane Restorative Care Center. It was found that the water would not get hot enough within the expected time frame in 6 resident rooms: RR 146, RR 147, RR 148, RR 154, RR 155 and RR 156. Upon identification of the temp concerns, maintenance supervisor contacted area plumber to review our facilities system efficiencies including replacement of the recirculation pump. The facility also increased early morning checks to ensure hot water was able to be obtained timely and in all resident rooms. 2. Because all residents residing at the facility are entitled to having hot water available; an environmental tour was conducted with Administrator and Director of Maintenance; no other areas noted to not have proper temperatures. The policy titled Safety and Supervision of Residents was reviewd and remains appropriate. 3. The maintenance logbook was reviewed with all employees, which indicated how to properly inform Maintenance of any concerns or repairs via the logbook. The policy entitled Safety	

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F 584	Continued From page 8 past. During an interview on 12/14/22, at 12:00 p.m. R137 indicated the water in his room at the sink area never got hot and it barely reached a warm temperature comfortable enough to use it. During an interview on 12/14/22, at 11:57 a.m. the MS confirmed the above temperatures were below acceptable temperatures of 105 to 115 (F). The MS indicated the water was too cold and that the current water temperatures were not at a comfortable temperature for residents. The MS verified he had received complaints from residents and staff that the water took a while to warm up. The MS indicated he completed water temperature audits weekly during the day and did not complete them on various shifts or times. During an interview on 12/14/22, at 1:00 p.m. the administrator indicated she would expect water temperatures to be within the facility's guidelines. The administrator stated she would expect water temperatures to be audited on a regular basis and at various times and shifts to maintain comfortable water temperatures for the residents. On 12/14/22, a facility policy for water temperatures was requested and one was not provided.	F 584	and Supervision of Residents was reviewed and staff directed to report any abnormal findings of temperatures as soon as able. Education for initial new hires and ongoing annual orientation plans have been updated to reflect this information. 4. Audits will be completed weekly for 6 weeks and monthly for the next 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification. Audits will be brought to and monitored through the QAPI (Quality Assurance and Performance Improvement) meetings or further recommendations and ongoing monitoring. 5. Maintenance Director or designee	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		1/20/23

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	245313	A. BUILDING _____ B. WING _____	C 12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	2209 UTAH AVENUE BENSON, MN 56215

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F 623	Continued From page 9 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623		

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F 623	Continued From page 10 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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F 623	Continued From page 11 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide written notification of a hospital transfer was provided to the resident and/or resident representative for 1 of 1 residents (R15) reviewed for hospitalization. Findings include: R15's quarterly Minimum Data Set (MDS) dated 10/18/22, identified R15 had severe cognitive impairment with diagnoses which included: schizophrenia, diabetes mellitus, and peripheral vascular disease. Identified R15 required limited assistance with dressing, and was independent with bed mobility, transfers, ambulation, and toileting. R15's care plan dated 7/12/21, identified R15 had impaired cognitive function related to short term memory loss. R15's care plan indicated R15 required supervision to assistance with dressing and personal hygiene and was independent with bed mobility, transfers, ambulation and toileting. Review of R1's progress notes from 10/5/22, to 10/7/22, identified the following: -10/5/22, at 6:00 p.m. R15 had a change in	F 623	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. It is the expectation of this facility to ensure that written notification is provided to the resident and/or resident representative when transferring to a hospital. When it was identified that this was not done for R 15, it was then reviewed and documented in his medical record. 2. The deficient practice has the potential to impact all residents who reside at Meadow Lane Restorative Care Center. The facility policy titled Transfer or Discharge Notice was reviewed and remains appropriate. All recent transfers were reviewed to ensure that no other residents were identified to be affected by	

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F 623	Continued From page 12 condition with elevated temperature of 101.5. Provider updated and new orders for Bactrim (antibiotic) and later sent to emergency room (ER) for further evaluation following continuous increase in temperature. -10/7/22, R15 returned to facility from hospital. Review of R15's medical record lacked documentation the resident or resident's representative had been notified of R15's hospital transfer in writing which occurred on 10/5/22. During an interview on 12/13/22, at 4:23 p.m. registered nurse (RN)-A confirmed nursing staff were responsible to complete all documentation for transfers including a written notification of transfer form. RN-A reviewed R15's electronic medical record and paper medical record chart and confirmed R15's medical record lacked documentation of a written notification of transfer form for R15's transfer to the hospital on 10/5/22. During an interview on 12/14/22, at 12:12 p.m. director of nursing (DON) confirmed R15's medical record lacked a written notification of transfer form for R15's transfer to the hospital on 10/5/22. DON stated she expected nursing staff to follow a transfer checklist to assure all documents were completed as required. DON indicated she would expect a written notification of transfer form would have been completed and present in R15's medical record. The facility policy titled Transfer Or Discharge Notice, dated 11/30/21, identified under the following circumstances, the notice would be given as soon as it was practicable but before the discharge which included: transfers necessary for the resident's welfare and the residents needs	F 623	the deficient practice. There were not any further concerns noted. 3. Education will be provided to all nurses on the facility policy titled Transfer or Discharge Notice to ensure that the nurses are compliant with providing the correct information and documentation to the resident and/or representative and documenting appropriately this in the resident’s medical record. 4. Audits will be completed weekly for 6 weeks and monthly for the next 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification. Audits will be brought to and monitored through the QAPI (Quality Assurance and Performance Improvement) meetings or further recommendations and ongoing monitoring. 5. Director of Nursing or designee responsible for compliance.	

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F 623	Continued From page 13 could not be met at the facility, and an immediate transfer or discharge was required by the resident's urgent medical needs. The policy further identified the reasons for the transfer or discharge would be documented in the resident's medical record. The facility policy titled Transfer Or Discharge Documentation policy dated 11/30/21, identified when a resident was transferred from the facility, the following information would be documented in the medical record which included: an appropriate notice was provided to the resident and/or legal representative, including the date and time of the transfer, new location of the resident, mode of transportation, summary of the resident's overall medical, physical and mental condition, disposition of personal effects, disposition of medications, others as appropriate or necessary, and the signature of the person recording the data in the medication record.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		1/20/23

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F 625	Continued From page 14 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure written notification of the facility's bed hold policy was provided for 1 of 1 residents (R15) at the time of transfer to the hospital. Findings Include: R15's quarterly Minimum Data Set (MDS) dated 10/18/22, identified R15 had severe cognitive impairment with diagnoses which included: schizophrenia, diabetes mellitus, and peripheral vascular disease. Identified R15 required limited assistance with dressing, and was independent with bed mobility, transfers, ambulation, and toileting. R15's care plan dated 7/12/21, identified R15 had impaired cognitive function related to short term memory loss. R15's care plan indicated R15 required supervision to assistance with dressing and personal hygiene and was independent with bed mobility, transfers, ambulation and toileting.	F 625	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. It is the expectation of this facility to ensure that written notification of the facilities bed hold policy is provided to the resident and/or resident representative at the time of transfer to a hospital. When it was identified that this was not done for R 15, it was then reviewed and documented in his medical record. 2. The deficient practice has the potential to impact all residents who reside at Meadow Lane Restorative Care Center. The facility policy titled Bed-Holds And	

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F 625	Continued From page 15 Review of R1's progress notes from 10/5/22, to 10/7/22, identified the following: -10/5/22, at 6:00 p.m. R15 had a change in condition with elevated temperature of 101.5. Provider updated and new orders for Bactrim (antibiotic) and later sent to emergency room (ER) for further evaluation following continuous increase in temperature. -10/7/22, R15 returned to facility from hospital. R15's medical record (MR) lacked documentation a written bed hold policy form had been completed for R15's transfer to the hospital on 10/5/22. During an interview on 12/13/22, at 4:23 p.m. registered nurse (RN)-A confirmed nursing staff were expected to complete written bed hold forms. RN-A reviewed R15's electronic medical record and paper medical record and confirmed R15's medical record lacked documentation of a written bed hold policy for R15's transfer to the hospital on 10/5/22. During an interview on 12/14/22, at 12:12 p.m. director of nursing (DON) confirmed R15's medical record lacked a bed hold form for R15's transfer to the hospital on 10/5/22. DON indicated she would expect R15 would have had a bed hold form completed and in R15's medical record. The facility policy titled Bed-Holds And Returns dated 11/30/21, identified prior to transfers and therapeutic leaves, residents or resident representatives would be informed in writing of the bed-hold and return policy.	F 625	Returns was reviewed and remains appropriate. All recent transfers were reviewed to ensure that no other residents were identified to be affected by the deficient practice. There were not any further concerns noted. 3. Education will be provided to all nurses on the facility policy titled Bed-Holds and Returns to ensure that the nurses are compliant with providing the correct information and documentation to the resident and/or representative at the time of transfer to hospital and documenting appropriately this in the resident’s medical record. 4. Audits will be completed weekly for 6 weeks and monthly for the next 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification. Audits will be brought to and monitored through the QAPI (Quality Assurance and Performance Improvement) meetings or further recommendations and ongoing monitoring. 5. Director of Nursing or designee responsible for compliance.	

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect an accurate skin condition for 1 of 2 residents (R30) reviewed for resident assessment. In addition, the facility failed to ensure the MDS was accurately coded to reflect weight loss for 1 of 3 residents (R26) reviewed for nutrition. The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, outlined an overview which included, "The purpose of this manual is to offer clear guidance about how to use the [RAI] correctly and effectively to help provide appropriate care ... The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan." The manual then outlined each MDS section with corresponding instructions and directions. This included Section M-Skin Conditions, report based on highest stage of existing ulcer(s) at its worst; do not reverse stage. This section included: M0150. risk of pressure ulcers, M0210. unhealed pressure ulcers, and M0300. current number of unhealed pressure ulcers at each stage. R30 R30's MDS dated 10/28/22, identified R30 was	F 641	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. It is the expectation of Meadow Lane Restorative Care Center that all residents have an accurately coded assessment. The MDS has since been modified to reflect accurate information related to a skin condition for R 30 and related to weight loss for R 26. 2. The deficient practice has potential to impact all residents. All at-like residents with weight loss and skin concerns were reviewed with no other discrepancies noted. A system change was initiated; a skin and wound app was implemented for accurate documentation of wound concerns; this will be reviewed by IDT at a minimum weekly. In addition, weight loss and wound documentation will be reviewed for accuracy of coding before the MDS Coordinator has signed off on the resident's MDS. The policy titled Resident Assessment was reviewed and	1/20/23

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F 641	Continued From page 17 cognitively intact and had diagnoses which included: stroke, dementia and seizure disorder. Identified R30 required extensive assistance with bed mobility, transfer, personal hygiene and toilet use. Indicated R30 was at risk for pressure ulcers, had one or more unhealed pressure ulcers, had two stage three pressure ulcers, and had two stage three pressure ulcers that were present upon admission. R30's Care Area Assessment (CAA) dated 11/2/22, identified R30 was at risk of pressure ulcer/injury due to limited mobility. Identified R30 was admitted with two stage III pressure ulcers, one on his right buttock and one on his left buttock. R30's care plan revised 11/2/22, identified R30 had an activity of daily living (ADL) self-care performance deficit and interventions included extensive assistance with dressing, personal hygiene, transfer, and toilet use. R30's care plan lacked documentation of a risk of pressure ulcers or current unhealed pressure ulcers. R30's Nurse Admission-Readmission assessment form dated 10/21/22, identified R30's skin was intact, with normal color and turgor (elasticity), and was warm and dry. R30's Weekly Bath Audit forms from 10/27/22, to 12/2/22, identified R30 had no new alterations in skin noted during that observation, which identified no bruises, skin tears, rashes, redness, blisters or open areas. R30's primary care providers nursing home progress note dated 11/3/22, identified R30's skin was normal color and turgor without rashes or	F 641	remains appropriate. 3. Education on policy titled Resident Assessments, will be reviewed with all nurses and all staff who complete resident assessments. In addition, further education on the new skin and wound app, skin conditions and weight changes will be reviewed with appropriate departments to ensure understanding and compliance. 4. Audits will be completed weekly for 6 weeks and monthly for the next 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification. Audits will be brought to and monitored through the QAPI (Quality Assurance and Performance Improvement) meetings or further recommendations and ongoing monitoring. 5. MDS or designee responsible for compliance.	

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F 641	Continued From page 18 lesions. During an interview on 12/13/22, at 12:39 p.m. clinical manager (CM)-A reviewed R30's admission MDS dated 10/28/22, which identified R30 was admitted to the facility with two stage three pressure ulcers, and R30's Nurse Admission-Readmission assessment form dated 10/21/22, which identified R30's skin was intact. CM-A confirmed R30 did not have pressure ulcers. CM-A confirmed R30's admission MDS dated 10/21/22, was inaccurate. During an interview on 12/13/22, at 2:52 p.m. director of nursing (DON) confirmed R30's MDS was inaccurate. DON stated she would expect R30's MDS to be accurate and indicated when R30's MDS was inaccurate it would potentially affect the facility's payment and R30's plan of care. R26 The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment	F 641		

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F 641	Continued From page 19 Instrument 3.0 User's Manual, dated 10/2018, outlined an overview which included, "The purpose of this manual is to offer clear guidance about how to use the [RAI] correctly and effectively to help provide appropriate care ... The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan." The manual then outlined each MDS section with corresponding instructions and directions. This included section K which identified significant weight loss. R26's quarterly MDS dated 10/28/22, identified R26 had diagnoses which included stroke, dysphasia, end stage renal disease and acute pain. R26 had severe cognitive impairment, was dependent with ADL's of bed mobility, transfers and required assistance with eating. R26 has limited ROM of one side of his upper and lower extremity. R26 weight was 200 lbs and had no weight loss. The MDS lacked documentation of R26's loss of 16% of his body weight. R26's care plan lacked any documentation of R26's nutritional risks or weight loss. Review of R26's weight and vitals summary report identified the following weights in pounds (lbs) from 6/8/22, to 11/21/22; -6/8/22, 240.8 lbs -9/21/22, 200.4 lbs, which identified a weight loss of 40.4 lbs from 6/8/22, weight of 240.8 lbs, a total of 17% of R26's body weight. -11/21/22, 195 lbs, which identified an additional loss of 4.6 lbs from 9/21/22.	F 641		

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(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 641	Continued From page 20 R26 had a total weight loss of 45.8 lbs from 6/8/22, to 11/21/22, which was 19% of R26's body weight in approximately five months. R26's medical record lacked any assessment of R26's significant weight loss from 6/8/22, to 11/21/22. R26's medical record lacked any weights for the months of July, August, and October of 2022. During an interview on 12/13/22, at 2:19 p.m. clinical nurse manager (CM)-A confirmed R26 required assistance with eating and had a significant weight loss between June, September, and November of 2022. During an interview on 12/13/22, at 2:35 p.m. the director of nursing (DON) confirmed R26 had lost over 40 lbs within the last six months, or 19% of his total body weight. The DON confirmed R26's quarterly MDS lacked identification of his significant weight loss. During an interview on 12/14/22, at 1:05 p.m. the dietary manager (DM), indicated she had been made aware R26 had lost some weight, however was not aware he had a significant weight loss. The DM confirmed she had completed R26's quarterly MDS dated 10/28/22, and verified the MDS lacked identification of R26's significant weight loss. During an interview on 12/14/22, at 2:27 p.m. the administrator indicated the MDS Coordinator was out on medical leave and could not be reached for an interview. She confirmed R26's quarterly MDS lacked identification of his significant weight loss and should have reflected it.	F 641		

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F 641	Continued From page 21 Policy titled, Resident Assessment, revised November 2019, identified it was purpose of the policy to complete accurate, comprehensive MDS assessments mandated by federal and state guidelines.	F 641		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 676		1/20/23

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F 676	Continued From page 22 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided for 1 of 1 residents (R287) who required assistance with activities of daily living (ADL's). Findings include: R287's admission Minimum Data Set (MDS) dated 11/29/22, indicated R287 had diagnoses which included heart failure, renal insufficiency, diabetes mellitus and was cognitively intact. Identified R287 required extensive assistance of two staff with bed mobility, transfers and required extensive assistance of one staff with toileting, personal hygiene, and bathing. R287's care plan revised on 11/30/22, indicated R287 had an ADL self care deficit related to activity intolerance, fatigue and limited mobility. The care plan indicated staff were to assist R287 with personal hygiene, which included checking his nail length, trimming and cleaning his nails on bath day and as necessary. During observations on 12/12/22, at 5:51 p.m. R287 was seated in his wheel chair in his room and was observed to have long jagged nails with a build up of black/gray substance underneath his nails. R287 stated he had asked staff several times to trim and clean his nails over the last five	F 676	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. It is the expectation of the facility to ensure nail care is completed for residents who require assistance with activities of daily living. Upon identification, R287 nails were cleaned and trimmed to his preference. 2. All residents have the potential to be affected by the deficient practice; all residents were audited, and nail care provided as needed. The policy titled fingernails/Toenails, Care of was reviewed and remains appropriate. 3. Education on nail care; including the policy titled fingernails/toenails, care of was provided to all direct care staff to ensure understanding. 4. Audits will be completed weekly for 6	

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F 676	Continued From page 23 days and stated his nails were disgusting. R287 indicated he would like staff to assist him with his nail care. During observations on 12/13/22, at 11:58 a.m. R287 was seated in his wheelchair while director of rehabilitation (DR)-A pushed him out of the therapy room down the hallway. R287's continued to have long jagged nails with a build up of black/gray substance underneath his nails. During observations on 12/14/22, at 7:02 a.m. R287 was in a standing mechanical lift and licensed practical nurse (LPN)-A was observed lowering R287 into his wheel chair. LPN-A proceeded to exit R287's room and indicated she had just provided morning cares. R287 remained in his room seated in his wheel chair and continued to have long jagged nails with a build up of black/gray substance underneath his nails. During an interview on 12/14/22, at 9:00 a.m. LPN-A confirmed the above findings and indicated R287 required staff assistance with personal hygiene. LPN-A indicated she had assisted R287 with morning cares and had not offered or provided nail care. LPN-A indicated R287 was diabetic and she would expect licensed staff to provide nail care weekly on his bath days. During an interview on 12/14/22, at 11:00 a.m. the director of nursing (DON) confirmed the above findings and indicated R287 required staff assistance with personal hygiene and nail care. The DON stated she would expect licensed staff to provide nail care weekly on resident bath days and as needed for diabetic residents. Review of the facility policy titled,	F 676	weeks and monthly for the next 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification. Audits will be brought to and monitored through the QAPI (Quality Assurance and Performance Improvement) meetings or further recommendations and ongoing monitoring. 5. Director of Nursing or designee responsible for compliance.	

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F 676	Continued From page 24 Fingernails/Toenails, Care of reviewed on 2/8/22, indicated staff were to include daily cleaning and regular trimming of nails. The policy indicated the purpose of nail care was to clean the nail bed, keep nails trimmed, to prevent infection and skin problems around the nail bed. The policy identified if the resident refused treatment, document the reason(s) why and the interventions taken.	F 676		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete accurate assessments, interventions and ongoing	F 692	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission	1/20/23

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F 692	Continued From page 25 monitoring to address unplanned weight loss for 1 of 3 residents (R26) reviewed for nutrition. Findings include: R26's Significant Change of Status Assessment (SCSA) Minimum Data Set (MDS), dated 7/29/22, identified R26 had diagnoses which included stroke, dysphagia (difficulty swallowing) from intracranial bleed (brain bleed) end stage renal disease and acute pain. R26 had severe cognitive impairment and was dependent with activities of daily living (ADL's) of bed mobility, transfers and required extensive assistance with eating. R26 had limited range of motion (ROM) of one side of his upper and lower extremities. R26's height was 77 inches (in) tall and weighed 240 lbs, had no weight loss and had a feeding tube. R26's SCSA Care Area Assessment (CAA) dated 7/29/22, identified R26 had left sided paralysis from a stroke, required assistance with eating and was dependent for his ADLs. R26 was able to make his needs known and had severe cognitive impairment. R26 had a high body mass index ((BMI) (a person's weight in kilograms (or pounds) divided by the square of height in meters (or feet), a high BMI can indicate high body fatness, BMI screens for weight categories that may lead to health problems, however it does not diagnose the body fatness or health of an individual). R26 usually ate in his room, required assistance with eating a mechanically altered diet and received enteral feeding tube supplement fluid intake. R26 no longer received nutritional feedings by his feeding tube. R26's quarterly MDS dated 10/28/22, identified	F 692	of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. It is the expectation of the facility to complete accurate assessments, interventions and ongoing monitoring to address unplanned weight loss for residents reviewed for nutrition. Upon identification, R 26 was reviewed, new assessments and interventions initiated to maintain nutrition as determined by individualized assessment and appropriate plans to monitor were put in place to ensure compliance. 2. All residents have the potential to be affected by the deficient practice; all at like residents were reviewed for unplanned weight loss, for accurate assessments with appropriate interventions and monitoring was reviewed to ensure compliance. Policies titled Weighing and Measuring the Resident and Nutritional Assessment were reviewed and remain appropriate. 3. Education on policies titled Nutritional Assessment and Weighting and Measuring the Resident will be provided to all nursing staff and those responsible for assessments and providing recommendations to residents who have unplanned weight loss. 4. Audits will be completed weekly for 6	

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F 692	Continued From page 26 R26 had diagnoses which included stroke, dysphagia, end stage renal disease and acute pain. R26 had severe cognitive impairment, was dependent with ADL's of bed mobility, transfers and required assistance with eating. R26 had limited ROM of one side of his upper and lower extremity. R26's weight was 200 lbs and the MDS identified R26 had no weight loss. The MDS lacked identification of R26's weight loss of 16% of his body weight. R26's care plan revised 9/28/22, identified R26 required extensive assistance with eating, had cognitive impairment and was at risk for dehydration. R26's care plan lacked documentation of R26's nutritional needs, potential risks, or any interventions such as weight or intake monitoring. R26's nursing assistant (NA) care guide dated 12/13/22, identified R26 required assistance with eating. R26's physician orders signed 11/3/22, revealed an order for a regular diet, mechanical soft textures, advanced. R26's physician orders lacked any indication R26 was on a nutritional supplement. Review of R26's most current nutritional data assessment, dated 5/26/22, identified R26 weighed 235.8 pounds, had a moderate decrease in food intake, no weight loss in the last three months and had BMI of 23 or greater. The assessment identified R26 was at risk for malnutrition. Review of R26's weight and vitals summary report identified the following weights in pounds	F 692	weeks and monthly for the next 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification. Audits will be brought to and monitored through the QAPI (Quality Assurance and Performance Improvement) meetings or further recommendations and ongoing monitoring. 5. Director of Nursing or designee responsible for compliance.	

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F 692	Continued From page 27 (lbs). -2/8/22, 231.5 lbs -3/21/22, 232 lbs -4/11/22, 238.4 lbs -5/4/22, 235.8 lbs -5/25/22, 235.8 lbs -6/8/22, 240.8 lbs -9/21/22, 200.4 lbs, which identified a weight loss of 40.4 lbs from 6/8/22, weight of 240.8 lbs, a total of 17% of R26's body weight. -11/21/22, 195 lbs, which identified an additional loss of 4.6 lbs from 9/21/22. R26 had a total weight loss of 45.8 lbs from 6/8/22, to 11/21/22, which was 19% of R26's body weight in approximately five months. R26's medical record lacked any assessment of R26's significant weight loss from 6/8/22, to 11/21/22. R26's medical record lacked any weights for the months of July, August, and October of 2022. During a telephone interview on 12/12/22, at 3:15 p.m. R26's family member (FM)-A indicated R26 was totally dependent on staff for his cares which included eating. FM-A stated she routinely visited R26 at the facility at least several times a week, where she would often shave R26, feed him one of his meals, and would assist him to wash his hair. FM-A indicated R26 had significantly	F 692		

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F 692	Continued From page 28	F 692		

declined since his admission to the facility approximately a year ago. She indicated she felt R26 had lost approximately 40 pounds since June and was not sure what the facility was currently doing to maintain R26's weight. She indicated she had several conversations with facility nursing and leadership regarding concerns with R26 not being provided ADL assistance which included eating, most recently within the last few weeks.

On 12/13/22, at 11:35 a.m. R26 was observed lying in bed on his back, his eyes were closed, his head of bed elevated approximately 90 degrees (upright, sitting position) R26 was tilted to his right side, he had an over the bed table positioned on the right side of his bed which held a glass of milk.

On 12/13/22, during continuous observations from 12:30 p.m. to 1:30 p.m.. the following was identified:

-at 12:30 p.m. a tiered meal tray cart covered with clear plastic, which included R26's noon meal, was wheeled down the hallway of R26's room by the social service director (SSD), she was observed to pass meal trays to several other residents on R26's hallway.

-at 12:38 p.m. R26 was observed lying in bed on his back, his head of bed, elevated to a sitting position. His eyes were open, he had an over the bed table positioned on the right of his bed, with part of the table extended over his bed. He indicated he had not eaten yet and had been waiting for his food.

-at 12:44 p.m. a tiered meal tray cart remained in

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F 692	Continued From page 29 the hallway, which held R26's afternoon meal tray. At that time, SSD walked out of a room at the beginning of the hallway of R26's room, walked down to the meal tray cart, placed a cup on a tray and walked away back to her office. R26's meal tray remained on the cart. -at 12:51 p.m. R26 remained on his back in his bed, in a seated position, with his over the bed able in front of him, his eyes were opened. R26's meal tray continued to be on the meal tray cart. -at 1:03 p.m. R26 remained on his back, in a seated position, his over the bed table remained in front of him. R26 touched his flat gray call light with his right hand and turned his call light on. At that time, registered nurse (RN)-A entered his room, R26 indicated he had pain and requested to have his food brought into him. RN-A indicated his food would be brought to him shortly, left his room and walked towards the nursing station. -at 1:09 p.m. R26 remained on his back in a seated position, his over the bed table remained in front of him and his meal tray remained on the cart in the hallway. At that time, the activity director entered his room, R26 indicated he was thirsty, she gave him a drink of water from a water mug which was on the bedside table and exited his room. -at 1:15 p.m. R26 remained in bed on his back, in a seated position, his meal tray remained in the hallway on the tiered cart. No staff were observed to provide R26 assistance with eating his noon meal. -at 1:20 p.m. R26 remained in his bed, on his back in a seated position, his meal tray remained	F 692		

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in the hallway on a tiered cart. At that time, the SSD indicated she was not able to pass R26's meal tray to him until nursing staff was available to help feed him. The SSD indicated she was not aware of how long R26 had been waiting for his meal and indicated it was not unusual for his tray to remain on the cart for a long period of time.

-at 1:24 p.m. R26 remained in bed on his back, at that time, RN-A walked towards his room, removed his meal tray from the cart, and brought to R26's room. RN-A placed the tray which held a covered plate, cup of milk, juice, and a cup of jellied cranberries. RN-A lifted the condensation saturated cover off the plate which revealed mashed potatoes, gravy, peas, and meat. RN-A indicated he felt R26's food was still warm and proceeded to feed R26. R26 indicated he felt the food was warm and proceeded to eat approximately 75% of his meal.

During an interview on 12/13/22, at 1:24 p.m. RN-A stated R26 required assistance with eating and felt it was very challenging to feed him when the trays were sent down. RN-A indicated he had voiced concerns meal trays were sent out during the dining room mealtime while staff were assisting with feeding residents in the dining room. RN-A stated residents who required assistance with eating, and preferred to stay in their rooms, such as R26 oftentimes ended up waiting up to an hour to get fed. RN-A indicated R26 routinely ate above 50% of his meals when he fed him, which was several times a week. RN-A stated he was unaware if R26 had any weight loss.

During an interview on 12/13/22, at 1:35 p.m. SSD indicated R26 required assistance with

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F 692	Continued From page 31 feeding and felt he routinely had to wait to be fed in his room for meals. SSD indicated room trays were sent out of the kitchen at the same time food was served in the dining room. She indicated non-nursing staff, such as herself, were assigned to pass room trays to residents who were able to feed themselves. She indicated residents who required feeding assistance, such as R26, had to wait for nursing staff to assist him with eating, and his meal tray would oftentimes remain on the cart for long periods of time. She stated the facility had received complaints from residents in the past who ate in their rooms, the food was cold, and the facility purchased different plate covers which had kept the food warmer longer. SSD indicated she felt it was a "failed system" with meal service and needed to be revised. On 12/13/22, at 2:22 p.m. R26 was observed lying in bed on his back, his eyes were open, and he was covered with a blanket. At that time, clinical nurse manager (CM)-A and registered nurse (RN)-B entered R26's room with a full mechanical lift, and proceeded to weigh R26, he weighed 197.2 lbs. During an interview on 12/13/22, at 1:46 p.m. RN-B indicated R26 required assistance with eating, would routinely have to wait for up to an hour or more to be fed during mealtimes which had occurred that morning for breakfast. He indicated he felt the meal service for room trays did not work as staff were assisting residents in the dining room, at the same time residents required assistance to be fed in their rooms. RN-B stated he had voiced his concerns regarding room trays to dietary and nursing leadership several times. RN-B stated he had	F 692		

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F 692	Continued From page 32 notified dietary and the clinical manager R26 had lost weight a few months ago and R26 had been started on a supplement at that time. R26's medical record eating and supplement intake tasks were reviewed with RN-B, he confirmed R26's meal and supplement intakes had not been documented since 12/11/22, and were not routinely documented. Review of R26's progress notes from 4/8/22, to 12/13/22, revealed the following: -4/8/22, revealed an order was obtained to discontinue R26's tube feedings related to resident eating a regular diet by mouth. -11/21/22, R26 was seen by nurse practitioner for redness around his feeding tube site. The notes lacked documentation of R26's significant weight loss. Review of R26's nurse practioner's progress note dated 10/27/22, revealed R26 was seen for a rash. The note lacked documentation of R26's significant weight loss. During an interview on 12/13/22, at 2:19 p.m. CM-A confirmed R26 required assistance with eating and had a significant weight loss between June and November of 2022. CM-A stated R26 used to receive all his nutrition via tube feeding, though this had stopped sometime in April of 2022. She stated she had been made aware of his weight loss in September 2022, and had notified the dietician at that time via email. CM-A indicated R26 was started on a magic cup (nutritional supplement) in October 2022, and was unaware of R26's intake of the supplement. She indicated she was not aware if the facility's dietary manager or dietician had completed a formal assessment of R26's nutritional needs	F 692		

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	245313	A. BUILDING _____ B. WING _____	C 12/14/2022

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F 692	Continued From page 33 prior to or since his weight loss was identified. R26's medical record was reviewed with CM-A, she confirmed R26's care plan lacked documentation of R26's nutritional status, goals, or interventions. CM-A confirmed R26's weight had not been checked during the months of July, August, or October of 2022, and should have been checked monthly. She confirmed R26's medical record lacked routine documentation of his meal and supplement intakes. CM stated she could not recall if R26's provider had been made aware of his significant weight loss. During an interview on 12/13/22, at 2:35 p.m. the director of nursing (DON) confirmed R26 had lost over 40 lbs. within the last six months, or 19% of his total body weight. The DON confirmed R26's medical record lacked an assessment of R26's significant weight loss which had occurred between June and November 2022, which would have included possible causative factors, identification of barriers, goals, and interventions. She confirmed R26's medical record lacked routine monitoring of his weights, meal, and supplement intake. The DON confirmed R26's care plan did not address his nutritional needs or identified his risk of weight loss, and malnutrition. The DON stated she was unaware if the facility dietician was aware of R26's significant weight loss and would have expected her to be made aware and to have completed an assessment with identified interventions. The DON confirmed R26's medical record revealed the last entry from the facility's dietician was in February of 2022, and his last assessment from the dietary manager was in from 5/26/22, prior to his significant weight loss. She indicated R26 was started on a magic cup supplement in October 2022, however confirmed his medical record	F 692		

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F 692	Continued From page 34	F 692		

lacked documentation of the amount and routine documentation of his acceptance of the magic cup. Further, the DON confirmed R26's medical record lacked routine documentation of his meal intakes.

During an interview on 12/13/22, at 2:51 p.m. the facility administrator stated the contracted dietician visited the facility monthly and would have been available to address R26's significant weight loss. The administrator indicates she was unaware of when or if the dietician had been notified.

Review of an email dated 9/21/22, identified CM-A sent an email to the dietician which identified R26 had lost 40 lbs, was asking nursing to re-weigh him before laying down and to please advise.

Review of an email dated 9/22/22, identified the dietician's email response to CM-A, that she had received her email and would get back to her that day.

During a telephone interview on 12/13/22, at 3:01 p.m. the facility's dietician confirmed she had last completed a comprehensive assessment of R26's nutritional needs in February 2022, during which time he had received most of his nutrition via his feeding tube. The dietician indicated R26 last received nutrition via his feeding tube in April 2022, and stated she would expect R26's weight to be checked a minimum of monthly, though weekly would be ideal. The dietician indicated she had been made aware R26 had some weight loss in September 2022, and nursing had started a magic cup supplement. She confirmed she was not aware of R26's acceptance of the magic cup

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F 692	Continued From page 35	F 692		

and indicated she expected staff to monitor R26's intakes of the supplement and the amount taken. The dietician confirmed R26 had a significant weight loss when he had lost 19% of his body weight in six months.

During an interview on 12/14/22, at 1:05 p.m. the dietary manager confirmed she had not been monitoring R26 for weight loss, his meal or supplement intakes. The dietary manager indicated she had been made aware R26 had lost some weight, however was not aware he had a significant weight loss.

During a telephone interview on 12/14/22, at 1:11 p.m. R26's primary medical doctor (MD)-A stated she had not been notified R26 had lost over 40 lbs, approximately 19% of his body weight, in the last six months. She indicated R26 had received all his nutrition via feeding tube which had been discontinued once he was able to eat by mouth. She indicated she would have wanted to be made aware of his weight loss and would have certainly wanted his nutritional needs, risks assessed, and interventions identified and implemented. She indicated R26 needed to be fed by staff and indicated having to wait to be fed for prolonged periods of time, could impact his appetite. MD-A stated she would expect the facility to complete a comprehensive assessment of R26's nutritional needs, risks, goals, and interventions based off the assessment. MD-A stated she expected R26's meal and supplement intakes to be monitored and re-assessed as needed.

The facility policy titled Weighing And Measuring The Resident revised 3/2011, identified the purpose was to determine the resident's weight and height to provide a baseline and an ongoing

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F 692	Continued From page 36 record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident. The policy further identified that a report of significant weight loss/weight gain would be reported to the nurse supervisor. The facility policy titled Nutritional Assessment revised 10/2017, identified as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, would be conducted for each resident. The policy identified the dietician, in conjunction with the nursing staff and healthcare practitioner would conduct a nutritional assessment for each resident upon admission, and as indicated by a change in condition that placed the resident at risk for impaired nutrition. The policy further identified the nutritional assessment would identify components which included; usual weight, current weight, description of the resident's usual intake and appetite, meal, and snack patterns.	F 692		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		1/20/23

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F 732	Continued From page 37 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect all 34 residents who resided in the facility and/or any visitors who may have wished to view the information. Findings included: During observations on 12/12/22, at 1:30 p.m. the facility's Daily Staffing Report dated 12/12/22, was located in a black metal holder on the wall near	F 732	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. It is the expectation of the facility to ensure the required nurse staffing information is posted daily. It was	

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F 732	Continued From page 38 the entrance of the facility. Review of the daily posting lacked the facility's daily census. -at 8:00 p.m., posting remained the same. During observations on 12/13/22, at 11:41 a.m. the facility's Daily Staffing Report dated 12/12/22, continued to be located in a black metal holder on the wall near the entrance of the facility. Review of the daily posting lacked the facility's daily census. -at 4:37 p.m., posting remained the same. During observations on 12/14/22, at 6:56 a.m. the facility's Daily Staffing Report dated 12/12/22, continued to be located in a black metal holder on the wall near the entrance of the facility. Review of the daily posting lacked the facility's daily census. -at 10:00 a.m., posting remained the same. Review of the black metal holder on the wall revealed the facility lacked Daily Staffing Reports for 12/13/22, and 12/14/22. During an interview on 12/14/22, at 11:12 a.m. the administrator confirmed the above findings. Administrator indicated her expectation of staff would be for the staff posting to be completed daily and to include the daily census. Review of the facility policy titled, Posting Direct Care Daily Staffing Numbers, reviewed on 7/2022, indicated the staff posting would include the resident census at the beginning of the shift for which the information is posted. The policy identified the posting of direct care daily staffing numbers would be posted within two hours of the beginning of each shift.	F 732	identified that the facility lacked the required components on the daily posting which upon identification was updated to ensure compliance. 2. All residents have the potential to be affected by inaccurate or missing components of the daily nurse staff posting. The facility updated the posting to reflect the required components to ensure compliance with posting. The policy titled Posting Direct Care Daily Staffing Numbers was reviewed and remains appropriate. 3. All licensed nurses and nurse management were educated in their role and expectations with the staff posting to ensure compliance. The licensed nurse orientation packets have been updated to ensure proper training of the required nurse staff posting. 4. Audits will be completed weekly for 6 weeks and monthly for the next 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification. Audits will be brought to and monitored through the QAPI (Quality Assurance and Performance Improvement) meetings or further recommendations and ongoing monitoring. 5. Administrator or designee responsible for compliance.	

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F 770	Continued From page 39	F 770		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure labs were drawn according to physician (MD) orders to determine therapeutic dosing for 1 of 1 residents (R15) reviewed for unnecessary medications who received Depakote (antiseizure medication also used for mood altering affect). Findings include: R15's quarterly Minimum Data Set (MDS) dated 10/18/22, identified R15 had severe cognitive impairment with diagnoses which included: schizophrenia, diabetes mellitus, and peripheral vascular disease. Identified R15 required limited assistance with dressing, and was independent with bed mobility, transfers, ambulation, and toileting. R15's care plan dated 7/12/21, identified R15 had impaired cognitive function related to short term memory loss. R15's care plan indicated R15 required supervision to assistance with dressing and personal hygiene and was independent with bed mobility, transfers, ambulation and toileting.	F 770	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. 1. It is the expectation of the facility to ensure compliance with physician ordered laboratory monitoring. R15 has since been reviewed to ensure compliance with physician ordered labs. 2. All residents who require laboratory services have the potential to be affected by the deficient practice. The policy titled Lab and Diagnostic Test Results – Clinical Protocol was reviewed and remains appropriate. All other at like residents reviewed to ensure compliance with laboratory services; no other residents were found to be affected by deficient	1/20/23

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F 770	Continued From page 40 R15's care plan identified interventions which included to administer medications as ordered, observe labs and response to medications and treatment. R15's Order Summary Report dated 12/1/22, identified the following: -divalproex sodium (Depakote) 750 milligram (mg) by mouth one time a day related to major depressive disorder, single episode, unspecified -A1C (blood test that measures average blood sugar levels) and Depakote level (blood test that measures therapeutic Depakote levels) one time only related to Type 1 diabetes mellitus with diabetic neuropathy, unspecified schizophrenia, unspecified, for 1 day order date 9/16/22, start date of 12/8/22. Review of R15's progress notes from 9/16/22, to 12/13/22, identified the following: -9/16/22, at 9:15 a.m. pharmacy consult reviewed by physician, recommendation for routine labs, accepted by primary care provider (PCP), scheduled for 12/8/22. -12/8/22, at 7:20 a.m. A1C and Depakote level, called lab and left a message to bring supplies for the lab today if not already done. Review of R15's medical record (MR) lacked any documentation R15's labs had been drawn as ordered on 12/8/22, or since that time. During an interview on 12/14/22, at 1:04 p.m. clinical manager (CM)-A confirmed an order had been received for R15 to have an A1C and Depakote level drawn on 9/16/22. CM-A verified the labs had not been drawn as ordered. During an interview on 12/14/22, at 1:52 p.m.	F 770	practice. 3. All licensed were educated in their role and expectations with the laboratory services to ensure compliance. The licensed nurse orientation packets have been updated to ensure proper training. 4. Audits will be completed weekly for 6 weeks and monthly for the next 3 months to ensure compliance in this area. Any deficiencies will be corrected upon identification. Audits will be brought to and monitored through the QAPI (Quality Assurance and Performance Improvement) meetings or further recommendations and ongoing monitoring. 5. Director of Nursing or designee responsible for compliance.	

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F 770	Continued From page 41 director of nursing (DON) confirmed R15's Depakote level had not been drawn as ordered. DON stated she expected labs to be completed as ordered. DON indicated Depakote levels were important to assure R15 received a therapeutic level of the Depakote. A facility policy was requested however was not provided.	F 770		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 12/13/2022, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Meadow Lane Restorative Care Center was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/09/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Meadow Lane Restorative Care Center is a one-story building with a partial basement. The building was constructed at three different times. The original building was constructed in 1958; it is an NF2 facility and was determined to be of Type V(000) construction. In 1970, the SNF/NF facility was built that was determined to be of Type II(222) construction. In 1976 an addition was added to connect the SNF/NF building to the NF2 building, which was determined to be of Type II(000) construction. Because the original building	K 000		

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K 000	Continued From page 2 and the two additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled throughout, and the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 34 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.3.1, 14.4.5.3, and 14.6.2.4. This deficient finding could have a widespread impact on the residents within the facility.	K 345	1. Upon identified lack of proper documentation from vendor; Lloyd's Security was called and paperwork requested to obtain the required information. The facility has not recieved to date this information from Lloyd's Security, but has continued to call and request.	1/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW LANE RESTORATIVE CARE CENTER	**2209 UTAH AVENUE** **BENSON, MN 56215**

(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
K 345	Continued From page 3 Findings include: On 12/13/2022, at 10:47 AM, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor that the facility could not provide a current annual fire alarm testing document that provided a complete listing of each individual device tested, to include device type, address, location and the test results for each individual device. The last annual fire alarm testing document was dated 05/23/2022 and it did not have an annotated listing of all of the devices that were tested. An interview with the Maintenance Supervisor verified this deficient finding at the time of the discovery.	K 345	2. The facility has choosen to go with a different vendor, Annual Fire Systems Inspection, as in the past they have been able to provide the required information that is needed for facility inspections. 3. After each inspection, the facility will verify the report to ensure documentation needed has been obtained and that complaince is achieved. 4. Maintenance Manager or designee is responsible for the corrective actions and monitoring of ongoing complaince. This will be brought to and monitored through the facility Quality Assurance committee. 5. The facility will continue to attempt to obtain needed information from Lloyd's Security, however will going forward ensure that Annual Fire System's Inspection vendor is used. Next inspection is planned this spring.	