DEPARTMENT OF HEALTH	MEDICA	ARE/MEDICAI			CENTERS FOR M AND TRANSMITTAL TE SURVEY AGENCY	4	& MEDICAID SERVICES ID: RSG4 Facility ID: 00930
1. MEDICARE/MEDICAID PROVIDEI (L1) 245313 2.STATE VENDOR OR MEDICAID NO (L2) 306920600		(L3) MEADOW I (L4) 2209 UTAH	 3. NAME AND ADDRESS OF FACILITY (L3) MEADOW LANE RESTORATIVE C. (L4) 2209 UTAH AVENUE (L5) BENSON, MN 		CARE CENTER (L6) 56215	1. Ir 3. Te 5. V	ermination 4. CHOW alidation 6. Complaint
 5. EFFECTIVE DATE CHANGE OF O (L9) 11/01/2020 6. DATE OF SURVEY 08/27/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	PPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	03 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. F	n-Site Visit 9. Other ull Survey After Complaint . YEAR ENDING DATE: (L35) 12/31
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	56 (L18) 56 (L17)	X B. Not in Com	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waiver 2. Technical Perso 3. 24 Hour RN 4. 7-Day RN (Rur 5. Life Safety Cod * Code: B *	al SNF)	<u>ving Requirements:</u> 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 37 (L37) (L38)	19 SNF 19 (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1	1):	(L15)
16. STATE SURVEY AGENCY REMA 17. SURVEYOR SIGNATURE Susan Bachleitner, HFE - NE II	RKS (IF APPLICA	Date :	0/25/2021		18. STATE SURVEY AGE		10/20/2021
PAR	T II - TO BE (COMPLETED F	RV HCFA RI	(L19) EGIONAI	OFFICE OR SINGL		(L20)
19. DETERMINATION OF ELIGIBILI _X_ 1. Facility is Eligible to Pa 2. Facility is not Eligible	ГҮ	20. COM	IPLIANCE WITI		21. 1. Statement of	Financial Solver Control Interest D	
22. ORIGINAL DATE OF PARTICIPATION 05/01/1986 (L24)	23. LTC AGREEM BEGINNING (L41)		4. LTC AGREEN ENDING DA (L25)		26. TERMINATION ACT <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reim	00	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	<u> </u>		03-Risk of Involuntary Termi 04-Other Reason for Withdra		OTHER 07-Provider Status Change

(L44)

(L45)

30. REMARKS

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

01111

(L27)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

B. Rescind Suspension Date:

(L28)

(L32)

00-Active



Electronically delivered September 21, 2021

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

RE: CCN: 245313 Cycle Start Date: August 27, 2021

Dear Administrator:

On August 27, 2021, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 21, 2021.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 21, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 21, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 21, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Meadow Lane Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 21, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

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 Office: (218) 332-5140 Mobile: (218) 403-1100

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 27, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <u>Tamika.Brown@cms.hhs.gov.</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 21, 2021

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

Re: State Nursing Home Licensing Orders Event ID: RSG411

Dear Administrator:

The above facility was surveyed on August 23, 2021 through August 27, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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 Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	alth					AT TROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		()		(X3) DATE COMP	SURVEY PLETED
		00930		B. WING		08/2	C 2 7/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	E CARE CENTE	2209 UTAH BENSON,	HAVENUE MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORD	ER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has	issued ion, it is cited violation rdance rule of been tag below. ure to sidered a upon rule will f the item				
	that may result from orders provided tha the Department with	hearing on any assent n non-compliance wit t a written request is hin 15 days of receip nt for non-compliance	th these made to t of a				
	conducted at your f Minnesota Departm facility was found N State Licensure and orders are issued. F electronic plan of co	FS: /21, a licensing surve acility by surveyors fi ent of Health (MDH) OT in compliance wi d the following correct Please indicate in you prrection you have re	rom the . Your th the MN ction ur				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESEN	TATIVE'S SIGN	IATURE	TITLE		(X6) DATE 10/01/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 113

Minneso	ota Department of He	alth			FORM	APPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00930	B. WING			C 2 7/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/F CARE CENTEE	AH AVENUE , MN 56215			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	these orders and id be completed.	entify the date when they will				
	The following complaints were found to be SUBSTANTIATED: H5313059C (MN00055846), with a licensing order issued at L920. H5313061C (MN00073747), with a licensing order issued at L920 and L830.					
	AND The following comp UNSUBSTANTIATE H5313060C (MN00					
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." For	nent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for the assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is tary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and rrection.				
	receipt of State lice the Minnesota Dep Informational Bullet https://www.health. n/infobulletins/ib14_ orders are delineate Department of Hea					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	Сом	E SURVEY PLETED
		00930			08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEADOV	W LANE RESTORATIV	/F CARE CENTER	AH AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 000	enter the word "corn text. You must then State licensure proc completion date, the corrected prior to el Minnesota Departm PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF	2 000			
2 800	MN Rule 4658.0510 Staffing requiremen Subpart 1. Staffing home must have or number of qualified registered nurses, I nursing assistants t residents at all nurs in all buildings if mo	requirements. A nursing n duty at all times a sufficient nursing personnel, including icensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends,	2 800			10/11/21
	by: Based on observati review, the facility fa staffing to provide r activities of daily livi personal hygiene at	ent is not met as evidenced on, interview and document ailed to ensure sufficient outine assistance with ing (ADL's) of grooming, nd dressing for 7 of 7 , R11, R14, R6, R1, R21 and		"corrected"		

Minnesota Department of Health STATE FORM

RSG411

If continuation sheet 3 of 113

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00930	B. WING			C 27/2021
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
EADOV	V LANE RESTORATI	VF CARE CENTEE	H AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 800	Continued From page 3		2 800			
	dependent on staff	assistance and were for ADL's. This deficient otential to affect all 25 residents facility.				
	Findings include:					
	R1					
	8/17/21, identified l depression weakne (numbness/tingle in identified R1 had s and required exten	mum Data Set (MDS) dated R1 had diagnoses of dementia, ess and peripheral neuropathy n extremities.) The MDS evere cognitive impairment sive assistance with activities 's) of dressing, personal ng.				
	impaired cognition, required extensive hygiene, dressing a	sed 7/12/21, revealed R1 had function, thought process and assistance with personal and bathing. R1's care plan facial hair removal.				
	in bed, eyes closed her feet to mid che her abdomen abov dozen four (4) to fin thick black coarse chin and jaw line. F	8 p.m. R1 was observed lying d, covered with a blanket from st. R1's hands were rested on re the blanket. R1 had several ve (5) millimeters (mm) long, facial hairs along her upper lip, R1 had several six (6) to ten e wispy facial hairs along both th and chin.				
	in a wheelchair in t table next to anoth combed straight to have several dozen) a.m. R1 was observed seated he dining room at a squared er resident. R1's hair was her head and she continued to n 4 to 5 mm long, thick black along her upper lip, chin and				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Сом	E SURVEY PLETED
		00930	B. WING			27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/F CARE CENTEE	H AVENUE MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From page 4		2 800			
2 000	jaw line. R1 had sev	veral 6- 10 mm long white ong both corners of her mouth	2 000			
	in a wheelchair in h closed, head was ti open. R1 continued mm long, thick blac upper lip, chin and j mm long white wisp corners of her mout nursing assistant (N	a.m. R1 was observed seated er room, her eyes were lted back and her mouth was I to have several dozen 4 to 5 k coarse facial hairs along her jaw line. R1 had several 6- 10 by facial hairs along both th and chin. At that time, NA)-E confirmed R1's facial she did not have a razor to air.				
	On 8/25/21, at 8:30 a.m. NA-E stated she had assisted R1 with morning cares and had not removed R1's facial hair. NA-E indicated R1 did not have a razor to remove the facial hair and further indicated she would not have had time that morning to shave R1 since they were short staffed that morning. NA-E indicated she felt she was not able to provide R1 with standard cares due to insufficient staffing. NA-E indicated that morning an NA did not show up for the day shift and a NA from the night shift had stayed over that was not familiar with morning cares.					
	(TMA)-A indicated F all of her ADL's and verbalized her need hair should have be was not aware if R1 she felt the NA's did cares, such as shaw sufficient staff. TMA the floor as she was	1 a.m. trained medication aid R1 was dependent on staff for I felt R1 was not able to ds. TMA-A stated R1's facial een removed as needed and I had a razor. TMA-A indicated d not have time for routine ving, routinely due to lack of A-A stated she would help on s able between medication re were call ins. She indicated				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Сом	E SURVEY PLETED
		00930	B. WING			27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From page 5		2 800			
	few months which h stated this past wee	n using pool staff for the past had been helpful. TMA-A ek, they had a call in and had not been able to find				
	R18					
	7/21/21, indicated F obstructive pulmona and was severely c indicated R18 was i	imum Data Set (MDS) dated R18 had diagnoses of chronic ary disease, arthritis, anxiety ognitively impaired. The MDS independent with bed mobility, toileting, eating and personal				
	had a physical func care impairment an care plan indicated	ised on 3/23/20, indicated R18 tioning deficit related to self d mobility impairment. The R18 required assistance from ist as needed and assist of personal hygiene.				
	was walking around independently with noted to be uncomb to the back of her h her head. R18's hai	s on 8/23/21, at 2:38 p.m. R18 I the nursing home her walker. R18's hair was bed, and her hair was pasted ead and to the right side of ir was also sticking straight up her head and the right side of				
	was standing up at walker talking to the (TMA)-A and hair w back and left side o	s on 8/24/2,1 at 9:41 a.m. R18 the nurses station with her e trained medication aid as uncombed, pasted to the f her head. R18's hair was on the left and back of her	5			

(X4) ID PREFIX TAGSUMMARY STATEME (EACH DEFICIENCY MUS REGULATORY OR LSC ID)2 800Continued From page 6During observations on R18 walked down the ha her walker and sat down entrance area. R18's ha to the back and left side was sticking straight up her head.During observations on R18 walked down the ha her walker and sat down entrance area. R18's ha to the back and left side was sticking straight up her head.During observations on R18 walked down the ha her walker and R18's ha hair sticking straight up	STREET AD				27/2021
PREFIX TAG (EACH DEFICIENCY MUS REGULATORY OR LSC ID 2 800 2 800 Continued From page 6 During observations on R18 walked down the his her walker and sat down entrance area. R18's has to the back and left side was sticking straight up her head. During observations on R18 walked down the his her walker and R18's has hair sticking straight up		DRESS, CITY, ST	ATE, ZIP CODE	• • •	-
PREFIX TAG (EACH DEFICIENCY MUS REGULATORY OR LSC ID 2 800 2 800 Continued From page 6 During observations on R18 walked down the his her walker and sat down entrance area. R18's has to the back and left side was sticking straight up her head. During observations on R18 walked down the his her walker and R18's has hair sticking straight up	ARE CENTER	HAVENUE , MN 56215			
During observations on R18 walked down the ha her walker and sat down entrance area. R18's ha to the back and left side was sticking straight up her head. During observations on R18 walked down the ha her walker and R18's ha hair sticking straight up	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
 (NA)-A indicated she was and was not familiar with she had access to resid were stored at the nurse NA-A attempted to retrie unable to locate it at the indicated that day she h medical records to work in. NA-A located R18's facility's electronic medi and indicated R18 requ ADL's. NA-A did not ide assisted with grooming R11 R11's annual MDS date had diagnoses which in depression, muscle weat 	8/25/21, at 10:38 a.m., hallway independently with on in a chair in the main air was uncombed, pasted e of her head. R18's hair o on the left and back of 8/26/21, at 11:13 a.m. hallway independently with air was uncombed and all over. m. nursing assistant orked as a casual NA-A th R18's needs. She stated dent care guides which es station in a binder. eve the binder, and was e nurses station. NA-A had been pulled from k on the floor due to a call plan of care in the ical record (MR) system, uired staff assistance with entify why R18 was not that morning.				

TATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00930	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IEADOV	V LANE RESTORATI	VE CARE CENTEE				
	SUMMARY STA		N, MN 56215	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLET DATE
2 800	Continued From page 7 indicated R11 required limited assistance from staff for dressing and personal hygiene.		2 800			
	During observations on 8/23/21, at 4:53 p.m. R11 was seated in the chair in her room, wore a white turtle neck with blue snow flakes and a pair of blue shoes. R11's shirt had several soiled white/brown spots on the chest area and her shoes had several soiled white spots on the top of the shoes.					
	hallway with her wa R11 wore a light blu light brown colored her legs, half way to entire buttocks area was darker brown i noted. R11 sat dow independently, whil flies buzzed around clothing. R11 had s	walked independently in the alker and back to her room. ue pair of denim jeans with stain noted on the inside of o her knees and over her a. The outer ring of the stain n color and no odor was <i>n</i> in her chair in her room le visiting with her, multiple d and landed on her and her several white long hairs on her n measuring approximately 1/4				
	independently with	walked down the hallway her walker, continued to wear irt and pants and R11's facial same.				
	was seated out in the with several other right clothing from yester soiled red/brown sp	s on 8/24/21, at 1:09 p.m. R11 he activity room playing bingo residents. R11 wore the same rday, her shirt had several bots on her chest and belly remained the same.				
	R11 was seated in	s on 8/25/21, at 11:59 a.m. the dining room and continued hirt from Monday, 8/23/21,	1			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	Сом	E SURVEY PLETED
		00930	B. WING		08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IEADOV	W LANE RESTORATIN	/F CARE CENTEE	AH AVENUE N, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ae 8	2 800			
	with a pair of yellow to be soiled and sta	/ pants. R11's shirt continued ined with red/brown spots on area and R11's facial hair				
	R11 walked indepedining room area, of shirt from Monday & yellow pants. R11's and stained with rea	s on 8/26/21, at 12:20 p.m. ndently with her walker to the continued to wear the same 8/23/21, with the same pair of shirt continued to be soiled d/brown spots on her chest R11's facial hair remained the				
	for four days and th	R11 was observed to wear the same soiled shirt for four days and the same soiled pants for two days and had not been shaven in four days.				
	worked as an NA of familiar with R11's r access to resident of at the nurses statio to retrieve the binde at the nurses statio had been pulled fro the floor due to a ca of care in the facility indicated R11 requ	1 a.m. NA-A indicated she n a causal basis and was not needs. She stated she had care guides which were stored n in a binder. NA-A attempted er, and was unable to locate it n. NA-A indicated that day she m medical records to work on all in. NA-A located R11's plar y's electronic MR system, and irred staff assistance with t identify why R11 was not hing that morning.	1			
	R14					
	R14 had diagnoses poly-arthritis, lymph and was severely c indicated R14 requi	S dated 7/13/21, indicated which included depression, nedema (swelling of the legs) ognitively impaired. The MDS ired two staff assistance with ers, dressing, toileting, one				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00930	B. WING			C 27/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IEADOV	V LANE RESTORATIN	/F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From page 9		2 800			
	staff for personal hy eating.	ygiene and supervision with				
	R14's care plan revised on 2/9/21, indicated R14 had physical functioning deficit related to mobility impairment. The care plan indicated R14 required one staff to assist with oral care and personal hygiene.					
	was noted to have the back of her hea	s on 8/23/21, at 5:05 p.m. R14 her hair uncombed, matted to id and sticking straight up on id. R14 had several long white nately 1/4 inch long.				
	was seated in her v	s on 8/24/21, at 8:18 a.m. R14 vheel chair in her room and ave several long white chin / 1/4 inch long.				
	was in bed on her b began to make R14 straightened up the and soiled linen. NA garbage and soiled hallway on the othe NA-B entered the u	s on 8/25/21, at 8:17 a.m. R14 back, NA-B entered her room, 4's room mates bed, a room, collected the garbage A-B left R14's room with the linen and walked down the er end of the nursing home. Itility room, placed the linen proper bins and washed her				
	NA-B wheeled R14 hallway towards the to have several long approximately 1/4 in	ion on 8/25/21, at 9:03 a.m. out of her room, down the e dining room. R14 continued g white chin hairs nch long. NA-B was not r provide oral cares or shaving				

If continuation sheet 10 of 113

	OF CORRECTION	DENTIFICATION NUMBER:			СОМ	E SURVEY PLETED C
		00930	B. WING		08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
VEADOV	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	DATE
2 800	required assistance with all of her cares. NA-B indicated she forgot to provide R14 with oral cares and shaving that morning, stated she had		2 800			
		e night shift due the facility				
		She stated she was not familia				
		routines and indicated she had	1			
		pplies to provide cares with,				
	such as oral cares a	and shaving.				
	R6					
		dated 5/27/21 indicated D6				
		dated 5/27/21, indicated R6 ch included diabetes mellitus,				
		nia and was cognitively intact.				
		R6 required extensive				
	assistance of one staff with bed mobility, toileting,					
	personal hygiene, li	mited assistance with				
	dressing and super	vision with transfers.				
	R6's care plan revis	sed on 8/25/21, indicated R6				
		performance deficit related to				
		r, confusion, impaired balance				
		plan identified R14 required				
	one to two staff ass	istance with dressing,				
	personal hygiene a	nd toileting.				
	During observations	s on 8/25/21, 7:33 a.m. R6				
	5	oom in a wheelchair and a				
		avy odor of urine was				
		er room. R6's bed and				
	bedding were comp	pletely saturated with urine and				
		ne was noted. Clinical				
		nd NA-E removed R6's				
		ich was completely saturated				
		a streak of bowel in it. R6's				
		pink, puckered and wrinkled, d from the soiled brief. CM-A				
		ed to assist R6 with peri-cares				
		back into the wheelchair. R6				
		her morning cares and				

TATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	N LANE RESTORATIN	/F CARE CENTER	AH AVENUE			
		BENSON	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ige 11	2 800			
	she had not receive night shift and state Both NA-E and CM when the last time I changed or offered - at 7:41 a.m. CM-A last time R6 had be CM-A reported R6 I changed at 3:40 a.r time of urine. R6's MR lacked any	t of the room. NA-E indicated ed report that morning from the ed she never received report. -A stated they were not aware R6 had been checked or assistance with toileting. A reviewed R6's MR, to see the een checked and changed. had last been checked and m. and was incontinent at that y further documentation when hecked and changed since				
	(MDS) dated 8/4/21 cognitive impairment included: Alzheiment and thyroid disorder required total assist extensive assistant and personal hygie R21's care plan rev required extensive personal hygiene a however was expect	rised 7/12/21, identified R21 assistance with dressing, nd R22 did not use the toilet, cted to be checked and	t			
	R21 had impaired t Alzheimer's disease include specific inst removal. On 8/23/21, at 2:31	ly. R21's care plan identified hought processes related to e. R21's care plan did not tructions for facial hair p.m. R21 was observed lchair in her room. R21 had				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	COMI	E SURVEY PLETED
		00930	B. WING		08/2	27/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IEADOV	V LANE RESTORATI	VE CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 800	Continued From pa	age 12	2 800			
	 multiple long wispy white hairs on her chin and neck ranging from 1/8 inch with 4-5 hairs up to 3/4 inches long. On 8/24/21, at 8:13 a.m. R21 was observed seated in her wheelchair in her room. R21 continued to have multiple facial hairs, white in color on her chin and neck, ranging from 1/8 inch long to 3/4 inch long. 					
	seated in her whee multiple other resid present. R21 cont present as before,	45 a.m. R21 was observed elchair in the activity room with dents and staff members inued to have facial hairs with multiple white wispy hairs on her chin and neck.				
	(NA)-E indicated s with cares howeve	09 a.m. nursing assistant he did not usually assist R21 r had helped another staff s cares that morning.				
	R22					
	(MDS) dated 8/6/2 cognitive impairme included: dementia (high blood pressu indicated R22 requ	hange Minimum Data Set 1, identified R22 had significan ent and diagnoses which a, arthritis and hypertension re). R22's MDS further lired extensive assistance with sing, and personal hygiene.	t			
	had an activities of performance defici and limited mobility included extensive	vised 8/13/21, identified R22 daily living (ADL) self-care t related to advanced dementia y. R22's care plan interventions assistance of one staff for hygiene and oral care.				
	On 8/25/21 at 7:36	6 a.m. to 8:16 a.m. NA-B				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMF	E SURVEY PLETED
		00930	B. WING	B. WING		27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIN	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	ge 13	2 800			
	assisted R22 with morning cares, then assisted in her wheelchair out into the hallway after the cares were completed. During the observation, NA-B had not completed oral cares for R22. On 8/25/21, at 9:37 a.m. during an interview, NA-B indicated her typical shift was working the					
	night shift, 10:30 p.m. to 6:00 a.m., however within the last few weeks the facility had direct care staff calling in sick or just not showing up for their morning shifts. NA-B stated upon shift start, several residents were routinely saturated with urine and would require complete bed changes, which included R1, R6 and several other					
	residents. NA-B ind been struggling with had improved some couple of months a again the last seven the facility had a ca	licated she felt the facility had n staffing for several months, e when pool staff came in a go and had been worsening al weeks. She indicated when Il in or a no show for the				
	would stay or the da one NA. NA-B indic patterns would inclu- shift. She stated the within the last few r	r someone from the night shift ay shift would work with only ated the usual staffing ude at least two NA's on each are had been several times nonths when she had to work				
	on the day and eve occurred most rece indicated she was t night. NA-B indicate	other NA's had worked alone ning shifts. NA-B stated this ently as the week prior and he only NA scheduled for that ed when she worked alone, it would provide care for				
	for repositioning, tra changing which inc stated some of the	e care planned for two assist ansfers, or checking and luded R16, R4, and R9. NA-B nurses would help with				

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, ST	TATE, ZIP CODE		
	V LANE RESTORATIV	2209 []]	AH AVENUE			
	V LANE RESTORATION	BENSON	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ige 14	2 800			
	administration and the director of nursing (DON) as recently as that day regarding concerns with sufficient staffing and had been informed the facility was working on a solution.					
	interview, NA-B sta perform R22's more with her morning ro had not completed morning, but indica be to complete oral	6 a.m. during a follow up ted she typically did not ning cares and was unfamiliar putine. NA-B stated no, she oral cares for R22 that ted her usual practice would cares. NA-B indicated she om the night shift that morning show.				
	NA-C indicated the and two nurses eac the last few weeks, in the schedule and short nursing assist daily, when they sta would be soaked w felt the prior shift wa cares with one NA. take a break during would be no one to NA-C indicated they repositioned but wh they would not be a and cares and esse such as repositionin indicated shaving, s not generally be indi- indicated the charg of the staffing conc	e p.m. during an interview facility usually had two NA's ch shift. NA-C indicated within there had been call-ins, holes d they would end up working tants. NA-C stated almost arted their shift, residents ith urinary incontinence and as not able to keep up routine NA-C stated they would not g their eight hour shift, as there answer resident call lights. y made sure residents were nen they were short staffed able to give residents baths ential cares would be provided ing and toileting. NA-C showering and hair care would cluded in essential cares. NA-C e nurse and DON were aware erns and as recently as that they were working on it.				
		p.m. during an interview, ual staffing was for two NA's				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING	B. WING		27/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IEADOV	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE N, MN 56215			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5) COMPLET
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	DATE
2 800	Continued From pa	ige 15	2 800			
	on each shift and two nurses. NA-G indicated					
		times an NA had called in and				
		onsible for working the floor				
		the nurses would help as the	y			
		ntimes they were responsible				
	for getting residents up for meals and all routine					
		ted this occurred as recently				
		he week prior. NA-G stated sh				
		ot receive quality of care during ere short staffed, however felt				
	they did they best they could. NA-G stated the facility had pool staff come in several months					
	ago, which had helped though call-ins still					
		ith the NA's. NA-G indicated				
		o the DON and charge nurse				
		ing as recently as that day and	1			
		acility was working on it.				
	On 8/25/21, at 12:3					
		d the facility schedule was				
		elf and the DON and stated				
		through significant process				
		ng currently. The administrato / had a high staff turnover				
		nonths, with several long term				
	staff having been le					
		ership. She indicated the facilit	v			
		pool agency staff and had				
		vice for the past few months.				
		tated they had moved all of				
		e residents up to one wing of				
		side while renovations took				
		and care, which also helped to				
		ff. She indicated within the last	t			
		ility has had an increase in				
		for their shifts and call ins. She	e			
		ad recently implemented a				
		who was responsible for data taff notification of open shifts.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930			(X3) DATE SURVEY COMPLETED C 08/27/2021	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			21/2021
		2209 UT	AH AVENUE	TATE, ZIF CODE		
IEADOV	V LANE RESTORATI	VE CARE CENTEF BENSON	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 800	Continued From pa	age 16	2 800			
	current weeks staffing shortages and had replaced the open shifts with licensed staff and NA's from other shifts.					
	licensed practical r day an NA had call therefore the clinica floor in the morning arrived early. LPN- daily, the prior day show NA and that I the last few months time, the facility was stay from the previ in, though there we was only one NA fr also worked the ev those days, he felt the quality of care to have received care stated he had rece residents or family sufficient staffing h concerns about res as recently as that able to help answe cares at times how administer medica well. LPN-A stated facility DON and as (ADON) as recently lack of sufficient st indicated they had	21 a.m. during an interview, hurse (LPN)-A indicated that ed in for the day shift, al manager had helped on the g until one of the evening NA's A stated this occurred almost the facility had a no call no had been a problem off and on s. LPN-A indicated most of the is able to mandate an NA to ous shift when there was a call ere occurrences when there om nights and that NA had rening shift. He indicated on residents would not receive they would like and may not as or medications timely. LPN-A ived no complaints from members regarding lack of owever staff had voiced sident care due to lack of staff, day. LPN-A indicated he was r call lights and assist with rever he was expected to titions in a timely manner as I he had voiced concerns to the sistant director of nursing y as the day prior regarding aff on the day shift and promised to resolve the issue.				
	NA's was two per s NA's had not show	y's usual staffing pattern for shift and that day one of the n up for her shift. NA-F stated sly and the facility routinely				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED C 08/27/2021	
		00930	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
IEADOV	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
	NA-F indicated ther where upon starting one NA on the prior had appeared to have including R1. NA-F recently as the day within the last few r not have sufficient so in a timely manner. that day, they had so administrator and D calling in for shifts a NA-F indicated the indicated they were working to resolve in On 8/26/21, at 2:01 NA-E indicated the work with her that of shown up for work a help. NA-E indicated	taff to piece a shift together. The had been several occasions of her shift there had been only shift and several residents the not gotten out of bed at all stated it had occurred as prior. NA-F stated she felt nonths the facility routinely did staff to provide resident cares NA-F indicated as recently as poken with the facility DON regarding staff routinely and/or not showing up at all. facility management had aware of the issue and were t. p.m. during an interview, NA that was scheduled to lay during the day shift had not and the night NA had stayed to d this occurred weekly, almost ked. NA-E stated there were	t			
	times when an NA of shift, the facility was then the facility had work the floor. NA-If for work in the more including R6, R9, R and required comple she felt it occurred on the night shift. S patterns for NA's was stated more freque during the nights. N DON and administr	did not come in for the day s unable to replace the NA one of the charge nurses E indicated when she arrived hing, several residents 16 and R1 were routinely wet ete bed changes. NA-E stated when there was only one NA he indicated the usual staffing as two per shift, however she ntly they only had one NA IA-E stated she spoke to the ation regarding staffing as and had been told "things will				
	On 8/26/21, at 3:15					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/2	27/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IEADO	W LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 800	Continued From page 18		2 800			
	the floor that day ar facility was short sta not routinely schedu maintained her NA to help when neede On 8/27/21, at 9:53 (CM)-A indicated th no shows for direct and was responsibl assisting with cares worked the floor at concerned for the s required to work alc not received any co family members reg several staff memb residents cares wer such as incontinent and bathing. She st would piece shifts, f show up for work, s aid would stay and evening NA to come up the whole shift. O was only one NA or worked the evening stay for the day shift to help on the floor. the facility DON as regarding lack of su told they were work On 8/27/21, at 10:1 interview, the AD st floor approximately times due to lack of	a.m. the clinical manager e facility had frequent ill calls/ care staff or NA's routinely e for filling the shift and on the floor. CM-A stated she a minimum of weekly and was cheduled NA's who were one. CM-A indicated she had implaints from residents or garding staffing however ers voiced concerns that re not being routinely provided be cares, grooming, oral cares ated oftentimes the facility for example if a day NA did no such as the day prior, the night they would try to get an e in early, or find one to pick CM-A stated at times there in nights who had already g shift and would not be able to ft, then the CM was expected CM-A indicated she spoke to recently as the day prior ufficient staffing and had been	t			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	·	
		2209 UT	AH AVENUE			
IEADO	W LANE RESTORATIV	BENSON	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From page 19		2 800			
	staff and they contin to help meet reside	nued to use agency pool staff nt needs.				
	with the facility adm administrator stated facility staffing cond process of hiring dia indicated she felt the improved within the indicated this past with challenge with call is schedule. The adm had implemented d responsible for the staffing and were re- in the event of a cal administrator stated nurse was also resp the shift. The admir several months the staff hired, they wer and then never can facility was currently positions and had he in place for for staff The DON stated sh a management/lead clinical managers, o overall workflow wo she planned to have floor to ensure reside routinely. The current identified: - day shift; one licer 12 hour shifts 5:00 6:00 a.m. to 2:00 p.	6 a.m. during a joint interview inistrator and DON, the d they were aware of the cerns and were currently in the rect care staff. The DON he facility's staffing had overall e last few months, though week staffing had ben a ins and unfilled holes in the inistrator indicated the facility aily charge nurses who were daily work flow which included esponsible to help on the floor II in or no show. The d at those times, the charge ponsible for attempting to fill histrator indicated in the last facility had several direct care in through some orientation he back. She indicated the y hiring for several NA's iring bonuses and incentives who picked up extra shifts. e felt now that the facility had dership team established with charge nurses, ADON the build improve. She indicated e nursing leadership on the dent cares were completed ont staffing pattern was hesed staff were scheduled for a.m. to 5:00 p.m., a TMA from m. and two NA's from 5:30 poal with full census would be				

If continuation sheet 20 of 113

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		COM	E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IEADOV	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 20	2 800			
	licensed nurse) and	0 p.m. to 10:30 p.m. (or d two NA's from 1:30 p.m. to th full census would be three				
		urse 5:00 p.m. to 5:00 a.m. 10:00 p.m. to 6:30 a.m.				
	confirmed the facilit identified required s resident cares durin both stated they fel	ninistrator and the DON ty did not routinely have the staff on each shift available for ng the week of survey, though t it was a fluke and staffing g within the last few months.				
	stated he had just s coordinator, was pr the facility administ staffing pattern and the month. The stat posted the opening up. He indicated he open shifts caused indicated it was the	p.m. the staffing coordinator started the role of staffing ovided the staffing data from rator and DON, such as developed the schedule for ffing coordinator indicated he s for the month for staff to pick was not responsible for filling by a call in or a no show, and e charge nurses responsibility int in those situations.				
		ty staffing schedule from identified the following				
	-8/22/21, revealed u NA shift.	unfilled 5:30 a.m. to 2:00 p.m.				
	-8/25/21, revealed u NA shift.	unfilled 1:30 p.m. to 10:00 p.m				
		ty daily schedule for the week o 8/27/21, identified the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LETED	
		00930	B. WING			C 08/27/2021	
	PROVIDER OR SUPPLIER	/E CARE CENTER 2209 UTA	DDRESS, CITY, S ⁻ A H AVENUE I , MN 56215	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 800	Continued From page 21		2 800				
	following unfilled sh	following unfilled shifts/open shifts:					
	-8/17/21, revealed NA shift	unfilled 10:00 p.m. to 6:30 a.m					
	-8/20/21, revealed NA shift	unfilled 10:00 p.m. to 6:30 a.m					
	-8/21/21, revealed TMA shift	unfilled 6:00 a.m. to 2:00 p.m.					
	-8/22/21, revealed TMA shift	unfilled 6:00 a.m. to 2:00 p.m.					
	-8/23/21, revealed NA shift	unfilled 10:00 p.m. to 6:30 a.m					
	-8/24/21, revealed NA shift	unfilled 10:00 p.m. to 6:30 a.m					
	p.m., one night NA	call in NA on 5:30 a.m. to 2:00 stayed from previous shift, o 10:00 p.m. NA shift and a a.m. NA shift.					
	p.m., CM was pulle	call in NA on 5:30 a.m. to 2:00 d to the floor, and evening NA filled 10:00 p.m. to 6:30 a.m.					
		unfilled 5:30 a.m. to 2:00 p.m. NA stayed from previous shift.					
	facility assessment the facility was licer beds, 19 board and beds, had an avera	Lane Restorative Care Center updated 7/25/21, identified nsed for 37 skilled nursing I care beds, for a total of 56 ige daily census of 34. The identified the following staffing					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00930	B. WING			C 08/27/2021	
AME OF F	PROVIDER OR SUPPLIER	l.	JDRESS, CITY, ST				
		2209 UT	AH AVENUE				
IEADOV	V LANE RESTORATIN	BENSO	N, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	ige 22	2 800				
	hours and one for s	sed nurses, one for eight six and a half hours, TMA for ee NA's for eight hours each.					
		licensed nurses for four hours ight hours, TMA for eight hour eight hours each.					
	-night shift, one lice and two NA's for ei	ensed nurse for eight hours ght hours each.					
	Facility administratic could utilize employ to evaluate staffing places where those be adjusted and im order to meet all re- manner. Facility por sufficient staffing or Pertinent employee policies/ practices. developed to obser care, meeting all re- their care plan. The & Assurance common findings and developed actions for any patt	THOD OF CORRECTION: on and the director of nursing yee, resident and family input patterns and identify times/ e staffing patterns could/should plement those adjustments in sident needs in a timely olicies and procedures for ould be reviewed/ revised. es could be retrained on those Audit tools could be ve for timely and complete esident needs as identified in e facility's Quality Assessment intee could review those op/ implement corrective erns or root/cause on-going compliance.	d				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-on	e				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			10/11/2	
		general. A resident must e and treatment, personal and	k k				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION ()	(X3) DATE SURVEY COMPLETED	
		00930	B. WING		C 08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	(X5) BE COMPLET	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
2 830	Continued From pa	ge 23	2 830			
	custodial care. and	supervision based on				
		d preferences as identified in				
	the comprehensive	resident assessment and				
		scribed in parts 4658.0400 and				
		ing home resident must be out				
		possible unless there is a he attending physician that the				
		in in bed or the resident				
	prefers to remain in					
	-	ent is not met as evidenced				
	by: Based on observati	on, interview and document		"corrected"		
	review, the facility facility facility facility facility					
		assessments to determine				
		patterns of falls and effective				
		of 1 resident (R16) who had				
		her, the facility failed to				
	, i	t interventions to prevent 3 residents (R16 and R21)				
		alls in the facility and				
	remained at high ris					
	Findings include:					
	R16's significant ch	ange of status (SCSA)				
		(MDS) dated 7/15/21,				
		diagnoses which included				
		gia rheumatica (inflammatory				
		uscle pain and stiffness				
		rs and hips) and psychosis. R1 had severe cognitive				
		uired extensive assistance				
		ly living (ADL's) of bed				
		and toileting. The MDS				
		disorganized thinking,				
	inattention, altered	levels of consciousness and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00930	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IEADOV	W LANE RESTORATIN	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	maintain her baland	b identified R16 was unable to ce during transition without	2 830			
	last MDS assessme	and had one fall since the ent. Area Assessment (CAA) dated				
	7/15/21, identified F in her ability to perf and required extens referred to both occ therapies though R CAA's revealed R1 remained at risk for impaired mobility at ADL's. The CAA lis included, gripper so	R16 had a significant change form her ADL's independently sive assistance, had been cupational and physical 16 refused services. The 6 had one in the last quarter, r falls due to incontinence, nd need for assistance with ted fall interventions which bocks, keeping environment her call light was to be within				
	form dated 8/21/21 form that listed sev conditions/factors v affect R16's fall risk form identified R16 conditions/risk factor confusion, 1-2 falls medications that hat could increase risk predisposing diseas condition, etc. The score of 17, however	sident fall risk assessment , identified a check list type eral headings and subsets of which had the potential to c. The checklist assessment had the following ors present: intermittent in the last three months, 1-2 ad possible side effects which for falls, and three or more ses, circulatory, cognitive form identified R16 had a er the form did not identify or ore meant in relation to R16's				
	had cognitive impair required extensive used a full body me	rised 7/12/21, revealed R16 irment, was at risk for falls, assistance with ADL's and echanical lift for transfer. The ious interventions for fall				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00930	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 25	2 830			
	prevention which included: mat on the floor by R16's bed, gripper socks to be worn or non-skid footwear and directed staff to keep her room free of clutter and ensure her call light was within reach.					
	On 8/24/21, 9:07 a.m. during a telephone interview with R16's family member (FM)-C, he stated R16 had been declining overall in the last few months, had fallen a few days ago and had sustained a bump on her forehead. FM-C stated R16 had severe dementia, was not able to voice her needs or concerns and felt she was not able to remember to call for help when she needed to get out of bed. FM-C stated he had visited R16 the evening of 8/23/21, at approximately 8:00 p.m. During the half hour long visit, R16 had attempted to get out of bed by placing her legs/feet towards the floor and attempting to pull herself up with the grab bar. He indicated R16 was barefooted and he had notified staff of R16's attempts to get out of bed. FM-C stated staff was responsive to his request for help, had come into R16's room, placed her legs back into bed and reminded her to stay laying down. FM-C indicated he felt R16 would have fallen if she had been able to sit up on her own and stated he was not aware of what the facility was currently doing to decrease R16's risk for falls.		l			
	1/27/21, to 8/21/21, - on 1/27/21, at 7:19 identified R16 had of lowered to the grou	Is incident reports from , revealed the following: 5 p.m. the incident report called for help and had been nd by a trained medication aid erring from toilet to the				
	wheelchair. The rep indicated her legs h	port revealed R16 had nad given out and she couldn't report revealed a check list				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					с	
		00930	B. WING			27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IEADOV	V LANE RESTORATIN	/F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET
2 830	Continued From pa	ge 26	2 830			
	type assessment w which included; inj the time of the incic predisposing enviro situational factors. confused, had a ga memory and had be - on 1/29/21, a follo would screen reside candidate and staff with laying down in lacked any analysis interventions, poter implemented interv R16's medical reco evaluation following - on 6/25/21, at 11:3 identified R16 had I from her room and near her bed. The r independent with tr had indicated she h from her bed to the revealed R16 had o one bare foot. The to person, place, tir was not able to wal and from the toilet v incident report reve however the report	 ith several areas to assess uries, pain, mental status at dent, post incident, onmental, physiological, and The report revealed R16 was it imbalance, impaired een incontinent. w up note revealed therapy ent to see if she would be a would offer to assist resident the afternoon. The report of the fall, current fall ntial patterns and newly entions. rd lacked any therapy g the fall on 1/27/21. a p.m. the incident report been heard calling for help had been found on the floor note revealed R16 was ansfers at the time of the fall, nad tried to transfer herself wheelchair and fell. The note one gripper stocking on and report listed R16 was oriented ne, situation and revealed R16 k, but was able to transfer to without assistance. The aaled R16 likely slid out of bed, lacked any analysis of R16's potential patterns or newly 	3			
	identified R16 was	I follow up note dated 6/27/21, alert, oriented, was able to own and had no complications room on 6/25/21.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00930 B. WING				C 08/27/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
	V LANE RESTORATIV	/F CARE CENTEE	H AVENUE				
		BENSON	, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
2 830	Continued From page 27		2 830				
	R16's medical record lacked a therapy evaluation following the fall on 6/25/21.						
	-on 8/21/21, at 7:20 p.m. the incident report identified R16 had been found on the floor of her room lying on her right side by the doorway. The incident report revealed R16 was last seen at						
	approximately 6:30 p.m. when she wheeled herself out of the dining room following the evening meal, to her and had been waiting for						
	staff to help her get ready for bed. The report identified R16 was alert, confused and was not able to identify what had happened. The report revealed R16 had a bump on her forehead, ice						
	was applied and ne (assessment of neu determine possible	urological checks were started urological status to help brain impact from a head dentified R16 was recently					
	(anti-anxiety) and h p.m. that day. The i analysis of R16's fa	ad received a dose at 7:00 ncident report lacked any II, interventions, potential nplemented interventions.					
	Review of R16's pro 8/27/21, revealed th	ogress notes from 5/30/21, to ne following:					
	was alert, oriented a complications from revealed R16 had o	w up fall note revealed R16 and had no new injuries or the fall on 6/25/21. The note lifficulties with moving from a					
	been using her call	ion, with transfers and had light for assistance. The note ed a therapy evaluation.					
	alert, oriented, had	ress note revealed R16 was episodes of hallucinations and call for help with transfers.					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00930	B. WING	B. WING		27/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MEADO	W LANE RESTORATIV	F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	 -on 6/29/21, a progratroubles transferring more than a couple note revealed a fax R16's primary provious on 7/1/21, a prographic primary physician hevaluation for R16's and transfers. -on 7/2/21, a progratrous on 7/2/21, a progratrous on 7/2/21, a progratrous on 7/5/21, a progratrous on 7/5/21, a progratrous on 7/14/21, a social BIMS (test to assest declined from cognic cognitive impairmer -on 7/15/21, a progratrous on a routine vision and need on 7/15/21, a progratrous on a routine vision and need on 7/15/21, a progratrous on 7/15/21, a progratrous on a routine vision and need on 7/15/21, a progratrous on a routine vision and need on 7/15/21, a progratrous on 7/28/21, a progratrous on 7/28/21, a progratrous on a routine vision of lethargy not answering quest R16 was returned to emergency room with heart failure and was returned to the social failure and was returned to the social failure and was returned to a social failure and was returned to the social failu	ress note revealed R16 had g, could not pick her bottom of inches from the chair. The communication was sent to der for therapy evaluation. ess note revealed R16's ad ordered a therapy s difficulties with bed mobility ess note revealed R16 fficulty performing ADL's and with transferring from her ilet. ess note revealed R16 moved rd and care to the skilled facility due to increased ling more assistance. al service note revealed R16's es cognition) had significantly itively intact, to severe nt.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	W LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 29	2 830			
	-on 8/8/21, a progre	ess note revealed R16 was hergency room for lethargy and				
		ess note revealed R16 ity and was expected to vices.				
		ress note revealed R16 tance of 1-2 staff for all cares.				
	anxious, exit seekir an anti-anxiety med	ress note revealed R16 was ng, was seen by hospice and lication (Ativan) was ordered as needed for anxiety.				
	fall in her room on 8 a painful bump on h	ress note revealed R16 had a 8/21/21, at 7:20 p.m., R16 had her forehead and had required The note revealed R16 was htly.				
	been calm, the burr resolved and she ha	ress note revealed R16 had np to her forehead had ad no changes in her range of revealed R16 had been calm ed every two hours.				
	R16 had been asse	es lacked any documentation essed by therapy or any by therapy following her fall on 1.				
	on her back in a low affixed to the left sid doorway,) her bare	p.m. R16 was observed lying v bed, she had a grab bar de of her bed (faced the feet hung off of the lower end the floor. R16 had a rug on				
	the floor next to her	bed towards the head of her et hovered over laminate				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00930			(X2) MULTIPLE A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 08/27/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	• • • •	
MEADO	W LANE RESTORATIV	A CARE CENTEE 2209 UTA	H AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	flooring. At 2:36 p.m grab bar with both h attempted to pull he her bare feet toward was unable to pull h back and forth in a attempted to pull he R16 was not able to the bar and moved again. -at 2:38 p.m. R16 w her back in a low be assistant (NA)-G er barefooted feet into her bed and left the barefooted. -at 2:46 p.m. R16 w her back, R16 then grabbed onto the gi the side of the bed rocked back and fo her legs back into b -at 2:54 p.m. R16 w back, eyes were clo feet and remained a her legs and bare fe flooring. She made the side of her bed. the right side of her feet back into bed. -at 4:29 p.m. R16 w in a low bed, her ey was on. At that time picked up yellow gr	ge 30 h. R16 reached towards the her right and left hands and erself upwards while moving ds the laminate flooring. R16 herself up, she began to rock momentum type motion and erself up with the assist bar. o pull herself up, she let go of her legs in and out of the bed vas observed lying in bed on ed, at that time nursing hered the room, lifted R16's the bed, raised the head of room. R16 remained vas observed lying in bed on reached her left arm up and rab bar, moved her legs over and attempted to sit up. R16 rth several times. R16 moved hed and let go of the grab bar. vas observed lying on her osed, blanket was off of her around her waist. R16 moved et off the bed, towards the no attempt to grab the bar on R16 had a call light button on upper body. She moved her vas observed lying on her back res were closed and call light a, NA-G entered R16's room, ipper socks from the floor and feet. R16's eyes remained	2 830			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			21/2021
		2209 117	AH AVENUE	ATE, ZIF CODE		
IEADOV	W LANE RESTORATIN	/E CARE CENTEF BENSON	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 31	2 830			
	NA-G told R16, "yo NA-G indicated R16 following a fall over "comfort cares." NA and about on her or recently moved to t facility. NA-G proce incontinent cares, p her chest and left h -at 5:55 p.m. R16 w her back, moved he bed towards the flo with her left hand a was unable to sit up her eyes. At that tim picked up the yellow indicated R16 was told the nurse about	g her legs out of the bed, u gotta stay in bed, it's okay." 6 had remained in bed the weekend and was on A-G indicated R16 had been up win a few weeks ago, and had he skilled living side of the beded to assist R16 with blaced R16's flat call light on the room. was observed lying in bed, on er legs and bare feet out of or, took hold of the grab bar ind attempted to sit up. R16 b, let go of the bar and shut ine, NA-G entered R16's room, w gripper socks from the floor, restless and stated she had it R16's restlessness. NA-G R16's legs remained out of				
	reached her left arr her chest, took hold attempted to sit up, pillows and closed remained hanging o	vas observed lying in bed, n up and her right arm over d of the grab bar and R16 fell back against the he eyes. Her legs/bare feet off the side of her bed.				
	on her back, eyes v over the side of the At that time, NA-H her legs and placed	vas observed lying in a low bec were closed, and her legs hung bed with her bare feet visible. entered R16's room, picked up them in bed and covered nket. R16 remained without	3			
		vas observed lying in a low bec were closed, her body was	k			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00930	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE			
		BENSON	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 32	2 830			
	covered with a shee lower body.	et, a pink blanket covered her				
	had a pillow tucked	vas observed lying in bed, she between her body and the feet were visible, call light was				
	in a low bed, on her on her right side, sh legs and body up to	a.m. R16 was observed lying r back, pillows were positioned he had a blanket covering her her mid chest. R16's feet gripper socks were observed.				
	her back, pillows we left sides of R16. H	was observed lying in bed on ere positioned on the right and er eyes were closed, she was eet to her mid chest.				
	back, her eyes wer feet to her mid ches her room, asked if blanket, looked at h	as observed lying in bed on her e closed, covered from her st, at that time NA-C entered she was alright, lifted up her her feet which revealed yellow covered R16 back up. NA-C	r			
	in bed on her back, were closed, she ha right and left sides	a.m. R16 was observed lying covered with a sheet, eyes ad pillows placed on both her and underneath her legs. R16 move her legs out of bed or				
	her back, eyes were on either side of he trained medication nurse entered R16'	vas observed lying in bed on e closed, pillows were placed r upper body, at that time aid (TMA)-A and hospice s room. TMA-A and the oved the blanket from R16 and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COMF	E SURVEY PLETED
		00930	B. WING		08/2	27/2021
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
IEADOV	V LANE RESTORATIV	/F CARE CENTEF	H AVENUE , MN 56215			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 33	2 830			
	proceeded to assist R16 with morning cares, positioned R16 on her right side with pillows. At that time, the hospice nurse indicated R16 had been kept in bed since her fall on 8/21/21, for comfort per facility report.					
	NA-G, she stated R staff for all of her Al declining over the p indicated R16 had a and had remained i indicated she was r	p.m. during an interview with R16 was totally dependent on DL's and had been rapidly bast couple of weeks. NA-G a fall over the past weekend in bed since the fall. She not aware if R16 had any vere any changes with her plan teeping her in bed.				
	NA-C, indicated R1 staff for all of her ne recently fallen and I her comfort. NA-C it tell staff of her need routine cares of rep changing. NA-C inc get out of bed at tim have the strength to anymore. NA-C furt prevention interven	p.m. during an interview with 6 was totally dependent on eeds. NA-C indicated R16 had had been in bed since then for indicated R16 was not able to ds and indicated she needed positioning and checking and dicated R16 would attempt to nes, though felt she did not o get out of bed on her own ther stated R16 had fall tions of a low bed, gripper sure her call light was by her.				
	hospice nurse indic risk for falls and sho place, such as grip get out of bed. How	a.m. during an interview the cated she felt R16 remained at ould have fall interventions in per socks should R16 try to vever, the hospice nurse stated 6 had the strength to get out of her current state.				
	On 8/25/21, at 11:4 occupational therap epartment of Health	5 a.m. the certified by assistant (COTA) stated				

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STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C					
		00930	B. WING			27/2021				
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE						
MEADOW LANE RESTORATIVE CARE CENTEF 2209 UTAH AVENUE BENSON, MN 56215										
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF			PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE				
2 830	Continued From pa	ae 34	2 830							
	not within the last fe had been referred i refused any treatme stated she could no been seen by thera On 8/26/21, at 10:2 licensed practical n had been declining and had recently fa R16 had been in be did not appear to be overall was not eati night R16 had faller what footwear R16 call light within reac R16's fall, she was and mobility, thoug and was unable at LPN-A indicated fol frequent checks we the shift. LPN-A wa	not receiving therapy and had ew months. COTA stated R16 in the past, however she ent and likely evaluation. She ot recall the last time R16 had ipies. 1 a.m. during an interview with urse (LPN)-A, indicated R16 within the last couple weeks llen in her room. LPN-A stated ed since the fall on the 8/21/21 e in pain, but was lethargic and ing well. LPN-A indicated the n, he was not able to recall was wearing or if she had her ch. LPN-A stated at the time of independent with transfers h had been having weakness times to transfer herself. lowing R16's fall on 8/21/21, ere done for the remainder of s not sure what other een implemented following the								
	NA-E, indicated R1 staff for all of her A been independent a and had moved ove she needed increas stated R16 had bee	p.m. during an interview with 6 was totally dependent on DL's. NA-E stated R16 had approximately a month ago er from the board and care as sed help with her cares. NA-E en in bed since her fall on ure if it was for her comfort or								
	because R16 could NA-E indicated R16 get out of bed that lay back down. NA- nurse and the nurse	I no longer hold herself up. 6 had been observed trying to morning and was redirected to E stated she had told the e had given something to R16 id since she had not attempted								

TATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
IEADOV	W LANE RESTORATIN	/F CARE CENTER	HAVENUE MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 35	2 830			
	to get out of bed. NA-E stated R16 was supposed to wear gripper socks, have her bed in the low position and have a mat on the floor by her bed for fall prevention. On 8/26/21, at 2:34 during an interview with NA-F, indicated R16 was totally dependent on staff for all ADL's and had been rapidly declining in her overall condition in the last few weeks. NA-F stated R16 had fallen the past weekend and no longer was helped out of bed. NA-F indicated she had thought R16 was in bed for her comfort and overall she was not able to hold herself up anymore. She stated R16 still attempted to get out of bed, which occurred that morning, though was not able to get herself into a sitting position. NA-F indicated she did not feel R16 had the strength to make it out of bed. NA-F indicated R16 had fall interventions in place of gripper socks, low bed, mat on the floor by her bed and call light within reach.					
	clinical manager (C back to work at the and on, and had no assessment. CM-A R16's fall to have b factors, review all fa review current inter immediate and long interdisciplinary tea stated R16 had bee comfort and her we would expect R16 to	during an telephone interview M)-A stated she had been facility for several weeks off ot completed R16's post fall stated she would expect een assessed for causative alls to see if a pattern and to ventions and implement an ger term intervention with the m (IDT) as appropriate. CM-A en in bed since her fall for eakness. CM-A indicated she to wear gripper socks when in ase R16 was able to get g position.				
		7 a.m. during a telephone s primary physician, medical				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING	· · · · · · · · · · · · · · · · · · ·	08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
MEADOV	W LANE RESTORATIV	/F CARE CENTEF	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 36	2 830			
	rapidly declining with had been notified of She indicated she he evaluation following feel R16 would be of on previous attemp R16. She indicated to look at other inte been complaints with footwear in place the further stated she we complete a comprese R16's falls to help of	indicated R16 had been thin the last few weeks and f R16's two falls since June. had ordered a therapy g the fall in June, but did not compliant with therapy based ts from therapy to work with she would expect the facility reventions that R16 would have th, and felt R16 should have hat prevents slipping. She would expect the facility to shensive assessment following determine causative factors, reventions and implemented reventions post fall.				
	R21					
	(MDS) dated 8/4/21 cognitive impairment included Alzheimert and thyroid disorde identified R21 requi transfers, and exter mobility, dressing a MDS identified R21 surface transfer wa	ange Minimum Data Set I, identified R21 had significan nt and diagnoses which 's disease, muscle weakness r. R21's MDS further ired total assistance with nsive assistance with bed and personal hygiene. R21's 's balance during surface to us not steady, and unable to man assistance. R21's MDS no falls since prior	t			
	8/5/21, identified R2 a history of falls sin dependent on staff lift for all transfers. required extensive	essessment (CAA) dated 21 was at risk for falls and had ce admission and was for all transfers with a full body R21's CAA identified R21 assistance from staff for all s CAA indicated interventions				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021	
		00930	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W LANE RESTORATIN	/F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	nge 37	2 830			
	included gripper so care plan.	cks and to proceed to R21's				
	required extensive personal hygiene a assistance with tran all transfers. R21's impaired thought pr Alzheimer's disease R21 was at high ris interventions include ensuring R21 wore footwear when tran wheelchair and R2 during periods of w R21's kardex dated interventions for sa wore appropriate for transferring or mob	e. R21's care plan indicated k for falls and the following led: bedside mat during naps, appropriate footwear no skid sferring or mobilizing in 1 was to be up in wheelchair akefulness.				
	8/4/21, identified R times, had 3 or mo and was wheelchai	l Risk assessment dated 21 was disorientated X 3 at all re falls in the past 3 months r bound. R21's assessment h was high risk for falls.				
	on her back, slightl with a sheet and bl over the edge of he (TMA)-B entered R water, and assisted the bed. R21's bed concave mattress v the bed. At 2:25 p.	p.m. R21 was observed lying y onto her right side, covered anket, with her feet hanging bed, trained medication aide 21's room, with a glass of ice R21 to put her feet back onto was in low position, had a with a mat on the floor next to m. R21's feet were again out yen, alert, informed TMA-B who				

Iinnesota Department of Hericiencies ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00930	B. WING		08/	27/2021
AME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
IEADOW LANE RESTORATI	VE CARE CENTER 2209 UT	AH AVENUE			
	BENSON	I, MN 56215			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 830 Continued From pa	age 38	2 830			
was outside of R21 she wanted to get assisted R21 to pur response to TMA-F p.m. R21's eyes wit touching the mat in her bed was slight was lying on her rig the pillow, covered R21's feet were ag R21 moved her lef front of her face. A (NA)-G entered R2 going to put her fee R21's feet to her b NA-G exited R21's were on the floor a position. NA-H ente was not time to get up, told R21 he wo was time to get up checked her brief, place, raised up her lowered her bed ba would come back to R21's feet were blanket and sheet side of the bed. R2 open and she was exited a room acro look into R21's room, asked	I's room. TMA-B asked R21 if up, or was uncomfortable and t her feet back into bed. R21's 3 could not be heard. At 2:26 ere open and her feet were ext to her bed and the head of y elevated. At 2:30 p.m. R21 ght side, her head resting on with blanket and sheet and ain noted to be out of the bed. t arm to her mouth and back in t 2:34 p.m. nursing assistant t1's room, told her she was et up, then quickly moved ed, while R21 said "ow" and room. At 2:41 p.m. R21's feet nd she was in a partial sitting ered the room and told R21 it t up. NA-H raised R21's bed uld come to get her when it , pulled R21's sheet down, placed R21's bed back in er head of bed slightly and ack down. NA-H told R21 he o check on her and instructed to get up on her own. At 2:54 re wrapped up tightly in her and were hanging from the t1's eyes were noted to be lying on her right side. NA-H ss the hallway however did not m. At 2:55 p.m. NA-G entered if she could turn her again and not the bed. R21 made a noise,				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021		
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
		2209 117	AH AVENUE				
IEADOV	V LANE RESTORATIN	VE CARE CENTER BENSON	I, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 39	2 830				
3:03 p.m. R21 moved her feet off on NA-H walked by R21's room twice look into the room. NA-H was obse into R21's room again, said Oh, ge again. At 3:05 p.m. NA-H entered and NA-H told R21 he was going to back into bed, assisted her to put fe bed, then he untangled her sheets her feet and legs. At 3:08 p.m. NA would come check on her again the room. At 4:34 p.m. NA-H entered F with the mechanical lift and TMA-B surveyor they were getting R21 up then closed the door. At 4:39 p.m. sitting up in her wheelchair with her foot pedals, sitting in her room. R2 or shoes on, her feet had leg ace w strips of cloth used for dressings at he legs) with her toes exposed.		21's room twice and did not NA-H was observed looking ain, said Oh, getting down . NA-H entered R21's room he was going to put her feet sted her to put feet back into gled her sheets from around At 3:08 p.m. NA-H told R21 he on her again then left the NA-H entered R21's room, al lift and TMA-B. NA-H told getting R21 up for supper, or. At 4:39 p.m. R21 was eelchair with her feet on the in her room. R21 had no socks et had leg ace wraps, (elastic for dressings and swelling of					
	room, sitting in her or shoes on, with to with ace wrap.	wheelchair, no slipper socks bes exposed and feet wrapped					
	usually did not take aware if she had ar	99 a.m. NA-E indicated she e care of R21 and was not ny falls. NA-E stated R21 had a t did not wear any socks, just	a				
	not usually work wir put her feet out, an to make sure she w	87 a.m. NA-F stated she did th R21, but stated she does d NA-F said she would check vas dry. NA-F stated if R21 et out of he bed, she would get					
		54 p.m. during a phone ated yes, R21 kept getting out					

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	CONSTRUCTION		E SURVEY PLETED	
		00930	B. WING			C 08/27/2021	
	PROVIDER OR SUPPLIER	VE CARE CENTER 2209 UT	DRESS, CITY, ST AH AVENUE J, MN 56215	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
2 830	of bed on 8/23/21. feet back into bed, at that time. NA-H the night shift, and out in bed, and his include getting her was awake. NA-H socks on, before he stated on 8/23/21, feet while she was they were not on at wheelchair. NA-H incontinence at one her feet out of the H at that time. On 8/27/21, at 11:4 remembered R21 at 8/23/21. NA-G said would readjust her NA-G indicated she R21's interventions she was awake. N was to have grippe did not realize R21 On 8/26/21, at 2:42 (LPN)-A stated R22 included her bed at and keep her door also to have slippe walk. LPN-A stated out of bed, they she kept putting her fee be checked for pair and should be repo	NA-H said he kept putting her and no, he did not get her up indicated he usually worked he would just straighten R21 usual intervention did not up from her bed when she said R21 was to have gripper e got her out of bed. NA-H R21's socks would fall off her in bed and was the reason fter she was up in her stated he had checked R21 fo e time 8/23/21, when R21 had bed but had not gotten her up 47 a.m. NA-G stated she attempted to get out of bed on d R21 kept getting up, so they and check on her more often. e was not aware that one of a included to get her up when A-G said she was aware R21 r socks on over her wraps, but did not have them on. 2 p.m. licensed practical nurse 1's interventions for falls ways low, check on her often open. LPN-A sated R21 was r socks on, but R21 did not d if R21 kept trying to get up build get R21 up, and if she et out of the bed, R21 should n, discomfort or incontinence bisitioned. LPN-A stated for bwing R21's care plan he no leave her in bed, because	r				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 08/27/2021		
JAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		1 001	
	V LANE RESTORATIV	Z209 UT	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	interview, clinical m often would hang he air. CM-A confirme attempted to get up needs, get her up a CM-A confirmed sh slipper socks when also. On 8/27/21, at 1:29 (DON) reviewed R2 medical record. DO stated R21 was to periods of wakefuln gripper socks on wh wheelchair. DON s follow R21's care pl unaware if R21 had she believed R21 had she believed R21 had she believed R21 had	9 a.m. during a phone anager (CM)-A indicated R21 er feet over the bed, floating ir d if R21 was awake, and , they should address R21's and not tell R21 to stay in bed. e would expect R21 to have she was up in the wheelchair p.m. director of nursing t1's care plan in her electronic N confirmed R21's care plan be up in wheelchair during ess and R21 was to have nen she was up in her tated she expected staff to an. DON stated she was a history of falls, but indicated as had no falls since she				
	position on 3/27/21, noted at time of inci (IDT) reviewed the	ne floor next to her bed in low , at 11:00 a.m., no injuries ident. Interdisciplinary team fall dated 3/30/21, and rvention for a fall mat next to				
	found by staff lying on 3/30/21, at 3:32 of incident. IDT rev included an interver assist with fall risk, day for activities. A	nt report identified R21 was on the fall protection mattress p.m., no injuries noted at time riew of fall dated 3/31/21, ntion of a concave mattress to with plan to get R21 twice a lso the incident report ented a wake/sleep schedule.	\$			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00930	B. WING			08/27/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
MEADO	W LANE RESTORATIN	/F CARE CENTEE	AH AVENUE I, MN 56215				
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
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2 830	Continued From pa	ge 42	2 830				
	 4/7/21, at 9:44 p.m. incident. Notes on identified intervention (pain medication) to Noted resident likes bed. R21's primary phys 4/1/21, identified R2 falls out of bed, and concave mattress to R21's primary phys 4/15/21, identified F days. R21's falls w apparent pattern. F identified the facility methods and were 	g on floor in front of bed on , no injuries noted at time of report dated 4/26/21, on for 3 day trial of Tylenol b assess for neuropathy pain. s to have feet hanging over ician's progress note dated 21 continued to have frequent had been switched to a o try to help with that. ician's progress note dated R21 had 5 falls in the past 30 ere at different times with no R21's physician note further / had tried multiple prevention trying a concave mattress as red when R21 rolled out of					
	director of nursing (plan, fall prevention the floor, call light w free of clutter and d socks/non-skid foot stated since R16 w bed, she would exp She indicated with not feel R16 had th her own and felt R1 uncomfortable vs w bed. The DON state staff to ask R16 wh she attempted to ge incidents were revise	4 a.m. during an interview, the (DON) confirmed R16's care interventions included mat to vithin reach, keep environment lirected staff to ensure gripper twear was worn. The DON as no longer getting out of bect gripper socks to be worn. R16's current state, she did e strength to get out of bed on 6 may have been vanting to get up and out of ed she would have expected at she was trying to do when et out of bed. R16's fall ewed with the DON, she edical record lacked a	t				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IEADOV	V LANE RESTORATI	VE CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 43	2 830			
	record lacked any	/21, further R16's medical documentation R16 was rapy after her fall on 6/25/21.				
	The facility's physic for interview.	cal therapist was not available				
	Managing, dated 3 staff would identify resident's specific prevent the resider minimize complica directed facility sta centered fall preve subsequent falls an	d, Falls and Fall Risk /17/21, identified the facility interventions related to the risks and causes to try to nt from falling and to try to tions from falling. The policy ff to implement resident ntion plan and monitoring for nd fall risk. The policy lacked omprehensive fall assessment.				
	Director of Nursing policies and proced implement measur the risk for falls for are receiving the n The director of nur conduct random and ensure appropriate	THOD OF CORRECTION: The or designee could review dures, train staff, and res to prevent and/or minimize residents at risk to assure they eccessary treatment/services. sing or designee, could udits of the delivery of care; to a care and services are etter ensure implementation of				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			10/11/2
	comprehensive res home must ensure	of daily living. Based on the sident assessment, a nursing that: o is unable to carry out				

STATE FORM

RSG411

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STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
		00930	B. WING		C 08/27/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
/IEADO	W LANE RESTORATIV	/F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 920	Continued From pa	ge 44	2 920			
		ing receives the necessary n good nutrition, grooming, ral hygiene.				
T E T T T F C C T	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance with routine grooming which included facial hair removal and oral cares for 7 of 7 residents (R18, R11, R14, R6, R1, R21, R22) who were dependent on facility staff for activities of daily living (ADL's). Further, the facility failed to provide routine incontinence cares and changing of soiled clothing for 1 of 1 resident (R6) reviewed for routine checking and changing cares.			"corrected"		
	Findings include:					
	R18					
	7/21/21, identified F impairment and had chronic obstructive and anxiety. The M independent with be	imum Data Set (MDS) dated R18 had severe cognitive d diagnoses which included: pulmonary disease, arthritis DS indicated R18 was ed mobility, transfers, eating and personal hygiene.				
	had physical function impairment and more plan indicated R18	vised on 3/23/20, indicated R18 oning deficit related to self care obility impairment. The care required assistance from staff s needed and assist of one for al hygiene.	•			
manada D	was walking around	s on 8/23/21, at 2:38 p.m. R18 d the nursing home her walker. R18's hair was				

Opg30 E. WING C. 08/27/2021 VALUE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2290 UTAH AVENUE BENSON, MN 56215 MEADOW LANE RESTORATIVE CARE CENTER 2290 UTAH AVENUE BENSON, MN 56215 CONSERVENTION SHOULD BE (EACH GENERCING NUMBER BERECEDED BY FULL TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH GENERCING SHOULD BE CONSERVENCE) TO THE APPROFINATE (%) 2 920 Continued From page 45 2 920 2 920 CONTINUE AT 18' shair was also sticking straight up on the back side of her head and the right side of her head. 2 920 2 920 Continued to be uncombed. 2 920 - at 4:32 p.m. R18 was seated on the edge of her head. - at 4:32 p.m. R18 was seated on the edge of her head. 2 920 2 920 Continued to be uncombed. 2 920 - at 4:32 p.m. R18 was seated on the edge of her head. - at 4:32 p.m. R18 was seated on the edge of her head. 2 920 During observations on 8/25/21, at 9:41 am. R18 was standing up at the nurses station with her was sticking straight up on the left and ber hair continued to be uncombed. 2 920 During observations on 8/25/21, at 10:38 a.m. R18 walked down in a chair in the main entrance area, R18's hair was uncombed, pasted to the back and left side of her head. Continued to be incombed. - entrain the main in the main entrance area, R18's hair was uncombed, pasted to the back and left side of her head. </th <th>STATEMEN</th> <th>ota Department of He NT OF DEFICIENCIES OF CORRECTION</th> <th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th> <th>(X2) MULTIPLE A. BUILDING:</th> <th>CONSTRUCTION</th> <th></th> <th>E SURVEY PLETED</th>	STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
Detendow LANE RESTORATIVE CARE CENT 2209 UTAH AVENUE BEINGON, MN 58215 (PA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULTORY OR LSC IDENTIFYING INFORMATION) IP PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMME CACH SECURITY 2 920 Continued From page 45 2 920 1 onded to be uncombed and her hair was pasted to the back side of her head and to the right side of her head. 2 920 - at 4:32 p.m. R18 was seated on the edge of her bed and her hair continued to be uncombed. 2 920 - at 4:32 p.m. R18 was seated on the edge of her head. - at 4:32 p.m. R18 walked into the right side of her head. - at 4:32 p.m. R18 walked into the dining room area independently with her walker and her hair continued to be uncombed. - bit walker and her hair continued to be uncombed. During observations on 8/24/21, at 9:41 a.m. R18 was standing up at the nurses station with her walker talking to the trained medication aid (TMA)-A and her hair was uncombed, pasted to the back and left side of her heed. R18's hair was sticking straight up on the left and back of her head. - 11:39 a.m. R18 was seated in the dining room area dinking pop and her hair continued to be uncombed. - 11:39 a.m. R18 was seated in the dining room area dinking pop and her hair continued to be uncombed. - 11:39 a.m. R18 was seated in the dining room area dinking pop and her hair continued to be uncombed. - 11:39 a.m. R18 was seated in the dining ro			00930	B. WING			
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 noted to be uncombed and her hair was pasted to the back of her head and to the right side of her head. R18's hair was also sticking straight up on the back side of her head and the right side of her head. - at 4:32 p.m. R18 was seated on the edge of her bed and her hair continued to be uncombed. - at 4:34 p.m. R18 walked out of her room independently with her walker and her hair continued to be uncombed. - 5:26 p.m. R18 walked into the dining room area independently with her walker and her hair continued to be uncombed. - 5:26 p.m. R18 walked into the dining room area independently with her walker and her hair continued to be uncombed. During observations on 8/24/21, at 9:41 a.m. R18 was standing up at the nurses station with her walker talking to the trained medication aid (TMA)-A and her hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and back of her head. During observations on 8/25/21, at 10:38 a.m. R18 walked down the hallway independently with her walker and as town in a chair in the main entrance area. R18's hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and the back of her head. During observations on 8/25/21, at 10:38 a.m. R18 walked down the hallway independently with her walker and set down in a chair in the main entrance area. R18's hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and the back of her head. - 11:39 a.m. R18 was seated in the dining room area drinking pop and her hair continued to be uncombed. During observations on 8/26/21, at 11:13 a.m. R18 walked down the hallway independently with her walker and her hair was uncombed and 	PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	COMPLET
 the back of her head and to the right side of her head. R18's hair was also sticking straight up on the back side of her head and the right side of her head. - at 4:32 p.m. R18 was seated on the edge of her bed and her hair continued to be uncombed. - at 4:34 p.m. R18 walked out of her room independently with her walker and her hair continued to be uncombed. - 5:26 p.m. R18 walked into the dining room area independently with her walker and her hair continued to be uncombed. - 5:26 p.m. R18 walked into the dining room area independently with her walker and her hair continued to be uncombed. During observations on 8/24/21, at 9:41 a.m. R18 was standing up at the nurses station with her walker talking to the trained medication aid (TMA)-A and her hair was uncombed. During observations on 8/25/21, at 10:38 a.m. R18 walked down the hallway independently with her walker and set down in a chair in the main entrance area. R18's hair was uncombed, pasted to to the back and left side of her here and. During observations on 8/25/21, at 10:38 a.m. R18 walked down the hallway independently with her walker and set down in a chair in the main entrance area. R18's hair was succombed, pasted to to the back and left side of her head. R18's hair was sticking straight up on the left and the back of her head. During observations on 8/26/21, at 11:13 a.m. R18 walked down the hallway independently with her walker and her hair was uncombed and 	2 920	Continued From pa	ge 45	2 920			
On 8/26/21, at 11:11 a.m. nursing assistant		the back of her heal head. R18's hair way the back side of her head. - at 4:32 p.m. R18 way bed and her hair co- - at 4:34 p.m. R18 way independently with continued to be under - 5:26 p.m. R18 way was standing up at walker talking to the (TMA)-A and her has the back and left side sticking straight up head. During observations R18 walked down t her walker and sat entrance area. R18 to the back and left was sticking straigh of her head. - 11:39 a.m. R18 way area drinking pop a uncombed. During observations R18 walked down t her walker and her sticking straight up	Id and to the right side of her as also sticking straight up on r head and the right side of her was seated on the edge of her ontinued to be uncombed. walked out of her room her walker and her hair combed. Iked into the dining room area her walker and her hair combed. Is on 8/24/21, at 9:41 a.m. R18 the nurses station with her e trained medication aid air was uncombed, pasted to de of her head. R18's hair was on the left and back of her s on 8/25/21, at 10:38 a.m. he hallway independently with down in a chair in the main 's hair was uncombed, pasted side of her head. R18's hair at up on the left and the back as seated in the dining room and her hair continued to be s on 8/26/21, at 11:13 a.m. he hallway independently with hair was uncombed and all over.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/27/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W LANE RESTORATIV	VE CARE CENTEE	AH AVENUE N, MN 56215			
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2 920	Continued From pa	age 46	2 920			
	and verbal reminder personal hygiene ta should have followe have ensured her p been completed an On 8/26/21, at 2:07 (DON) confirmed th indicated staff should care plan. The DOM	ers to complete ADL's and asks. NA-A indicated staff ed R18's care plan and should personal hygiene tasks had ad her hair was combed. If p.m. the director of nursing ne above findings and ald have been following the N indicated her expectations sure the residents were				
	R11					
	had severe cognitiv diagnoses which in depression and mu indicated R11 was	dated 6/11/21, identified R11 /e impairment and had cluded: seizure disorder, iscle weakness. The MDS independent with bed mobility, , toileting, eating and personal				
	had ADL self care p confusion and impa identified R11 requi	rised on 2/10/21, indicated R1 ² performance deficit related to aired balance. The care plan ired limited assistance from nd personal hygiene.	1			
	was seated in the c noted to be wearing blue snow flakes an shirt had several so chest area and her white spots on the	s on 8/23/21, at 4:53 p.m. R11 chair in her room. R11 was g a white turtle neck shirt with nd a pair of blue shoes. R11's biled white/brown spots on the shoes had several soiled top of the shoes. walked independently in the				
	hallway with her wa	alker and back to her room. Le pair of denim jeans and the				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00930	B. WING		08/	27/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MEADO	V LANE RESTORATIV	F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	entire buttocks area stain. The outer ring brown in color and r down in her chair in Multiple flies flew ar and her clothing. R ² on her chin and neo approximately 1/4 to - at 6:42 p.m. R11 w independently with I be wearing the sam facial hair remained During observations was seated in the a several other reside wearing the same of shirt had several so chest and belly area same. -at 1:34 p.m. R11 st her walker and walk R11 continued to we denim jeans and on way to her knees ar light brown colored of the stain was dar odor was noted. - at 1:56 p.m. R11 w area and her clothir During observations R11 was seated in the same si pair of yellow pants	alf way to her knees and her had a light brown colored of the stain was darker ho odor was noted. R11 sat her room independently. ound R11 and landed on her 11 had several white long hairs k area measuring o 1/2 inch long. valked down the hallway her walker and continued to e soiled shirt, pants and R11's				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MEADO	V LANE RESTORATIV	VE CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 48	2 920			
	R11 walked indepedining room area. Fisame shirt from 8/2 yellow pants from 8/2 to be soiled and state her chest and belly remained. R11 conshirt for four days at two days and had refused staff assiss personal hygiene. If verbal reminders to should have supervised cares and a care plan.	s on 8/26/21, at 12:20 p.m. endently with her walker to the R11 continued to wear the 23/21, and the same pair of 3/25/21. R11's shirt continued ained with red/brown spots on a area and R11's facial hair tinued to wear the same soiled and the same soiled pants for not been shaved in four days. R1 a.m. NA-A confirmed R11 tance with ADL's, shaving and NA-A indicated R11 needed o change her clothes and staff vised her to ensure her clothes in. NA-A indicated R11 had not staff should have followed her				
	above findings and assistance with her she expected staff shaving, grooming,	7 p.m. DON confirmed the indicated R11 needed staff ADL's. The DON indicated to assist residents with personal hygiene, changing o aff should have followed the	f			
	R14 had severe co diagnoses which in poly-arthritis, lymph R14 required two s mobility, transfers,	DS dated 7/13/21, indicated gnitive impairment had icluded: depression, nedema. The MDS indicated taff assistance with bed dressing, toileting and one th personal hygiene and iting.				
		vised on 2/9/21, indicated R14 oning deficit related to mobility				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/2	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	W LANE RESTORATIV	F CARE CENTER	H AVENUE MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 49	2 920			
	impairment. The ca	re plan indicated R14 required vith oral care and personal				
	R14's hair uncombe head and sticking s head. R14 had seve approximately 1/4 ir - at 5:45 p.m. R14 v in the dining room a	vas seated in her wheel chair irea with several other remain uncombed and her				
	was seated in her w continued to have s approximately 1/4 ir - at 11:29 a.m. R14 in the activity room and her hair continu of her head and stic - at 1:07 p.m. R14 w in the activity room and her hair continu - at 2:22 p.m. R14 w	was seated in her wheel chair with several other resident led to be matted to the back cking straight up. vas seated in her wheel chair with several other residents led to be the same. vas in bed resting and R14 everal long white chin hairs				
	was in bed on her b room and said good R14's covers and u brief. NA-B washe tucked R14's brief of wash R14's peri are the right while she w removed the wet so garbage. NA-B place	s on 8/25/21, at 8:17 a.m. R14 back and NA-B entered her d morning. NA-B removed nhooked R14's incontinent d R14's hands and face, on the left side and began to ba. NA-B asked R14 to roll to vashed her buttocks area, biled brief and threw it in the sed a clean incontinent brief d her to roll to the left and				

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COMI	E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
/IEADO	W LANE RESTORATIV		AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 50	2 920			
nnesota	closet and picked of - at 8:39 a.m. NA-E R14 chose what sh obtained R14's par applied ace wraps slippers on R14's fe applied deodorant a head. NA-B assiste the right while strain placing the lift sling - at 8:52 a.m. NA-E ask for assistance NA-B positioned th hooked the sling to the room. NA-B and mechanical lift from unhooked the lift from unhooked the lift from washed her hands room. NA-B applied placed her feet on and placed her glas collected the soiled R14's supplies awa again at the sink. N covered R14's legs - at 9:03 a.m. NA-E area, down the hall Several residents v area. R14 continue chin hairs approxim not observed to offi- oral cares or assist - at 9:36 a.m. R14 room area and con white chin hairs approxim on 8/25/21, at 9:14 above findings and	B brought over the clothes and he wanted to wear. NA-B hts, donned the pants and to her lower legs. NA-B placed eet, removed her gown, and donned her shirt over her ed R14 to roll to the left and to ghtening her clothes and under her. B went out into the hallway to and returned to the room. e mechanical lift over R14 and the lift while TMA-A entered d TMA-A transferred R14 via her bed to her wheel chair, om the sling and TMA-A and immediately left R14's d peddles to R14's wheelchair, the peddles, combed her hair sses on her face. NA-B l linen, washed her hands, put ay and washed her hands JA-B grabbed a blanket and s with it. B wheeled R14 out of her room lway towards the dining room. vere seated in the dining room ed to have several long white hately 1/4 inch long. NA-B was er or attempt to provide R14				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/2	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATI	/F CARE CENTEE	AH AVENUE N, MN 56215			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE
			_	DEFICIENC	CY)	
2 920	Continued From pa	ige 51	2 920			
	•	0				
	facial hair removal.	provided R14 oral cares or				
	On 8/26/21, at 2:07	p.m. DON confirmed the				
		indicated R14 required staff				
		ADL's. The DON indicated				
	•	to assist residents with personal hygiene, grooming				
		ve followed the care plan.				
	R6					
	R6's quarterly MDS	dated 5/27/21, indicated R6				
		ict and had diagnoses which				
	included: diabetes	mellitus, anxiety and				
		MDS identified R6 required				
		ce of one staff with bed				
		ersonal hygiene, limited ssing and supervision with				
		the MDS identified R6 was				
		of bowel and frequently				
	incontinent of blade	ler, and was not on a bowel or	•			
	bladder toileting pro	ogram.				
	P6's caro plan rovid	sed on 8/25/21, indicated R6				
		berformance deficit related to				
		or, confusion, impaired balance	e			
	and pain. The care	plan identified R14 required				
		sistance with dressing,				
	personal hygiene a	nd toileting.				
	During observation	s on 8/23/21, at 2:12 p.m. R6				
		-D assisted R6 into her				
	wheelchair using a	gait belt. NA-C entered the				
		coffee and asked R6 if she				
		dining room and R6 agreed.				
		down to the dining room area				
		nd gave her the cup of coffee earing a purple sweat shirt with	n			
	flowers on it and the		•			1

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	V LANE RESTORATIV	Z209 UT	AH AVENUE			
		BENSON	N, MN 56215			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE
				DEFICIENC	Y)	
2 920	Continued From pa	ge 52	2 920			
	•	•				
		e spots on R6's chest area . heeled herself around the				
		her feet to peddle herself and	4			
	her shirt remained t		1			
		as seated in her wheelchair				
		y area and was asking for a				
		shirt remained the same.				
	- at 5:20 p.m. R6 wa	as seated in her wheelchair in				
		a and her shirt continued to				
		soiled white spots. R6 had				
		g around her and landing on				
	the chest of her shi					
		heeled herself around the	-			
		y her feet to peddle herself and the same. Nursing staff were				
		er or provide R6 with				
	assistance to chang					
		s on 8/25/21, at 7:03 a.m. R6				
		bed, covered up with blankets	,			
		thin reach and she said good				
	morning.	mained in hed				
	- at 7:24 a.m. R6 re	rned her call light on and				
		fer herself to her wheelchair.				
	•	gown and a sweater over it.				
		al manager (CM)-A entered				
		R6 if she needed assistance				
		to have a very strong pungent				
		r. CM-A washed her hands				
		was time to get washed up				
		tated she was last changed at				
		retrieved a pair of pants out of				
		ed them on R6 up to he knees				
		wheelchair. CM-A said R6				
		g changed and began to				
		b's bed and bedding was ad with urine and flies were				
		l landing on her bed and				
		e room was noted to have a				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	CONSTRUCTION		E SURVEY PLETED
ND F LAIN	OF CONTECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMPLETED	
		00930	B. WING		C 08/27/2021	
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST		•	
	TROVIDER OR SOFFEIER		AH AVENUE	TATE, ZIF CODE		
EADOV	V LANE RESTORATI	VE CARE CENTEE	I, MN 56215			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	THE APPROPRIATE	COMPLE DATE
				DEFICIENC	Y)	
2 920	Continued From pa	age 53	2 920			
	pungent odor of ur					
		E entered the room to assist				
		R6 about using the bathroom	-			
		aff encouraged her and CM-A				
	in her wheelchair.	t around her waist while she sa	L			
		A wheeled R6 into the				
		nd NA-E placed gloves on their				
		d R6 to stand while using the				
	0	NA-E removed R6's				
		nich was completely saturated				
		a streak of bowel in it as well.				
		wrinkled, pink in color and no				
		as noted. R6's plastic n was noted to have urine				
		A proceeded to cleanse R6's				
		area with wipes while NA-E				
		wheelchair cushion off with				
		with a paper towel. NA-E and				
		an incontinent brief on R6,				
		s and assisted her to sit in her				
		used the rest of her morning				
		herself out of her room. NA-E not received report that				
		hight shift. NA-E and CM-A				
		ot aware when the last time R6				
		, changed or offered				
	assistance with toil					
		A reviewed R6's medical record	l k			
	\ /	last time R6 had been				
		ged and indicated R6 had last changed at 3:40 a.m. and was				
	incontinent of urine					
	P6's MP looked on	w documentation of P6 boing				
		y documentation of R6 being ged by staff or offered toileting				
		7:33 a.m. for a total of 3 hours				
	and 53 minutes.					
	On 8/25/21 at 0.2/	4 a.m. NA-B confirmed R6 was				
	epartment of Health					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00930	B. WING	B. WING		C 08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
IEADOV	W LANE RESTORATIN	/F CARE CENTER	AH AVENUE I, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	ige 54	2 920				
rc n N a S C a b W a S C a S C a S C a S C a S C a S C a S C a S C a S C a S S C a S S S C a S S S S	Continued From page 54 routinely incontinent of bowel and bladder and needed to be checked/changed every two hours. NA-B indicated he thought she had last checked and changed R6 around 4:15 a.m. and thought she was dry at the time but could not remember. On 8/26/21, at 1:57 p.m. CM-A confirmed the above finding and indicated R6 was incontinent of bowel and bladder and required staff assistance with toileting. CM-A stated staff were to check and change R6 every two hours and indicated she expected staff to follow her care plan. On 8/26/21, at 2:07 p.m. DON confirmed the above findings and indicated R6 needed staff assistance with her ADL's. The DON indicated she expected staff to assist R6 with personal hygiene, grooming and incontinence cares. The DON indicated staff should have been checking and changing R6 per her care plan and if she refused to re-approach her at a later time.		f				
	R1 Findings include:						
	R1's quarterly Minir 8/17/21, identified F depression weakne (numbness/tingle ir identified R1 had so and required extens of daily living (ADL' hygiene, and bathir	mum Data Set (MDS) dated R1 had diagnoses of dementia ess and peripheral neuropathy n extremities.) The MDS evere cognitive impairment sive assistance with activities s) of dressing, personal ng. The MDS identified R1 had as during the assessment					
	impaired cognition,	sed 7/12/21, revealed R1 had function, thought process and assistance with personal					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED	
		00930	B. WING			C 08/27/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
MEADO	W LANE RESTORATIN	/F CARE CENTER	AH AVENUE I, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	ge 55	2 920				
		and bathing. R1's care plan facial hair removal.					
	R1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance with personal hygiene.						
	in bed, eyes closed her feet to mid ches her abdomen above dozen four (4) to fiv thick black coarse f chin and jaw line. R	p.m. R1 was observed lying l, covered with a blanket from st. R1's hands were rested on e the blanket. R1 had several ve (5) millimeters (mm) long, facial hairs along her upper lip, at had several six (6) to ten wispy facial hairs along both th and chin.					
	wheelchair, wheele assistant (NA)-H to hair was sticking up along the sides. R1 dozen 4 to 5 mm lo hairs along her upp had several 6- 10 m	as observed seated in a d down the hall by nursing wards the dining room. R1's o on the back of her head and continued to have several ong, thick black coarse facial her lip, chin and jaw line. R1 nm long white wispy facial rners of her mouth and chin.					
	in a wheelchair in the table next to anothe combed straight to have several dozen coarse facial hairs jaw line. R1 had se	a.m. R1 was observed seated ne dining room at a squared er resident. R1's hair was her head and she continued to a 4 to 5 mm long, thick black along her upper lip, chin and veral 6- 10 mm long white long both corners of her mouth)				
	wheelchair in the fa	was observed seated in a acility activity room with several continued to have several					

		Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
MEADO\	W LANE RESTORATIN	/F CARE CENTER	AH AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 56	2 920			
	hairs along her upp had several 6- 10 m hairs along both co - at 11:36 a.m. R1 w wheelchair, was wh towards her bedroo NA-D indicated and to transfer R1 into h provided R1 with he needed to go find th bed and NA-D exite R1 had remained s room, at that time N room and proceede her cares. R1 was o provided her call lig left R1's room. R1 of dozen 4 to 5 mm lo hairs along her upp	ng, thick black coarse facial per lip, chin and jaw line. R1 nm long white wispy facial rners of her mouth and chin. was observed seated in a neeled out of the activity room om by NA-D. At that time, other NA would need to assist bed. NA-C entered R1's room, er call light and indicated she ne other NA to assist R1 to ed R1's room. At 11:43 a.m. eated in her wheelchair in her NA-D and NA-C entered R1's ed to assist R1 to bed and with covered with a blanket, wht and both NA-D and NA-C continued to have several ng, thick black coarse facial per lip, chin and jaw line. R1 nm long white wispy facial				
	hairs along both co On 8/25/21, at 8:24 in a wheelchair in h closed, head was ti open. R1 continued mm long, thick blac upper lip, chin and mm long white wisp corners of her mou NA-E confirmed R1 did not have a razo - at 10:17 a.m. R1 w wheelchair, wheele (TMA)-A towards her	rners of her mouth and chin. a.m. R1 was observed seated er room, her eyes were lted back and her mouth was to have several dozen 4 to 5 k coarse facial hairs along her jaw line. R1 had several 6- 10 by facial hairs along both th and chin. At that time, 's facial hair and indicated she r to remove her facial hair. was observed seated in a d by trained medication aid er room. TMA- A proceeded to er from her wheelchair to bed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	·	
IEADOV	V LANE RESTORATIV	VE CARE CENTEE	, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMP THE APPROPRIATE DAT	
2 920	several dozen 4 to facial hairs along h R1 had several 6- hairs along both co On 8/24/21, at 11:4 totally dependent o not able to tell staff On 8/25/21, at 8:30 assisted R1 with m removed R1's facia not have a razor to further indicated sh that morning to sha staffed that mornin was not able to pro due to insufficient s morning an NA did and a night aid had familiar with mornin On 8/25/21, at 10:2 was dependent on felt R1 was not able TMA-A indicated R been removed as r R1 had a razor. TM	5 mm long, thick black coarse er upper lip, chin and jaw line. 10 mm long white wispy facial orners of her mouth and chin. 88 a.m. NA-C indicated R1 was in staff for all ADL's and was f of her needs. 0 a.m. NA-E stated she had orning cares and had not al hair. NA-E indicated R1 did remove the facial hair and he would not have had time ave R1 since they were short g. NA-E indicated she felt she ovide R1 with standard cares staffing. NA-E indicated that not show up for the day shift I stayed over that was not				
	On 8/26/21, at 10:4 placed to R1's fam was left.	due to lack of sufficient staff. 4 a.m. a telephone call was ily member and a message 2 p.m. NA-F indicated R1 was				
	dependent on staff included personal h indicated she often	for all of her ADL's, which nygiene and grooming. NA-F times would see residents there was not enough direct				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00930	B. WING		08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
MEADO	W LANE RESTORATIV	F CARE CENTER	H AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 58	2 920			
	standard cares, suc	on a routine basis to ensure h as facial hair removal, were ts, which included R1.				
	(DON) stated she e removed on a routir	a.m. the director of nursing xpected R1's facial hair to be he basis. The DON stated she or any other residents were in				
	R21					
	(MDS) dated 8/4/21 cognitive impairmer included Alzheimer' and thyroid disorder required total assist	ange Minimum Data Set , identified R21 had significant nt and diagnoses which s disease, muscle weakness r. R21's MDS indicated R21 rance with transfers, extensive mobility, dressing and				
	required extensive a personal hygiene ar but was to be check R21's care plan ide					
	wheelchair in her ro wispy white hairs or	p.m. R21 was sitting in her om. R21 had multiple long her chin and neck ranging -5 hairs up to 3/4 inches long.				
	wheelchair in her ro multiple facial hairs	a.m. R21 was sitting in her om. R21 continued to have , white in color on her chin and 1/8 inch long to 3/4 inch long.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00930	B. WING			27/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
/IEADO\	V LANE RESTORATIV	E CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIV		ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 920	wheelchair in the ac residents and staff continued to have fa with multiple white v on her chin and neo On 8/25/21, at 12:0 (NA)-E indicated sh member with R21's NA-E stated she ha morning and indicat provide a razor for F the female resident and thus staff were stated she had infor that morning of the was told the facility the female resident residents had their On 8/27/21, at 11:10 had been informed did not have any raz administrator would facility would discus with family member On 8/27/21, at 11:33 interview family met to remove R21's fac ON 8/27/21, at 10:2	 5 a.m. R21 was in her citivity room with multiple other members present. R21 acial hairs present as before, wispy hairs up to 3/4 inch long ck. 9 a.m. nursing assistant the had assisted another staff cares earlier that morning. Id noticed R21's facial hair thated the facility needed to R21. NA-E indicated none of s in the facility had any razors unable to shave them. NA-E rmed clinical educator (CE)-A need to purchase razors and would obtain some razors for s. NA-E indicated all the male own razors. 6 a.m. CE-A confirmed she by staff the female residents zors. CE-A stated the be obtaining razors and the as the need to purchase razors and the state are conferences. 3 a.m. during a phone mber (FM)-B stated she used cial hair for her. FM-B stated ial hair was important to her. 29 a.m. during a phone anager (CM)-A confirmed she 	t		.,	

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00930	B. WING			27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH			
2 920	Continued From pa	ge 60	2 920			
	On 8/27/21, at 1:29 p.m. director of nursing (DON) confirmed she expected staff to remove the residents' facial hair to maintain their dignity and for personal hygiene purposes.					
	R22					
	R22's significant change Minimum Data Set (MDS) dated 8/6/21, identified R22 had significant cognitive impairment and diagnoses which included: dementia, arthritis and hypertension (high blood pressure). R22's MDS indicated R22 required extensive assistance with bed mobility, dressing, and personal hygiene.					
	had an activities of performance deficit and limited mobility indicated R22 requi	ised 8/13/21, identified R22 daily living (ADL's) self-care related to advanced dementia . The care plan interventions red extensive assistance of ing, personal hygiene and ora				
	assisted R22 with n her in her wheelcha cares were complet medication aide (TM washed her hands a R22 out of the bed gait belt. TMA-A exi combed R22's hair. complete oral cares wheeled R22 in her into the hallway. Fro was observed prop- hallways and no ora	a.m. to 8:16 a.m. NA-B norning cares and wheeled air into the hallway after the ted. At 8:09 a.m. trained MA)-A entered the room, and assisted NA-B to transfer into her wheelchair using a ited the room and NA-B NA-B was not observed to a for R22. At 8:16 a.m. NA-B wheelchair out of her room om 8:16 a.m. to 8:40 a.m. R22 elling herself up and down the al cares were observed to be				
	observed in the din	t time. At 9:06 a.m. R22 was ing room with CE-A feeding E-A assisted R22 to the				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021		
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY ST	DDRESS, CITY, STATE, ZIP CODE			
	W LANE RESTORATIN	/E CARE CENTER 2209 UT/	AH AVENUE I, MN 56215	, , , , , , , , , , , , , , , , , , ,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From par hallway near the nut to self propel herse hallway. On 8/25/21, at 10:0 typically did not per usually worked the she had not complet morning. On 8/26/21, at 10:4 had not completed On 8/27/21, at 10:1 interview, CM-A sta perform oral cares been completed by toothettes. CM-A in especially importan tendency to pocket On 8/27/21, at 12:2 expected staff woul DON indicated oral the mouth clean, pr remove food. The facility policy tif (ADLs), Supporting	nge 61 Irsing desk, where R22 began If in her wheelchair down the 6 a.m. NA-B stated she form R22's morning cares and night shift. NA-B confirmed eted oral cares for R22 that 4 a.m. NA-E confirmed she oral cares for R22. 9 a.m. during a phone ted she expected staff to on R22 which should have swabbing R22's mouth with dicated oral cares were t for R22 as she had the	2 920				
	and services to ensign diminish unless the clinical condition(s) ADLs are unavoida that appropriate can provided for resider out ADLs independent and in according which included: hyperbolic hyperbolic and the service of the service	sure that their ADLs did not circumstances for their demonstrate that diminishing ble. The policy also identified re and services would be nts who were unable to carry ently, with the consent of the ordance with the plan of care, giene (bathing, dressing, care), mobility, elimination,					

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021	
					00/	21/2021
AME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST AH AVENUE	IATE, ZIP CODE		
IEADOV	W LANE RESTORATIN	/F CARE CENTEF	I, MN 56215			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5) COMPLET
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	IE APPROPRIATE	DATE
				DEFICIENCY)	
2 920	Continued From pa	ige 62	2 920			
	dining and commur	nication.				
		tled Shaving The Resident, tified the purpose was to				
		s and to provide skin care.				
		ed staff to review the resident's				
		s for any special needs of the				
		y further instructed staff to				
		or if the resident refused the information in accordance with				
	•	nd professional standards of				
	practice.					
		tled Dressing And Undressing,				
	Assisting The Resident With Level II dated					
		he purpose of this procedure				
		esident as necessary with essing to promote cleanliness.				
		nstructed staff to notify the				
	supervisor if the res	sident refused the procedure				
		n in accordance with the facility	/			
	policy and profession	onal standards of practice.				
	The facility policy ti	tled Mouth Care dated				
		he purpose of the procedure				
		sident's lips and oral tissues				
		nd freshen the resident's				
	· · ·	ent oral infection. The plies listed that would be				
		l: toothbrush, toothpaste,				
		applicators or gauze sponges.				
	The policy further in	nstructed staff to notify the				
		sident refused the mouth care				
		n in accordance with the facility onal standards of practice.	/			
	Policy and protocol					
		THOD OF CORRECTION:				
		sing (DON) or designee, could				
		nent policies and procedures assistance activities of daily				
	epartment of Health	assistance activities of ually				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
MEADO	V LANE RESTORATIV	/F CARE CENTEE	H AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ge 63	2 920			
	training for all nursi residents activities assessment and as perform random au	designee, could provide ng staff related assisting of daily living. The quality surance committee could idits to ensure compliance. R CORRECTION: Twenty-one				
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			10/11/2
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on observati review, the facility f comprehensive nut interventions were	ritional assessment and implemented to prevent oss for 1 of 1 residents (R6)		"corrected"		
	Findings include:					
	2/24/21, indicated F impairment and had diabetes mellitus, a	nimum Data Set (MDS) dated R6 had severe cognitive d diagnoses which included: Inxiety and schizophrenia. The required extensive assistance				

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021	
AME OF PROVIDER OR SUPPLIER				00/	21/2021
	2209 UT	DDRESS, CITY, ST AH AVENUE	IATE, ZIP CODE		
EADOW LANE RESTORATI	VE CARE CENTEE	N, MN 56215			
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965 Continued From pa	age 64	2 965			
 personal hygiene, mobility and super- identified R6's mos pounds (lbs) and h MDS further indica symptoms of a swa had a five (5) perce- last month and/or l six months. R6's admission Ca dated 2/24/21, iden impairment and ha anemia, diabetes r CAA indicated R6 of staff for transfer hygiene, limited as supervision with ea had no swallowing height was 66 inch (5) percent or more and/or had 10% w months. The CAA any nutritional app the nutritional app the nutritional statu related to R6's boo person's weight in square of height in screen for weight of health problems bu body fatness or he identified R6's BMI in an overweight ra R6's advanced age 	ansfers, dressing, toileting, limited assistance with bed vision with eating. The MDS st recent weight was 168 er height was 66 inches. The ted R6 had no signs or allowing disorder and had not ent or more weight loss in the had 10% weight loss in the last are Area Assessment (CAA) htified R6 had severe cognitive id diagnoses which included: nellitus and schizophrenia. The required extensive assistance s, dressing, toilet use, persona sistance with bed mobility and ating. The CAA indicated R6 disorders, weight was 168 lbs, es and R6 had not had a five e weight loss in the last month eight loss in the last six identified R6 was not receiving roaches. The CAA indicated us care area was triggered by mass index (BMI) (a kilograms divided by the meters). BMI can be used to categories that may lead to ut it is not diagnostic of the alth of an individual. The CAA was 27.1 which identified RR ange, however, indicated with e, she was at a "healthy indicated R6 received a	ə 			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/	27/2021
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	V LANE RESTORATI	VE CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY ST		ID ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLE DATE
2 965	Continued From pa	age 65	2 965			
	was cognitively inta included: diabetes schizophrenia. The extensive assistant mobility, toileting, p assistance with dre transfers. The MDS independent with e only from staff. The recent weight was inches. The MDS is symptoms of a swa unknown if R6 had weight loss in the la weight loss in the la weight loss in the la weight loss in the la Review of R6's adr dated 1/26/21, ider was 170 lbs and he completion of the fr assessment reveal weight, did not use averaged 65 plus 9 R6's nutritional ass estimated nutrition (kilocalorie (Cal or protein 90-95 gram needs were 2000 r R6's medical recor nutritional assessm Review of R6's sign an order dated 8/4/ 100 milligrams (mg day for urinary trac	ating and required set up help e MDS indicated R6's most 168 lbs and her height was 66 dentified R6 had no signs or allowing disorder and was a five (5) percent or more ast month and/or had 10% ast six months. mission Nutritional Data form ntified R6's admission weight er weight at the time of the orm was 170 lbs. The led R6 had no change in her adaptive equipment and % of her meal intakes per day. sessment revealed her needs as 1500 to 1600 kcal kcal) per day, estimated ns per day and estimated fluid milliliters (mI) per day.				

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IEADOV	W LANE RESTORATIN	/F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 66	2 965			
	dated 8/5/21, revea discontinue R6's M Simvastatin, Sitagli not improving due t weight loss and hyp Review of R6's Pro revealed staff had n requesting an order assist R6 with eatin order on 8/9/21, for	ned Order Summary Report aled an order was received to etformin, Fosamax, ptin and to consult hospice if to diagnoses of dementia with boalbumenia. blem Sheet dated 8/7/21, notified R6's primary doctor r for adaptive dining utensils to ng. R6's primary doctor gave R6 to be evaluated and onal therapy (OT) for adaptive				
	evaluation being co					
	(MAR) from 8/1/21, following: - R6 had received h	dication administration record , to 8/25/21, revealed the ner 120 ml of 2 Cal ay and had refused it twice				
	had a nutritional pro problem and was a altered state of min The care plan indic as ordered by med intake, monitor for dehydration, record facility protocol and	sed on 8/25/21, indicated R6 oblem or potential nutritional t risk for dehydration with an id, age and decrease mobility. ated staff were to follow diet ical doctor, monitor fluid signs and symptoms of d daily intake, weights per I snacks per R6's preference. tified R6 required set up help g.				
	Review of R6's wei revealed the followi	ghts from 2/17/21, to 8/23/21, ing:				

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00930	B. WING	B. WING		C 27/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	/F CARE CENTEF	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965	8/4/21. Review of R40's pro 8/10/21, revealed th - 8/4/21, medical do lethargy and very po today and had lost 2 Nursing reports she saying she just ate confused. R6 had a severe protein calor obtain labs due to b 100 mg twice a day urinary symptoms a ml by mouth twice a - 8/4/21, R6 seen by due to change in co agitated and not ea tract infection, R6 h when she admitted. Doxyclycline 100 m UTI and 2 Cal supp a day for weight los - 8/7/21, R6 had tro spilled a lot of her n sippy cup and work	y weights from 5/3/21, to ogress notes from 8/4/21, to ne following: octor noted having increased oor appetite. R6 was weighed 28 lbs in the last 2 months. The had refused nourishments and was increasingly a strong odor to her urine and rie malnutrition. Difficult to behaviors, start Doxyclycline to cover pulmonary and and start 2 Cal supplement 120 and start 2 Cal supplement 120 and start 2 Cal supplement 120 a day. y nurse practitioner for rounds ondition, more tired, confused, ting as well. Suspected urinary ad lost 30 lbs since January . New orders received for g twice a day for 7 days for ilement 120 ml by mouth twice s. puble feeding herself and neals. Tried lipped plate with ed well. Faxed medical doctor evaluate and treat for	/	DEFICIENCS	τ)	
	- 8/10/21, R6 refuse	ed to eat.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/2	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	ge 68	2 965			
	R6's MR lacked any other documentation of R6's unplanned significant weight loss of 28 lbs from her admission, 16.47% of her body weight within the last 6 months.					
	 her admission, 16.47% of her body weight with the last 6 months. During observations on 8/26/21, at 12:09 p.m. was seated at the dining room table waiting fo lunch. Dietary staff brought R6 a plate of food, it down in front of her, asked her if she needed any help, R6 declined and said she was ok. R6 had beans, diced potatoes, country fried steak with gravy on her plate, a cup of coffee and a of tea. R6 began to eat her potatoes independently with a silver spoon. at 12:22 p.m. R6 continued to eat her fried st with gravy independently. at 12:25 p.m. licensed practical nurse (LPN)-came over and asked R6 how she was doing a R6 responded ok. LPN-A asked R6 if she wan him to cut up her steak, R6 agreed and LPN-A cut up her fried steak for her. R6 indicated she wanted a cola, LPN-A went to the kitchen and brought R6 a can of cola back while R6 continue to eat and drink her food independently. at 12:28 p.m. dietary staff asked R6 if she were like a piece of cake or pudding for dessert and said she wanted cake. Dietary staff brought R6 piece of chocolate cake and she began to eat cake independently. R6 ate all of her potatoes 75% of her beans and approximately 75% of her second approximately 75% of her beans 	lining room table waiting for brought R6 a plate of food, se er, asked her if she needed ed and said she was ok. R6 otatoes, country fried steak late, a cup of coffee and a cup eat her potatoes a silver spoon. continued to eat her fried steak dently. nsed practical nurse (LPN)-A ed R6 how she was doing and .PN-A asked R6 if she wanted eak, R6 agreed and LPN-A ak for her. R6 indicated she I-A went to the kitchen and f cola back while R6 continued food independently. ary staff asked R6 if she would or pudding for dessert and R6 ke. Dietary staff brought R6 a cake and she began to eat her r. R6 ate all of her potatoes,				
	indicated nutritional completed on admis significant change. reviewed daily in the	p.m., dietary manager (DM)-A assessments were to be ssion, quarterly and with a DM-A stated weights were e MR and the reports would ight loss in one month or 10%				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	ge 69	2 965			
	facility until recently when the facility hired RD-B. DM-A stated when a significant weight change was identified, the expectation was for staff to contact the RD.					
	via phone R6's MR DM-A verified R6 re received 120 ml of 2 and started the sup weight loss. DM-A c weight loss from Ma DM-A reported the l 24 lbs from Februar was a 15% weight l confirmed the last r completed in Januar admitted and verifier assessments had b time. DM-A stated r have been complete quarterly and with a condition. DM-A stated assessments and F completed as indica normal process was doctor of any change the residents on a s the above findings a staff to complete R6	7 p.m. in a follow up interview was reviewed with DM-A. ceeived a diabetic diet, 2 Cal supplement twice a day plement on 8/4/21, due to confirmed R6 had a significant ay 2021, to August 2021. MR had revealed R6 had lost ry 2021, to August 2021, which oss in 6 months. DM-A nutritional assessment was ary 2021, when R6 was ed no other nutritional een completed since that nutritional assessments should ed on R6 upon admission, my significant change of ted he believed R6's weight en identified sooner if the R6's weights had been ated. DM-A indicated the is to notify the RD and the ges in weight loss and to start supplement. DM-A confirmed and indicated he expected 5's weights weekly on her bath e nurses, DM whenever a fied.				
	required one to two of daily living (ADL's hygiene and toiletin	4 a.m. NA-E indicated R6 staff assistance with activities s) for dressing, personal g. NA-E stated R6 was able to aff set up her tray and they				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
MEADOW	V LANE RESTORATIV	F CARE CENTER	H AVENUE MN 56215			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	ae 70	2 965			
	had good intake an received snacks du	d was not aware if she ring the day. NA-E stated she S received nutritional				
	On 8/25/21, at 12:09 p.m. LPN-A indicated R6 required extensive assistance of one staff for her ADL's and sometimes needed two staff during times when she was weaker. LPN-A stated R6 was independent with eating however staff were to supervise and encourage her to eat. LPN-A indicated R6 received snacks through out the day and additionally received 2 Cal supplement 120 ml twice a day. LPN-A stated R6 consumed the supplement the majority of the time however did refuse at times. LPN-A indicated when R6 refused the supplement staff were expected to re-approach her or offer an alternative. LPN-A stated staff were expected to weigh the residents on their weekly bath day, if a significant weight loss is identified or when dietary staff request the weight.					
		p.m. in an interview via the ed she had resigned from the				
	indicated she was a a little input, worked and as a result did facility's RD or cons not been informed I	p.m. in an interview RD-B asked by the facility to provide d full time at another facility not have the ability to be the sultant. RD-B stated she had R6 had a significant weight expected staff to contact the				
	RD for recommend and review again in had been identified staff would be comp monitoring intakes of	ations, provide supplements a week when a weight loss . RD-B indicated she expected bleting weekly weights, daily and to document the ed if a resident had refused				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00930	B. WING			27/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 965	meals, it was exper supplement. The R assessments shoul admission by the D thereafter. RD-B sta notified RD of R6's interventions in place which would include for four weeks. In a 8/27/21, at 11:03 a. no written contract dietician services. On 8/25/21, at 2:15 confirmed R6 had r and stated she had evaluate R6. OTA-A assistant (PTA)-A re nursing staff and P need to evaluate ar On 8/26/21, at 10:2 (MDSC) spoke with confirmed PT-A wa evaluate and treat F stated OT would ev On 8/26/21, at 10:2 phone PTA-A confir treated R6 yet for u equipment and had be completed on 8/	cted staff would start nutritional D-B indicated nutritional Id have been completed on M and quarterly after ated the DM should have weight loss and put ce to stabilize the weight loss e completing weekly weights follow up interview on m. RD-B confirmed she had with the facility to provide p.m. OT assistant (OTA)-A not been receiving OT services not received any orders to A indicated Physical therapist eceived the orders from TA-A then communicated the nd treat residents. 7 a.m., MDS consultant pTA-A via the phone and s not aware of the order to R6. MDSC indicated PTA-A valuate R6 on 8/30/21. 7 a.m., during an interview via med OT had not evaluated or se of adaptive eating scheduled the evaluation to 30/21.				
	clinical manager (C assistance with all o CM-A indicated R6 would spill her food issues with her plat	during an interview via phone M)-A stated R6 needed staff of her activities of daily living. would miss the spoon and on herself due to having e. CM-A stated when orders nerapy, nursing staff placed				

Minnesota Department of Health STATE FORM

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	00930		B. WING	· · · · · · · · · · · · · · · · · · ·	08/	27/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	ae 72	2 965			
	therapy staff the newere expected to pro OT should have evaluation of the evaluation	nputer and would email w order. CM-A indicated staff rocess orders immediately and aluated R6 soon after to a the adaptive equipment she neals. roximately 9:50 a.m. via phone (MD)-A indicated she recently f R6's primary physician and recently experienced weight R6 had diagnoses of advanced cophrenia and the combination loss. MD-A indicated lately R6 e, refused labs and R6 had o later stages of her dementia. ad ordered 2 Cal supplement for R6 and indicated she aluate residents within 2 weeks -A stated she expected staff prehensively assess R6, s weekly and update her with				
	(DON) confirmed th indicated she was ji significant weight lo expected staff to m ,to report nutritional team and MD. The staff to monitor weighthe RD and MD and DON indicated she comprehensive nut medications and fin problem. The DON evaluate and treat h	4 p.m. the director of nursing ne above findings and ust made aware of R6's oss. The DON indicated she onitor intakes, to offer snacks I changes to the nurse, dietary DON stated she expected ghts weekly, report changes to d follow up on MD orders. The expected staff to complete a ritional assessment, review ad out the root cause of the verified R6's OT order to nad not been processed as indicated the facility did not				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00930	B. WING		C 08/27/2021	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	N LANE RESTORATI	VE CARE CENTER	AH AVENUE			
		BENSO	N, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	age 73	2 965			
	the facility.					
	Assessment dated assessment, which status and risk fact should have been of The policy identified with the nursing sta were to conduct a r resident upon admic change in condition risk for impaired nur resident nutritional the following compo- current height and preferences, usual general appearance resident usual roution resident usual roution resident usual roution resident usual roution resident usual roution residents current control to be assessed, the care plan was to be minimize further nur SUGGESTED MET The Director of Nur develop and impler to ensure residents timely comprehens appropriate interver determined necess	olicy titled, Nutritional 3/17/21, identified a nutritional included current nutritional cors for impaired nutrition, conducted for each resident. d the dietician in conjunction aff and healthcare practitioners nutritional assessment for each ission, and as indicated a in that placed the resident at utrition. The policy revealed assessments included at least onents: usual body weight, weight, usual intake, food meal and intake patterns, e and clinical conditions and ine. The policy revealed onditions and risk factors were en analyzed and an individual e developed to address and utritional complications. THOD FOR CORRECTION: trising (DON) or designee could ment policies and procedures a at nutritional risk received ive assessments and ntions to maintain nutrition as eary by their individualized DON or her designee could				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
		00930	B. WING		C 08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MEADOV	W LANE RESTORATIN	/F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET E DATE	
2 980	Continued From pa	ge 74	2 980			
2 980	MN Rule 4658.060 service; Director	5 Subp. 2 Director of dietary	2 980		10/11/2	
	service who is enro minimum, a dietary receives frequently qualified dietitian. consultation must b the nursing home.	designate a director of dietary lled in or has completed, at a manager course, and who scheduled consultation from a The number of hours of be based upon the needs of Directors of dietary service 8, 1995, are not required to manager course.				
	by: Based on observati review, the facility f person to serve as oversee the dietary a full time dietitian.	ent is not met as evidenced ion, interview and document ailed to designate a qualified the director of food service to department in the absence of This had the potential to affect itors and staff who consumed en.		"corrected"		
	Findings include:					
		upport dietary manager were certified to be the				
	the kitchen, DM-A i	0 p.m. during the initial tour of ndicated DM-B was being take over the DM position in				
		p.m. DM-A confirmed the indicated registered dietician				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00930	B. WING	B. WING		C 08/27/2021	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE. ZIP CODE			
	V LANE RESTORATI	2209 UT	AH AVENUE	,			
		BENSON	N, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 980	Continued From pa	age 75	2 980				
	RD. DM-A explaine every two weeks to	ng for the facility until they hired ed RD-A came to the facility o assess the residents and umed this role to cover for the	E				
		37 p.m. in a follow up interview ne was not certified to be a DM					
		ວິ a.m. DM-B confirmed she nd was in the midst of new					
	indicated she rece and was not overse she had offered to	5 p.m. via phone call RD-A ntly resigned from the facility eeing the facility. RD-A stated fill in until the facility hired a cility had not followed up with offer.					
	indicated she was facility a little input indicated she work	1 p.m. via phone call RD-B only asked to provide the and to help them out. RD-B ted full time at another facility he capacity to be their RD or					
	confirmed the above and DM-B were no verified the facility	D7 p.m. the administrator ve findings and indicated DM-A t certified. The administrator had no written contract with as only a verbal agreement r and RD-B.					
		30 a.m. in a follow up interview ere was no written contact ne facility.	,				
		olicy titled, Director of Food ces Responsibility undated,					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED C
		00930	B. WING			27/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	E CARE CENTER	H AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 980	services would be r foods to all individu SUGGESTED MET The Administrator of review, and/or revise ensure the Dietary qualifications for the or designee could of the policies and pro- or designee could of ensure ongoing cor TIME PERIOD FOR	or of food and nutritional esponsible for providing safe als. THOD OF CORRECTION: or designee could develop, be policies and procedures to Manager has the proper e position. The Administrator educate all appropriate staff on ocedures. The Administrator levelop monitoring systems to				
21000	Requirements-Hygi Subp. 4. Hygiene. wash their hands and their arms with soar washing facility befor as often as is necess after smoking, eatir handling soiled equi	D Subp. 4 Dietary Staff ene. Dietary staff must thoroughly nd the exposed portions of p and warm water in a hand ore starting work, during work ssary to keep them clean, and ng, drinking, using the toilet, or ipment or utensils. Dietary ir fingernails clean and	21000			10/11/21
	by: Based on observati review, the facility fa and sanitary manne cross contamination the potential to affe	ent is not met as evidenced on, interview and document ailed to serve food in a safe er to prevent the spread of n. This deficient practice had ct all 13 residents who the facility and received food		"corrected"		

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021	
		00930	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
IEADOV	W LANE RESTORATIV	/F CARE CENTEE	AH AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21000	Continued From page 77		21000			
	from the Blue Horiz	on kitchenette.				
	Findings include:					
	dietary cook (DC)-A from the steam tabl area. DC-A had her plate, placed a scoo on the turkey and a plate. DC-A grabbe her gloved hand, pl set the plate on the - DC-A proceeded t her gloved hands, g the package setting placed it on the plate	s on 8/23/21, at 6:01 p.m. A was serving the supper meal le in the main dining room hands gloved, she grabbed a op of turkey, a scoop of gravy scoop of baked beans on the d a handful of raw carrots with aced them on the plate and steam table to be delivered. to touch the menu slips with grabbed a hot dog bun out of g on the back counter and te. DC-A grabbed the tongs, the bun, put a scoop of baked and set the plate on top of the elivered.				
	top of the steam tak grabbed a plate, gra the package, place tongs to place hotd poured chips onto t on the plate and mo touched the menu s placed a scoop of b	touched the menu slips on ole with both gloved hands, abbed two hot dog buns out of d them on the plate and used og's inside the buns. DC-A he plate, grabbed the hotdog's oved them over on the plate, slips with her gloved hands, baked beans on the plate and of the steam table to be				
	dirty gloves on the l carrots, buns and c plastic container of gloved her hands, g	a removed her gloves, set the back counter near her raw hips. DC-A then grabbed a cereal out of the cupboard, grabbed a bowl and poured grabbed a plate, placed the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00930		00930	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIN	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
21000	Continued From pa	ige 78	21000			
	bowl of cereal on it, set the plate down on top of the steam table to be served. DC-A grabbed the					
	menu slips off the top of the steam table with her					
		began to review them. DC-A				
		a plate, place a scoop of				
		e plate, a scoop of gravy on				
		d bowls out of cupboard and unter behind her. DC-A				
		s and set the dirty gloves on				
		ear the raw carrots, buns and				
		her hands, put a scoop of				
		powl, set the bowl on a plate,				
	placed a scoop of pureed turkey on the plate with					
	a scoop of gravy ar steam table to be d	nd placed it on top of the lelivered.				
	- at 6:11 p.m. DC-A	grabbed a plate, placed a				
		rkey, scoop of gravy and a				
		ans on the plate and set it up				
		table to be delivered. DC-A				
		aced a scoop of pureed turkey potatoes on the plate and	,			
		he steam table to be served.				
		grab a plate, grabbed a hot				
		package, placed it on the plate				
		place a hotdog inside the bun.				
		serve in this manner until she				
	was done serving a	at 6:31 p.m.				
		p.m. dietary manager (DM)-A				
		e findings and indicated staff				
		hange gloves, wash their				
		er with a clean pair of gloves				
		d. The DM-A stated the menu ed in the resident rooms and				
		were contaminated. DM-A				
		aff should not have been				
		slips while serving food and				
	touching ready to e	at foods thereafter. DM-A				
		pected to use utensils to				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	СОМ (°СОМ	E SURVEY PLETED C
		00930	B. WING	B. WING		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MEADO	W LANE RESTORATIN	/F CARE CENTER	AH AVENUE N, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21000	Continued From pa	ge 79	21000			
	serve with and to ne	ot use dirty gloved hands.				
	Preparation and Ha hands should never directly. Food would served with clean to	blicy titled, General Food andling undated, indicated bare r touch ready to eat raw food d have been prepared and ongs, scoops, forks, spoons, uitable implements to avoid prepared foods.	9			
	The Director Of Nu review and revise for procedures to assu sanitary manner. So necessary. The Ce monitor the service	THOD OF CORRECTION: rsing and the Dietician could ood service policies and re that food is served in a Staff could be trained as ertified Dietary Manager could of food on a periodic basis to owing safe food handling				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			10/11/21
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	This MN Requiremo	ent is not met as evidenced				
	Based on observati review, the facility f personal protective properly which had	ion, interview and document ailed to ensure appropriate equipment (PPE) was worn the potential to affect all 25 led in the facility. In addition,		"corrected"		

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00930	B. WING	·····		08/27/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IEADOV	V LANE RESTORATI	VF CARE CENTEE	AH AVENUE I, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
21375	Continued From pa	age 80	21375				
	the facility failed to assure appropriate hand hygiene and glove use while providing assistance with incontinence cares to prevent the spread of infection for 2 of 5 residents (R22, R14) observed during personal cares.						
	MASK USE						
	was in the hallway which hung below HK-A's mask would a.m. HK-A entered both R21 and R6 w continued to hang walked to R6's side who was in bed, wh her room. HK-A cor room and gathered cart outside the do stood next to R21 w when clinical mana HK-A's mask rema spoke to CM-A whi fitted on his face at while he spoke. At the hallway toward his cart away, wall entered the door. H loosely down below HK-A entered room his room. HK-A's r under his nose and mask fell down bel	9 a.m. housekeeper (HK)-A with his mask worn loosely, his nose. While HK-A spoke, d drop down to below. At 7:20 R21's and R6's room when were in the room while his mask loosely below his nose. HK-A e of the room and spoke to R6 hile he removed garbage from ontinued to walk around the d supplies periodically from the orway. At 7:27 a.m. HK-A who was in bed in her room, ager (CM)-A entered the room. ined below his nose. HK-A le his mask remained loosely nd falling below his mouth 7:28 a.m. HK-A walked down s the housekeeping closet, put ked to the basement door and dK-A's mask continued to hang w his nose. At 11:36 a.m. n 147, while R13 was sitting in mask continued to hang loosely d when he spoke to R13, his ow his mouth. HK-A cleaned l3's room while R13 remained					
	HK-A's mask conti	50 a.m. during an interview nued to hang down below his spoke his mask fell down					

STATE FORM

RSG411

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930		CONSTRUCTION	COMI	E SURVEY PLETED C 27/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST AH AVENUE	ATE, ZIP CODE		
IEADOV	V LANE RESTORATIV	/F CARE CENTEE	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 81	21375			
	his nose. HK-A stat was below his nose and fogging up his residents stated the him when his mask said he had receive week about proper he pulled it down si HK-A confirmed he 19 vaccination yet. On 8/26/21, at 9:29 (HM)-A confirmed t improper mask use mask would tend to stated he had remin nose and mouth co	K-A positioned his mask up to ed he was aware his mask and indicated it kept falling glasses. HK-A indicated some ey had a difficult time hearing was over his mouth. HK-A ed education this week and las mask use however indicated nce it fogged up his glasses. had not received the COVID a.m. housekeeping manager here had been concerns of by staff. HM-A indicated his o slip down as well. HM-A nded his staff to keep their vered with the mask and portant due the COVID-19 s.				
	R22					
	(MDS) dated 8/6/21 cognitive impairment included: dementia (high blood pressur indicated R22 requi	ange Minimum Data Set I, identified R22 had significan nt and diagnoses which , arthritis and hypertension re). R22's MDS further ired extensive assistance with ing, and personal hygiene.	t			
	had an activities of performance deficit and limited mobility included: extensive	rised 8/13/21, identified R22 daily living (ADL) self-care related to advanced dementia R22's care plan interventions assistance of one staff for hygiene, and bed mobility.				
		a.m. nursing assistant (NA)-E n and informed R22 she would				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021	
		00930	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W LANE RESTORATIN	/F CARE CENTEE	AH AVENUE , MN 56215			
(X4) ID	SUMMARY STA	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
21375	Continued From pa	ge 82	21375			
	observed to completentered R22's room in the sink and start while R22 sat on the gown was removed down and unfasten NA-B folded the bri- placed her bare han wetness. NA-B's go top of her head and was not observed to lowered R22's bed, proceeded to open was opening the dri- drawer handles and NA-B located some them on the counter into the basin of wa placed the basin of near R22's bed. NA- and assisted her to NA-B pulled R22's linside of her brief w proceeded to complete the handle of the cli- returned to R22's be to her side, washed R22's soiled brief a her. At this point, N skin protective ointri- perineal area. NA-B fastened the tabs o her gloves and was hands. NA-B's gogg her head during the	hing cares. NA-B was not be hand hygiene when she h. NA-B filled a basin of water ted to remove R22's gown e edge of the bed. After R22's I, NA-B assisted R22 to lie ed the tabs on R22's brief. ef down between her legs and nd onto the brief to check for oggles were noted to be on the d not covering her eyes. NA-B o perform hand hygiene. NA-B walked to the counter and multiple drawers. While NA-B awers, NA-B touched the d multiple items in the drawers e towels and socks and placed er top. NA-B put the washcloth iter, returned to R22's bed and water on the bed side table A-B began to wash R22's face wash her hands and arms. brief back down, touched the <i>i</i> th her bare hands and blete perineal cares with her walked to the closet, touched oset, removed a new brief and ed. NA-B assisted R22 to turn I R22's buttock, removed and placed the new brief under A-B placed gloves on, applied ment to R22's brief and n the sides. NA-B removed a not observed to sanitize her gles remained on the top of a time cares were provided to				
	closet door handle,	to the closet, touched the opened the door and				
	removed R22's clot	hing. At 7:55 a.m. NA-B				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930	. ,	CONSTRUCTION	Сомі Сомі	E SURVEY PLETED C 27/2021
					00/	21/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	VE CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21375	Continued From pa	age 83	21375			
	21375 Continued From page 83 assisted R22 to sit up, applied R22's shirt, pants, socks and shoes. NA-B went to the counter, opened multiple drawers and the closet and stated she was searching for the gait belt. NA-B located the gait belt on top of R22's chair, attempted to transfer R22 her self and stated she needed assistance. NA-B stopped the transfer attempt, opened R22's door and asked trained medication aid (TMA)-A for assistance. TMA-A entered the room, washed her hands in the sink and assisted NA-B to transfer R22 from her bed to her wheelchair. TMA-A washed her hands in the sink once the task was completed and exited the room. NA-B removed R22's gait belt and rinsed out R22's basin in the sink. NA-B wet R22's comb, combed her hair and placed R22's hair in a bun. At 8:16 a.m. NA-B washed her hands in the sink for the first time. NA-B's goggles remained on top of her head throughout the entire time. NA-B was observed in R22's room for 39 minutes.					
	confirmed she had she began R22's ca have washed her h about it due to the f cares. NA-B stated shift when she was	2 a.m. during interview NA-B not washed her hands before ares. NA-B stated she should ands however had not though fact staff were running late with she only worked the morning mandated to stay or a shift s available to cover. NA-B				
	wearing gloves and gloves when she w R22. NA-B d indica	aware of the importance of I stated should have worn orked on perineal cares for ited she had been "called on it ne had not work gloves while				
	providing cares. NA time she wore glove incontinence cares	A-B stated about 50% of the es when providing at night since the staff she				
magata Di		it worked very quickly. NA-B touched multiple items in				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00930			08/	27/2021
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
IEADOV	V LANE RESTORATI	VE CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE
21375	Continued From pa	age 84	21375			
	perineal cares and action breach in inf confirmed she had she was done with confirmed she had her head during R2 up. On 8/27/21, at 10:7 interview clinical m expected hand hyg staff entered reside worn during perine have been washed removed. CM-A in	ut washing her hands after indicated she was aware that fection control practices. NA-B only washed her hands after R22's morning cares. NA-B worn her goggles on the top o 22's cares as they kept fogging 19 a.m. during a phone anager (CM)-A confirmed she jiene to be completed when ent's rooms, gloves were to al cares and hands should or sanitized after gloves were dicated proper hand hygiene e important to prevent the				
	west hallway towar facemask was und into resident room seated in a wheelc HK-A spoke with th three feet from her	2 a.m. (HK)-A walked down the ds the end of the hall, erneath his nose. HK-A walked 115, which the resident was hair at a table by the wall. he resident, approximately his mask remained se. HK-A wiped the floor, then				
		was observed in the west underneath his chin, nose and				
	hallway, walked to	was observed in the west wards the nurses station, his ow his nose and mouth.				
	hallway and walked	was observed in the west d towards the end of the ce mask was below his nose				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00930	B. WING		08/2	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	/F CARE CENTEF	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 85	21375			
	and upper lip. HK-A walked past licensed practical nurse (LPN)-A and trained medication aid (TMA)-A and neither staff member directed him to cover his nose with his mask.					
	R14					
	R14's quarterly MDS dated 7/13/21, indicated R14 had severe cognitive impairment and had diagnoses which included: depression, poly-arthritis and lymphedema. The MDS identified R14 required two staff assistance with bed mobility, transfers, dressing, toileting, one staff for personal hygiene and supervision with eating.					
	was in bed on her b (NA)-B entered her was noted to be on proceeded to make straightened up the and soiled linen. NA garbage and soiled hallway on the othe while her eye protect head. NA-B entere linen and garbage i her hands. - at 8:26 a.m. NA-B and down the hallw remained on top of tissue at the nurses with her hand and b walked down the hal entered R14's room garbage, grabbed h	s on 8/25/21, at 8:17 a.m. R14 back when nursing assistant room and her eye protection the top of her head. NA-B e R14's room mates bed, room, collected the garbage A-B exited R14's room with the linen and walked down the r end of the nursing home ction remained on top of her d the utility room, placed the n the proper bins and washed walked out of the utility room ay while her eye protection her head. NA-B grabbed a s desks, pulled down her mask plew her nose while she allway to R14's room. NA-B n, threw the tissue in the her mask, pulled it back over h area and washed her hands				

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMF	E SURVEY PLETED
		00930	B. WING			27/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W LANE RESTORATIV	VE CARE CENTEE	AH AVENUE N, MN 56215			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21375	Continued From pa	age 86	21375			
	covers while her eye protection remained on top					
		ere were flies buzzing around				
		4 while NA-B collected her				
		nooked R14's incontinent brief,				
	touched the soiled surface with her bare hands					
		was wet. NA-B obtained a wet				
	wash cloth, washed	d R14's hands and face,				
	tucked R14's brief	on the left side and began to				
	wash R14's peri are	ea with her bare hands. NA-B				
		o the right while she washed				
		removed the wet soiled brief				
	with her bare hands and threw it in the garbage.					
		in incontinent brief under R14,				
		t and hooked the incontinent				
		over to the closet and picked				
	out some clothes for		4			
		B brought over clothes and R14 inted to wear. NA-B grabbed	+			
		ed the pants and applied ace				
		legs. NA-B placed slippers on				
		d her gown, put deodorant				
		and donned her shirt over her				
		R14 to the left then to the right				
		othes and placing the lift sling				
		ontinued to have her eye				
		p of her head while she				
	, provided cares.					
	- at 8:52 a.m. NA-E	went out into the hallway to				
	ask for assistance	and continued to have the eye				
		f her head. NA-B came back				
		tioned the mechanical lift over				
		e sling to the lift while trained				
		IA)-A entered the room. NA-B				
		rred R14 via mechanical lift				
		wheel chair, unhooked the lift				
		TMA-A washed her hands and				
		4s room. NA-B applied				
		heelchair, placed her feet on				
		ed her hair and placed her e. NA-B collected the soiled				
	aloooo on hor too					1

Minnesc	ota Department of He	alth			FORM APPROV	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00930	B. WING		C 08/27/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/F CARE CENTEF	AH AVENUE , MN 56215			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		
21375	Continued From pa	ge 87	21375			
	 21375 Continued From page 87 linen, washed her hands, put R14's supplies away and washed her hands again at the sink. NA-B grabbed a blanket and covered R14's legs with it at 9:03 a.m. NA-B wheeled R14 out of her room area, down the hallway towards the dining room with her eye protection on top of her head. Several residents were seated in the dining room area. On 8/25/21, at 9:14 a.m., NA-B confirmed the above findings and indicated R14 required assistance with all of her cares. NA-B verified she wore her eye protection on top of head due to they fogged up and she had difficulty seeing the residents. NA-B indicated staff were to wear their eye protection at all times and during cares. NA-B stated she should have worn gloves and washed her hands while providing peri cares to prevent the spread of infection. 					
	R6					
	was cognitively inta included: diabetes r schizophrenia. The extensive assistanc mobility, toileting, p	dated 5/27/21, indicated R6 ct and had diagnoses which mellitus, anxiety and MDS identified R6 required ce of one staff with bed ersonal hygiene, limited ssing and supervision with				
	was seated in her w herself towards the was sweeping R6's surgical mask. HK-, on the top of his chi exposed while R6 k At 7:27 a.m. registe	s on 8/25/21, at 7:25 a.m., R6 wheel chair and wheeling door. Housekeeper (HK)-A room and was wearing a A's surgical mask was down in with his mouth and nose poked in her closet for clothes. ered nurse (RN)-A entered her and HK-A left the room.				

		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY PLETED
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00930	B. WING		C 08/27/2021	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		•	-
	THO VIDEN ON SUFFLIEN		AH AVENUE	IATE, ZIF CODE		
EADOV	V LANE RESTORATI	VF CARE CENTEE	I, MN 56215			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	COMPLE DATE
				DEFICIENC	CY)	
21375	Continued From pa	age 88	21375			
	- at 7:41 a.m. R6 had soiled her bed and needed					
		housekeeping. RN-A left R6's				
	room to inform HK	-A. A cleaned R6's bed while R26				
		d. HK-A was wearing a surgica	1			
		ical mask was down on the top				
	of his chin with his	mouth and nose exposed.				
		slept while HK-A continued to				
	clean R6's room. F exposing his nose	IK-A mask continued the same				
	exposing his hose					
		9 p.m. director of nursing				
		he expected gloves to be worr	1			
		es and hand hygiene to be n glove changes and when				
		stated it was important to				
		l of infection, prevent cross				
	contamination and	for basic hygienic purposes.				
	On 8/27/21. at 2:47	7 p.m. during a joint interview				
		S consultant (MDSC)-A DON				
		re expected to wear masks at				
		asks were to cover the nose				
		 DON stated these practices prevent the spread of infection, 				
	• •	and COVID-19. DON confirmed				
		gles to be worn correctly at all				
	times for the same	reasons previously stated.				
	On 8/27/21 at 3:13	3 p.m. during a phone interview	,			
		nist (IP)-A confirmed staff were				
	expected to wear t	heir masks and goggles at all				
		it was important to keep the				
		safe and prevent them from COVID 19 or any other				
	respiratory illness.					
		itled Perineal Care, dated the purpose was to provide				
	cleanliness and co					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 08/27/2021	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
		2209 LIT	AH AVENUE			
/IEADO\	W LANE RESTORATIV	/F CARE CENTEF	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 89	21375			
	observe the resider instructions to staff their hands thoroug once completed to and dry hands thoroug The facility policy tit Hygiene, dated 3/12 considered hand hy prevent the spread identified all person regularly in-serviced hygiene to prevent care-associated infe followed the handw procedures to help infections to other p visitors. The policy rub or alternatively the following situatia and after direct con moving from a cont	nd skin irritation, and to nt's skin condition. The policy included: to wash and dry ihly and put on gloves, and remove gloves and to wash oughly. teled Handwashing/Hand 7/21, identified the facility rgiene the primary means to of infection. The policy inel would be trained and d on the importance of hand the transmission of health ections and all personnel vashing/hand hygiene prevent the spread of bersonnel, residents and instructed alcohol-based hand soap and water to be used in ons which included: before tact with residents, before tact with residents, before tact and after removing				
	Equipment-Using G identified the use of prevent the spread instructed staff to w gloves. The policy is be worn when touch blood, body fluids, r non-intact skin. SUGGESTED MET The director of nurs	tled Personal Protective Bloves, dated 3/17/21, f gloves listed, included to of infection. The policy vash hands after removing dentified when gloves were to hing excretions, secretions, mucous membranes, or THOD OF CORRECTION: sing or designee, could review actices during personal care				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00930	D. WING		08/	27/2021
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W LANE RESTORATIV	F CARE CENTER	AH AVENUE N, MN 56215			
(X4) ID	_		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
21375	Continued From pa	ge 90	21375			
	delivery of care to e	nduct random audits of the ensure appropriate care and nented in order to reduce the				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21530	A. The drug regim reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the ad report and the signi of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believes being adversely affer refer the matter to t if the medical direct	A.B.C Drug Regimen Review en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports n by the time of the next poner, if indicated by the strposes of this part, "acted cceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur its recommendation, or does te justification, and the s the resident's quality of life is eacted, the pharmacist must he medical director for review for is not the attending edical director determines that				10/11/2

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	•	-
FADOV	V LANE RESTORATIV	VE CARE CENTER 2209 UT/	AH AVENUE			
		BENSON	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 91	21530			
	justification for the physician does not must be referred for assessment and as by part 4658.0070. the medical director must refer the matt	cian does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality ssurance committee.				
	by: Based on interview facility failed to ens (PC) identified and to the lack of a ratio (GDR) for a psycho residents (R10 and	ent is not met as evidenced and document review, the ure the pharmacy consultant reported an irregularity related onal for gradual dose reduction otropic medication for 2 of 5 (R22,) and physician ordered 5 residents (R10) reviewed for cations.	1	"corrected"		
	Findings include:					
	6/11/21, identified F included cerebral v chronic pain, arthrit identified R10 had and required exten of daily living (ADL' received daily antip medications and id	nimum Data Set (MDS) dated R10 had diagnoses which ascular disease, depression, tis and depression. The MDS severe cognitive impairment sive assistance with activities s.) The MDS revealed R10 osychotic and antidepressant entified a gradual dose been attempted in the last				
	had behavior proble	vised 7/12/21, revealed R10 ems (alcohol abuse) related to ronic pain. The care plan listed ns which included:				

PREFIX TAG (EACH DEFICIENCY MU REGULATORY OR LSC II 21530 Continued From page administering medicati monitor/document side R6's care plan reveale antidepressants, psych	CARE CENTEF 2209 UTA BENSON, MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) 92 tions as ordered, e effects and effectiveness.	B. WING DRESS, CITY, ST H AVENUE MN 56215 ID PREFIX TAG 21530	•	(X5) COMPLET DATE
IEADOW LANE RESTORATIVE ((X4) ID PREFIX TAG SUMMARY STATEM (EACH DEFICIENCY MU REGULATORY OR LSC II 21530 Continued From page administering medicati monitor/document side R6's care plan reveale antidepressants, psych	CARE CENTEF 2209 UTA BENSON, MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) 92 tions as ordered, e effects and effectiveness.	H AVENUE MN 56215 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
(X4) ID PREFIX TAG SUMMARY STATEM (EACH DEFICIENCY MU REGULATORY OR LSC II 21530 Continued From page administering medicati monitor/document side R6's care plan reveale antidepressants, psych	CARE CENTEF BENSON, MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) 92 Stions as ordered, e effects and effectiveness.	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
PREFIX TAG (EACH DEFICIENCY MU REGULATORY OR LSC II 21530 Continued From page administering medicati monitor/document side R6's care plan reveale antidepressants, psych	UST BE PRECEDED BY FULL IDENTIFYING INFORMATION) 92 Lions as ordered, e effects and effectiveness.	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET
administering medicati monitor/document side R6's care plan reveale antidepressants, psych	ions as ordered, e effects and effectiveness.	21530		
monitor/document side R6's care plan reveale antidepressants, psych	e effects and effectiveness.			
 pharmacy review month R10's Consultant Pharmacy review dated 6/9/21, in taking a current dose of (mg) at bedtime since require at least quarter sedatives/hypnotics for dose reduction conside suggested course of a R10 for continued use bedtime for sleep. If a appropriate at the time for continuing current of the form on 7/15/21, we underline of "continuing above. The form lacked current dose. The form nursing (DON) on 7/20 R10's signed Order Suidentified the following -Trazodone (antidepresed to the form of 2021, revithe following medication Adma for August of 2021, revithe following medication for a state of the following medication following medic	hotropic medications and tions which included thly or per protocol. rmacist's Medication identified R10 had been of Trazodone 50 milligrams 12-2019. CMS guidelines rly assessment of or continued need and trial eration. The form's action included to assess e of Trazodone 50 mg at dose reduction was not e, provide clinical rational dose. The physician signed with a handwritten "ok", and ng current dose" in message ed a rationale for continuing n was signed by director of D/21. ummary dated 6/3/21, orders: essant medication) 50 mg elated to insomnia, start hinistration Record (MAR) vealed R10 had received ons: mouth one time daily at			

If continuation sheet 93 of 113

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Сом	E SURVEY PLETED
		00930	B. WING		08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	E CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	ae 93	21530			
21530	had received orders panel (CMP) and co draws to check pati due to increased in On 8/26/21, at 11:2 fax communication primary physician, i received for labs of The DON stated sh labs to be done at t would have been th confirmed the phan have R10's Trazodo	s for comprehensive metabolic omplete blood count (CBC) lat ents liver and heart function abdominal girth and pain. 5 a.m. the DON confirmed a had been sent to R10's n response an order had been a CBC and CMP to be drawn e would have expected the he next available visit, which e following day. The DON macy consultants request to one reviewed for a GDR had y addressed by R10's primary				
	coordinator, confirm had not been addre	1 a.m. the regional MDS ned R10's GDR for Trazodone essed by R10's primary cated an "ok" was not sufficien ued use.				
	interview R10's prin not ordered the labs remembered to che have expected R10 during the next ava stated she had not	4 a.m. during a telephone nary physician stated she had s on 5/24/21, and would have eck on them, however would 's labs to have been drawn ilable visit. R10's physician felt R10 was a candidate for a tion for his Trazodone.				
	interview, the PC st recommendations t 60 days after being been seen by psych months and she ha one of R10's provid	p.m. during a telephone ated she expected her o be addressed within 30 to written. She stated R10 had niatry within the last few d reminded the facility to have ers address his Trazodone ed she did not feel an "ok" in				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
		2209 []]	AH AVENUE	IATE, ZIF CODE		
MEADO	W LANE RESTORATIV	F CARE CENTER	I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	ge 94	21530			
21530	had voiced this to the management in the not aware of R10's CBC and CMP. The aware of the lab ord recommended the f R22 R22's significant ch (MDS) dated 8/6/21 cognitive impairment included: dementia, (high blood pressur indicated R22 requi bed mobility, dressi R22's MDS identified	past. The PC stated she was lab order on 5/25/21, for a PC confirmed had she been ders and she would have				
	had an activities of performance deficit and limited mobility included: extensive dressing, personal R22's care plan ide antidepressant med (antidepressant) rel behavioral disturban R22's care plan ind psychotropic medic (antipsychotic) relat R22's Consultant P Review dated 6/9/2 taking current dose	ated to dementia with nce and an aid to sleep. icated R22 received ations, risperidone ted to behavior management. harmacist's Medication 1, identified R22 had been of Trazodone 25 mg at 21. CMS guidelines required				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00930	B. WING		08/	27/2021
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
IEADOV	W LANE RESTORATIN	/F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 95	21530			
	dose reduction con suggested course of R22 for continued u bedtime for sleep. appropriate at the ti for continuing current the form on 7/15/21 underline of "contin above. The form la current dose. The f nursing (DON) on 7 R22's Order Summ included the followi -lorazepam (antian) mg (milligram). Giv	ary Report signed 4/15/21,	9			
	mg. Give 1 mg by r bedtime related to r	sychotic medication) tablet 1 mouth every morning and at unspecified dementia with nce, start date of 2/18/21.				
	mg by mouth at bee	hloride (HCI) tablet. Give 25 dtime related to unspecified avioral disturbance, start date				
	identified R22 was at bedtime, and if R day it would be disc continued use of Tr	ogress note dated 4/15/21, currently on Trazodone 25 mg R22 appeared fatigued the next continued. No rationale for razodone was included and no ue Trazodone were found.	t			
		p.m. DON indicated she review medications and				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00930	B. WING			27/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/F CARE CENTEF	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	gradual dose reduc recommendations by her primary physics should have gotten DON stated R22's preservers and indicated the facility follow-up of pharman June. DON confirmerecommendations to physician's response to contact the physic On 8/27/21, at 1:45 PC-A confirmed here facility to follow up of within 30-60 days. reviewing her document facility to follow up of within 30-60 days. reviewing her document planned to add the continuing R22's Tr in September. PC-A R22's primary care acceptable rationale SUGGESTED MET administrator, direct consulting pharmato policies and proceed pharmacy consultant staff could be educa- importance of the por or designee, along	tions. DON reviewed R22's from 6/9/21, and the response sician of "Ok" and said nursing clarification from the doctor. Drimary physician was not very cy recommendation follow ups acility needed to have a t22's primary physician. DON was inconsistent with their acy recommendations prior to ed she expected the PC's o be followed up on and if the se was unclear, nursing were cian to clarify. p.m. during a phone interview r expectation was for the on her recommendations PC-A indicated she was mentation and had noted on identified they would have had physician document about the n 8/13/21, however could not nation. PC-A stated she required rationale for azodone during her next visit A stated a response from physician of "ok" was not an				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ	E SURVEY PLETED
		00930	B. WING		C 08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 97	21530			
	TIME FRAME FOR (21) days.	CORRECTION: twenty-one				
21730		5 Subp. 11 Plant eration, & Maintenance	21730			10/11/21
	Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel.					
	by: Based on observati review, the facility fa safe, functional, sar environment for 2 of expressed concern for 4 of 4 residents observed to have fl during cares and w facility failed to ensi- related to flies land	ent is not met as evidenced on, interview and document ailed to provide and maintain a nitary, and comfortable of 2 residents (R4 and R9) who about the pest control of flies, (R16, R11, R14 and R6) ies on them while eating, hile sleeping. In addition, the ure a pest free environment ing on food during meal ent practice had the potential lents in the facility.	,	"corrected"		
	Findings include:					
	R4					
	5/31/21, identified F included multiple so neurological conditi	num Data Set (MDS) dated R4 had diagnoses which clerosis (progressive on affecting all bodily ia, diabetes and depression.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED - 08/27/2021	
		00930	B. WING			
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IEADOV	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE N, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21730	Continued From pa	nge 98	21730			
	required extensive daily living (ADL's) toileting. The MDS of motion to both he extremities. On 8/25/21, at 1:16 meeting, R4 stated flies in the facility b them herself. R4 st side of a barn," who provided with a fly s the staff should hav as they were all over	R4 was cognitively intact and assistance with activities of of bed mobility, transfers and indicated R4 had limited range er bilateral upper and lower b p.m. during a resident counci she was bothered by all of the ut was not able to swat at rated, "I couldn't hit the broad en asked if she had been swatter. R4 indicated she felt ve been aware of all of the flies er the facility. R4 stated she reported to staff the flies had				
	R9					
	had diagnoses white failure, diabetes, and MDS identified R9 required extensive mobility, transfers a	6, dated 6/9/21, identified R9 ch included, chronic heart thritis and depression. The was cognitively intact and assistance with ADL's of bed and toileting. The MDS mited range of motion of emities.				
	R9, several dozen room, flying around arms, on his table, time, R9 stated he was too weak at the flies. R9 stated the felt there was a hig average at that time	a.m. during an interview with flies were observed in his I, landing on his lower legs, bed and on his walls. At that had a fly swatter, though he at time to be able swat at the flies drove him crazy, and he her number of flies than the e of the year. R9 stated one of nts (NA) helped him kill the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00930	B. WING		08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOW	V LANE RESTORATI	VE CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21730	Continued From pa	age 99	21730			
r f f i a F F i c c c a i	care for other resid facility staff should flies in the building indicated he had no anyone about the fl R16 R16's significant ch Minimum Data Set identified R16 had dementia, polymyal disorder causing m around the shoulde The MDS identified impairment and rec with activities of dat	s killing flies when he had to ents. R9 stated he felt the have been aware there were as there were so many and ot "formally" complained to lies. mange of status (SCSA) (MDS) dated 7/15/21, diagnoses which included: lgia rheumatica (inflammatory suscle pain and stiffness ers and hips) and psychosis. I R1 had severe cognitive quired extensive assistance ily living (ADL's) of bed and toileting. The MDS				
	inattention, altered delirium. The MDS maintain her baland	disorganized thinking, levels of consciousness and disordentified R16 was unable to be during transition without and had one fall since the ent.				
	observed lying on h were closed and he several flies in her	2:35 p.m. to 2:54 p.m. R16 was her back in a low bed, eyes er mouth was opened. R16 had room, of which a few would her face towards her mouth				
	her back, moved he bed towards the flo with her left hand a was unable to sit up her eyes. At that tim	vas observed lying in bed, on er legs and bare feet out of or, took hold of the grab bar nd attempted to sit up. R16 p, let go of the bar and shut ne, NA-G entered R16's room, w gripper socks from the floor,				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00930	B. WING			27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATI	/F CARE CENTER	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21730	Continued From pa	ige 100	21730			
	told the nurse about left the room and R Several flies remain and on her body. N remove the flies. -at 6:37 p.m. R16 w on her back, eyes v	restless and stated she had it R16's restlessness. NA-G i16's legs remained out of bed hed flying around R16's room A-G made no attempt to was observed lying in a low bed were closed, her body was et, a pink blanket covered her				
	her room and on R and flying away. On 8/24/21, at 8:35 in a low bed, on her	I flies were observed flying in 16's body, periodically landing 6 a.m. R16 was observed lying r back, pillows were positioned ne had a blanket covering her	1			
	legs and body up to	o her mid chest. Several flies (16's room, periodically landing	3			
	in bed on her back, were closed, she ha right and left sides	a.m. R16 was observed lying covered with a sheet, eyes ad pillows placed on both her and underneath her legs. R16 move her legs out of bed or				
	dietary cook (DC)-A from the steam tab area. DC-A had her plate, placed a scor on the turkey and a	s on 8/23/21, at 6:01 p.m. A was serving the supper meal le in the main dining room r hands gloved, she grabbed a op of turkey, a scoop of gravy a scoop of baked beans on the d a handful of raw carrots with				
	her gloved hand, pl set the plate on the During this time mu	aced them on the plate and steam table to be delivered. Iltiple flies were flying around ding on the steam table and				

STATEMEN	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00930	B. WING			27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLET DATE
21730	Continued From pa	ge 101	21730			
	R11					
	had severe cognitiv diagnoses which in depression and mu identified R11 was i	dated 6/11/21, indicated R11 re impairment and had cluded: seizure disorder, scle weakness. The MDS independent with bed mobility, toileting, eating and personal				
	walked independen her room. R11 was denim jeans and the to her knees and he light brown colored chair in her room in	s on 8/23/21, at 5:08 p.m. R11 ttly in the hallway and back to wearing a light blue pair of e inside of her legs, half way er entire buttocks area had stain. R11 sat down in her idependently and she had ing around and landing on her				
	R14					
	R14 had severe coo diagnoses which in poly-arthritis and lyr identified R14 requi bed mobility, transfe	S dated 7/13/21, indicated gnitive impairment and had cluded: depression, mphedema. The MDS ired two staff assistance with ers, dressing, toileting, one ygiene and supervision with				
	NA-B approached F bed, removed R14's multiple flies buzzin while NA-B collecte provided cares to R around and NA-B m	s on 8/25/21, at 8:26 a.m. R14 while she was laying in s covers and there were ag around and landing on R14 ed her supplies. While NA-B R14, the flies continued to fly made several attempts to swat ked to the closet, picked out				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED			
		00930	B. WING			C 08/27/2021			
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE					
MEADOW LANE RESTORATIVE CARE CENTEF 2209 UTAH AVENUE BENSON, MN 56215									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
21730	Continued From pa	age 102	21730						
	around R14 and lar - at 8:39 a.m. NA-B and R14 chose wha grabbed R14's pan applied ace wraps	B brought over some clothes at she wanted to wear. NA-B ts, donned the pants and to her lower legs while she several flies that landed or							
	R6:								
	was cognitively inta included: diabetes in schizophrenia. The extensive assistance mobility, toileting, p assistance with dre transfers. The MDS incontinent of bowe	6 dated 5/27/21, indicated R6 inct and had diagnoses which mellitus, anxiety and MDS identified R6 required ce of one staff with bed ersonal hygiene, limited assing and supervision with 6 identified R6 was always and frequently incontinent of ot on a bowel or bladder							
	was seated in her v area and her shirt o several soiled white	s on 8/23/21, at 5:20 p.m. R6 wheelchair in the dining room continued to be wet with a spots. R6 had several flies and landing on the chest of							
	was seated in her v had several flies bu on her pants and sl	s on 8/24/21, at 1:49 p.m. R6 wheelchair in her room and uzzing around her and landing hirt. R6 was trying to swat r hands and had no success d of the flies.							
	was seated in her v	s on 8/25/21, at 9:52 a.m. R6 wheelchair in the dining room g a fig bar. While R6 ate her							

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _ B. WING	CONSTRUCTION	- C	
		00930	B. WING		08/2	27/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
MEADO\	W LANE RESTORATIV	/F CARE CENTEE	H AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
21730	Continued From pa	ge 103	21730			
	fig bar there were s and landing on her - at 12:21 p.m. R6 w her wheelchair at th flies were buzzing a while she tried to sk On 8/24/21, at 2:45 exterminator technic facility. The technic a routine visit to spr the facility had seve both wings, residen area of the facility. the facility would ha outside by the entra he felt the flies were bothersome this yea technician indicated fly trap by the kitche felt it would be bene hallway to control th through those doorn he was not aware o the company regard On 8/27/21, at 12:4 environmental tour manager he confirm the facility, though in flies were not abnor an "infestation." The stated he did not fer problem and reside	everal flies buzzing around while she ate. was laying in bed resting, with he side of the bed and several around her and landing on her eep. p.m. the facility's contracted cian was observed at the ian indicated he was there for ray for spiders. He confirmed eral dozen flies throughout t rooms and in the common The technician stated he felt we benefited from spraying ances for fly control. He stated e more prominent and ar versus previous years. The d the facility had a black light en entrance and indicated he eficial to place one in each he flies that could enter ways. The technician stated of the facility reaching out to ding pest control for flies. 7 p.m. during an with the facility maintenance ned there were flies present in ndicated he felt the number rmal and would not qualify as e maintenance manager el the flies in the facility were a nts had access to fly swatters.				
	which had been the He indicated he had about the flies as he concern. The maint	y had routine pest control, ere on Tuesday of this week. d not spoken to the technician e was unaware there was a cenance manager stated no ad voiced any concerns to him				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ (°СОМ	E SURVEY PLETED
		00930	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY,	STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/F CARE CENTEE	AH AVENUE , MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21730	Continued From pa	ge 104	21730			
	regarding the flies.					
	A policy was reques not provided.	sted on pest control and was				
	The administrator, in designee could ensignee could ensignee could ensigned and the second ended and the second ended and the second ensure adequate performance improvement these finding performance improvement ensure adequate performance improvement ensure adequate performance improvement ensure ensur	THOD OF CORRECTION: maintenance supervisor, or sure a preventative pest contro oped and implemented. The te staff on these policies and vironmental rounds/audits to est control. The facility could is to the quality assurance vement (QAPI) committee for ations to ensure ongoing				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			10/11/21
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review the facility fa utilizing a mechanic periods of time for 3 R21) who were de	ent is not met as evidenced ion, interview and document ailed to promote dignity while cal lift sling for extended 3 of 3 residents (R14, R1 and pendent on staff for activities equired the use of a ransfers.		"corrected"		

If continuation sheet 105 of 113

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED
		00930	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
MEADOV	W LANE RESTORATIV	/E CARE CENTEF	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
21805	Continued From pa	ige 105	21805			
	Findings include:					
	R14					
	R14 had severe con diagnoses which in poly-arthritis and lyr indicated R14 requi	S dated 7/13/21, indicated gnitive impairment and cluded: depression, mphedema. The MDS ired two staff assistance with ers, dressing, toileting, and hal hygiene.				
	had physical function impairment. The car staff assistance with	vised on 2/9/21, indicated R14 oning deficit related to mobility are plan indicated R14 required h using a full body lift (hoyer) ilized a wheel chair for				
	was seated in her w the door open. R14 visibly draped over wheelchair and was	s on 8/23/21, at 5:08 p.m. R14 wheel chair in her room with 's mechanical lift sling was the sides and back of her s not tucked in around her or sat in her wheel chair.				
	R14 was seated in with the door open. remained visibly dra of her wheelchair a her or removed whi	s on 8/24/21, at 10:02 a.m. her wheel chair in her room R14's mechanical lift sling aped over the sides and back nd was not tucked in around ile she sat in her wheel chair. was out in the activity room				
	seated in her wheel present and they we mechanical lift sling - at 1:07 p.m. R14 v	I chair with other residents ere playing family feud. R14's g remained the same. was out in the activity room I chair with other residents				
		ere playing bingo. R14's				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COMF	E SURVEY PLETED				
		00930	B. WING		C 08/27/2021					
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE						
MEADOW LANE RESTORATIVE CARE CENTEF 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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE				
21805	Continued From pa	ge 106	21805							
	mechanical lift sling	remained the same.								
	to ask for assistance positioned the mec the lift to the sling w (TMA-A) entered the transferred R14 via to her wheel chair, and TMA-A washed left R14's room. NA R14's wheelchair, p grabbed a blanket a - at 9:03 a.m. NA-B down the hallway to set her up to the tal area and immediate sling was visibly dra back of her wheelch around her or remo- chair. - at 9:36 a.m. R14 n room area with othe have her mechanic the sides and back not observed to offer mechanical lift sling it while R14 sat in h On 8/25/21, at 9:14	NA-B) went out into the hallway ce and returned to R14's room, hanical lift over R14, hooked while trained medication aid the room. NA-B and TMA-A the mechanical lift from her bed unhooked the lift from the sling d her hands and immediately A-B applied foot peddles to placed her feet on the peddles, and covered R14's legs with it. Wheeled R14 out of her room, powards the dining room area, ble with other residents in the ely left. R14's mechanical lift aped over the sides and the hair and was not tucked in oved while she sat in her wheel remained seated in the dining er residents and continued to al lift sling visibly draped over of her wheelchair. NA-B was er or attempt to tuck the g out of other's view or remove her wheel chair.								
	sling with a mechar NA-B indicated the	nical lift for all of her transfers. sling should have been tucked loved to maintain R14's								
nnesota D		a.m. attempted to call family hity with use of sling and family swer.								

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	RECTION Í IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C	
		00930	D. WING		08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	/F CARE CENTEE	AH AVENUE I, MN 56215			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLET DATE
21805	Continued From pa	ge 107	21805			
	R1					
	Findings include:					
	8/17/21, identified F depression weakner (numbness/tingle ir identified R1 had se and required extens of daily living (ADL' toileting and locome	num Data Set (MDS) dated R1 had diagnoses of dementia ess and peripheral neuropathy n extremities.) The MDS evere cognitive impairment sive assistance with activities s) of bed mobility, transfers, ption. The MDS identified R1 ces of a wheelchair.	,			
	impaired cognition, required the use of transfers. The care wheelchair and req with locomotion. R	sed 7/12/21, revealed R1 had function, thought process and a full body mechanical lift for plan revealed R1 used a uired extensive assistance I's care plan lacked direction e sling used to transfer R1 with anical lift.				
	revealed R1 require staff and the use of transfer. The care g	ant care guide dated 8/26/21, ed extensive assistance of two a full body mechanical lift to guide lacked direction for ing used to transfer R1 with anical lift.				
	in a wheelchair in the hall by nursing assidining room, a blue hung over the back approximately five to to the dining room of	p.m. R1 was observed seated ne hallway, wheeled down the stant (NA)-H towards the mechanical lift transfer sling and sides of R1's wheelchair to six inches. R1 was wheeled which held several residents, next to another resident and				

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	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00930	B. WING		08/	27/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
IEADO	W LANE RESTORATIV	/F CARE CENTEF	AH AVENUE I, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	ge 108	21805			
	in a wheelchair in the table next to another seated on a blue m which hung over the wheelchair approxin - at 11:32 a.m. R1 w wheelchair in the far other residents, a b sling hung over the wheelchair approxin - at 11:36 a.m. R1 w wheelchair approxin - at 11:36 a.m. R1 w wheelchair, with a b hanging over the bar wheelchair and NA- from the activity roc with a full body mee placed the mechan of the blue sling stra attached the sling stra	was observed seated in a s wheeled by trained A)-A towards her room. into her room, obtained a full				

EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930			(X3) DATE SURVEY COMPLETED C 08/27/2021	
R STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	•	
IVE CARE CENTEE				
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
derneath R1, attached the straps isted R1 to transfer from her I. TMA-A removed the sling from hd placed it into the wheelchair. :48 a.m. NA-C indicated R1 was on staff for all ADL's and was off of her needs. NA-C stated was kept underneath R1 when h the wheelchair for ease of use. 30 a.m. NA-E stated R1 was ff for transfers and required the mechanical lift. NA-E indicated pt underneath her in the vas easier on R1 to leave the her. NA-E indicated R1's sling usually visible when she was in :21 a.m. TMA-A indicated R1 n staff for all of her ADL's and of a full body mechanical lift for . TMA-A stated the sling used to eft underneath her when she and it was easier to transfer. the blue sling used to transfer sible when she was seated in :44 a.m. a telephone call was mily member and a message				
	TIVE CARE CENTER TIVE CARE CENTER STATEMENT OF DEFICIENCIES MARY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) page 109 derneath R1, attached the straps isted R1 to transfer from her d. TMA-A removed the sling from nd placed it into the wheelchair. :48 a.m. NA-C indicated R1 was con staff for all ADL's and was aff of her needs. NA-C stated g was kept underneath R1 when n the wheelchair for ease of use. 30 a.m. NA-E stated R1 was aff for transfers and required the mechanical lift. NA-E indicated ept underneath her in the vas easier on R1 to leave the her. NA-E indicated R1's sling usually visible when she was in 0:21 a.m. TMA-A indicated R1 on staff for all of her ADL's and of a full body mechanical lift for d. TMA-A stated the sling used to eft underneath her when she and it was easier to transfer. the blue sling used to transfer isible when she was seated in 0:44 a.m. a telephone call was mily member and a message	00930 B. WING	00930 B. WING INC 2209 UTAH AVENUE BENSON, MN 56215 TIVE CARE CENTER 2209 UTAH AVENUE BENSON, MN 56215 STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL RUSCIDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF I (EACH CORRECTIVE ACT CROSS-REFERENCE DO TO DEFICIENC page 109 21805 demeath R1, attached the straps isted R1 to transfer from her 1. TMA-A removed the sling from nd placed it into the wheelchair. Image: Comparison of the comp	00930 B. WING INF STREET ADDRESS, CITY, STATE, ZIP CODE 2009 UTAH AVENUE BENSON, MN 56215 INFERENT OF DEFICIENCIES CC/ MUST BE PRECEDED BY FULL USC IDENTIFYING INFORMATION) INFERENCE TAG PROVIDER'S PLAN OF CORRECTION CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 126 IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 128 05 IDENTIFYING INFORMATION) PREFIX TAG PREFIX (RACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 128 05 IDENTIFYING INFORMATION PREFIX TAG IDENTIFYING INFORMATION 128 05 IDENTIFYING INFORMATION PREFIX TAG IDENTIFYING INFORMATION 128 05 IDENTIFYING INFORMATION PREFIX TAG IDENTIFYING INFORMATION 128 05 IDENTIFYING INFORMATION IDENTIFYING INFORMATION IDENTIFYING INFORMATION 138 0.m. NA-G indicated R1 was aff of transfers and required the mechanical lift. NA-E indicated R1 was easier on R1 to leave the her. NA-E indicated R1's sling usually visible when she was in IDENTIFY INFORMATION 121 1.m. TMA-A indicated R1 was easier to transfer. the blue sling used to transfer. the blue sling use

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00930			(X3) DATE SURVEY COMPLETED C 08/27/2021
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST		
		VE CARE CENTER 2209 UTA	AH AVENUE , MN 56215	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE
21805	Continued From pa	age 110	21805		.,
	identified R21 required transfers, and exte	er. R21's MDS further ired total assistance with nsive assistance with bed and personal hygiene.			
	(CAA) dated 8/5/21 dementia and was wants or needs. Th dependent on staff locomotion. R21's	nange Care Area Assessment I, identified R21 had advanced not able to communicate her ne CAA indicated R21 was for all transfers and CAA identified R21 required ce with bed mobility and ring (ADLs).			
	required extensive	vised 7/12/21, identified R21 assistance with full body lift for ad impaired thought processes er's disease.			
	wheelchair in her ro visible from the hal sling was visibly dr of her wheelchair b was in the dining ro	p.m. R21 was in her com with the door open and lway. R21's mechanical lift aped over the sides and back by 3-4 inches. At 5:57 p.m. R21 com in her wheelchair while the g remained visibly draped over of her wheelchair.			
	wheelchair in her row was visible from the	i6 a.m. R21 was sitting in her oom with the door open and e hallway. R21's mechanical draped over the sides and hair.			
	(LPN)-A was transp to her room. R21's visibly draped over wheelchair by 3-4 i	B p.m. licensed practical nurse porting R21 down the hallway mechanical lift sling remained the sides and the back of the nches. At 1:36 p.m. nursing nd NA-G were in R21's room			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMI	E SURVEY PLETED
		00930			08/2	27/2021
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST AH AVENUE	TATE, ZIP CODE		
IEADOV	V LANE RESTORATIV	F CARE CENTER	, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ge 111	21805			
	wheelchair to her be draped around R21	a mechanical lift from her ed. R21's sling had remained 's wheelchair sides and back d R21's transfer from her ed.				
	wheelchair and the visibly draped on bo	5 a.m. R21 was in her mechanical lift sling was oth sides and above her back was in the activity room with staff members.				
	usual process for m leave them in the w	9 p.m. NA-E indicated her nechanical lift slings was to heelchair of the residents. to tuck them in so the slings others.				
	(CM)-A confirmed n have been removed indicated the mecha used were designed the wheelchair or be stated she expected be removed for all n keeping them in the residents' risk of de	9 a.m. clinical manager nechanical lift slings should d after each use. CM-A anical lift slings the facility d to be easily removed from ed after each use. CM-A d the mechanical lift slings to residents and indicated e wheelchair increased the veloping skin tears or bruises. was a dignity issue as well.				
	confirmed the above the resident was up should have remove sight so it was not v administrator confir	p.m. the administrator e findings and indicated once and in their wheel chair staff ed or tucked the sling out of risible to others. The med it was a dignity issue emove or tuck the sling out of				
	On 0/07/04 at 0.50	a.m. the director of nursing				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00930	B. WING			C 08/27/2021		
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE				
EADO\	W LANE RESTORATIV	VE CARE CENTEF	AH AVENUE I, MN 56215					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
21805	Continued From pa	age 112	21805					
	sling for transfers v the sling hidden or dignity. Review of facility po Dignity dated 3/17/2 should be cared for and enhanced his of level of satisfaction and self esteem. R with dignity and res SUGGESTED MET director of nursing of policies and proceo treated with dignity designee could edu members on the pr nursing or her desig systems to ensure	expected residents who used a vith a mechanical lift to have removed in order to maintain olicy titled, Quality of Life 21, indicated each resident r in a manner that promoted or her sense of well being, with life, feeling of self worth esidents were to be treated spect at all times. THOD OF CORRECTION: The or her designee could develop dures to ensure residents are . The director of nursing or her ucate all appropriate staff rocesses. The director of gnee could develop monitoring ongoing compliance R CORRECTION: Twenty-One						

		& MEDICAID SERVICES				. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	`´CON	TE SURVEY MPLETED
		245313	B. WING _			C / 27/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				2209 UTAH AVENUE		
MEADOV	V LANE RESTORATIV	/E CARE CENTER		BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	0		
E 024 SS=C	with Appendix Z, Er Requirements, §48 during a standard re facility was NOT in The facility's plan or as your allegation of Department's acception Department's acception on the bottom of the form. Upon receipt of an a onsite revisit of you validate substantial regulation has been Policies/Procedurest CFR(s): 483.73(b)(0) §403.748(b)(6), §46 §441.184(b)(6), §46 §483.73(b)(6), §485 §485.68(b)(4), §485 §485.920(b)(5), §485 [(b) Policies and pro- develop and implempolicies and proced plan set forth in para assessment at para and the communicat this section. The pro- be reviewed and up [annually for LTC far	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 acceptable electronic POC, an r facility may be conducted to compliance with the n attained. s-Volunteers and Staffing	E 02	4		10/11/21
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					10/01/2021

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.

DEDADTMENT OF LIEALTH AND LIUMAN CEDVICES

		AND HUMAN SERVICES				PRINTED: 10/07/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245313	B. WING	;		C 08/27/2021
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	00/21/2021
MEADO	V LANE RESTORATIN	/E CARE CENTER			209 UTAH AVENUE	
					BENSON, MN 56215	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
E 024	Continued From pa	ge 1	E	024		
	volunteers in an err staffing strategies, i for integration of St health care profess during an emergen *[For RNHCIs at §4 procedures. (6) The emergency and oth	 as noted above] The use of hergency or other emergency including the process and role ate and Federally designated ionals to address surge needs cy. 03.748(b):] Policies and e use of volunteers in an her emergency staffing as surge needs during an 				
	procedures. (4) Th an emergency and strategies, including integration of State health care profess needs during an em This REQUIREMEN by: Based on interview facility failed to dev for volunteer suppo part of the facility's plan. This deficient affect all 25 resider facility. Findings include: A review of the facil	NT is not met as evidenced y and document review, the elop policies and procedures of during an emergency as emergency preparedness practice had the potential to the who currently resided in the lity's Meadow Lane			 It is the expectation of the factorial have policies and procedures for volunteer support during an emergant of the facility semergency preparedness plan. The facility emergency policies and procedur requested on August 27th were rand provided via email on August 2021. All residents have the potentia affected by failure to have policies 	rgency as res were reviewed it 31st, Il to be es and
	A review of the facility's Meadow Lane Restorative Care Center Disaster manual, updated August 2020, was conducted with the administrator present and she confirmed the findings. The manual included various topics which included bomb threat, fires, active shooter				procedures on volunteer support of the emergency preparedness The facility had last reviewed and the orientation for newly hired en transfers, volunteers last on Mar	plan. d revised nployees,

Facility ID: 00930

If continuation sheet Page 2 of 151

		AND HUMAN SERVICES			F	ORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION (X:	COM	E SURVEY PLETED
		245313	B. WING			(08/2	27/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	V LANE RESTORATIN	/E CARE CENTER			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
E 024	lacked documentat volunteer support d Additional facility vo	ge 2 rs. However, the manual ion of a policy for the use of uring an emergency. Iolunteer support during mentation was requested and	EC	024	 2021 and has since re-reviewed the policies and procedures. 3. The facility has assigned routine reviewing of annual requirements thromonthly QAPI to ensure that the facilith has at a minimum annually reviewed a revised policies and procedures to encompliance with regulatory requireme All staff in-service education is planned 10/4/2021 to include volunteer support during emergency. The expectation of facility is to educate and train new volunteers and new employees upon and annually. 4. Under the direction of the Administrative facility will review current policy ar update as indicated. Audits for new employee semergency preparedness policies and procedures for volunteers and staff weekly for 6 weeks and monifor 3 months. All findings will be brow to and monitoring through the monthly and the monthly and the monthly and the procedures and the monthly and	ty and isure ents. ed for rt of the hire rator, nd ss s s hthly ight	
	EP Training Progra CFR(s): 483.73(d)(EC	37	quality assurance committee.		10/11/21
	§441.184(d)(1), §48 §483.73(d)(1), §483 §485.68(d)(1), §483 §485.920(d)(1), §48	16.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 5.625(d)(1), §485.727(d)(1), 36.360(d)(1), §491.12(d)(1).					
	Hospitals at §482.1 at §484.102, "Orga OPOs at §486.360,	03.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs nizations" under §485.727, RHC/FQHCs at §491.12:] m. The [facility] must do all of					

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		AND HUMAN SERVICES				FORM	: 10/07/202 ² APPROVED . 0938-039 ²	
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE SURV COMPLETE C		
		245313	B. WING				3/27/2021	
	PROVIDER OR SUPPLIER	/E CARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
E 037	 (i) Initial training in opolicies and procedstaff, individuals produces arrangement, and vexpected roles. (ii) Provide emerge least every 2 years. (iii) Maintain documpreparedness training (iv) Demonstrate steprocedures. (v) If the emergence procedures are sign must conduct training procedures. *[For Hospices at § hospice must do all (i) Initial training in opolicies and proced hospice employees services under arrae expected roles. (ii) Demonstrate staprocedures. *[For Hospices at § hospice must do all (i) Initial training in opolicies and proced hospice employees services under arrae expected roles. (ii) Demonstrate staprocedures. (iii) Provide emerger least every 2 years. (iv) Periodically revemergency prepare employees (includin special emphasis procedures necess others. (v) Maintain documpreparedness training (vi) If the emergency preparedness training (vi) If the emergency procedures are signing the services are signing to the services are signing the services are signing to t	emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their ncy preparedness training at nentation of all emergency ing. taff knowledge of emergency y preparedness policies and nificantly updated, the [facility] ng on the updated policies and 418.113(d):] (1) Training. The l of the following: emergency preparedness dures to all new and existing a, and individuals providing angement, consistent with their aff knowledge of emergency ency preparedness training at iew and rehearse its edness plan with hospice ng nonemployee staff), with blaced on carrying out the arry to protect patients and entation of all emergency	EC	137				

If continuation sheet Page 4 of 151

		AND HUMAN SERVICES				FOR	D: 10/07/202 [,] M APPROVEE <u>D. 0938-039</u> ,	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURV COMPLETED C		
		245313	B. WING			08	3/27/2021	
NAME OF F	PROVIDER OR SUPPLIER	L		5	STREET ADDRESS, CITY, STATE, ZIP C	•		
MEADO	V LANE RESTORATIV	/E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 037	Continued From pa procedures.	age 4	E()37				
	program. The PRT (i) Initial training in policies and proced staff, individuals pro- arrangement, and v expected roles. (ii) After initial training preparedness train (iii) Demonstrate st procedures. (iv) Maintain docum preparedness training (v) If the emergence procedures are sig must conduct training procedures. *[For PACE at §460 organization must of (i) Initial training in policies and proced staff, individuals pro- arrangement, contr volunteers, consist (ii) Provide emergence least every 2 years (iii) Demonstrate st procedures, includii what to do, where to case of an emergence (iv) Maintain docum (v) If the emergence procedures are sig	aff knowledge of emergency nentation of all emergency ing. y preparedness policies and nificantly updated, the PRTF ng on the updated policies and 0.84(d):] (1) The PACE do all of the following: emergency preparedness dures to all new and existing oviding on-site services under ractors, participants, and ent with their expected roles. ncy preparedness training at aff knowledge of emergency ng informing participants of o go, and whom to contact in						

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245313	B. WING _				C 27/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT 2209 UTAH AVENUE	Y, STATE, ZIP CODE		
MEADO	V LANE RESTORATIV	E CARE CENTER		BENSON, MN 5621	15		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 037	Continued From pa	ge 5	E 03	7			
	Program. The LTC following: (i) Initial training in e policies and proced staff, individuals pro arrangement, and v expected role. (ii) Provide emerger least annually. (iii) Maintain docum preparedness traini (iv) Demonstrate sta procedures. *[For CORFs at §48 CORF must do all c (i) Provide initial tra preparedness polici and existing staff, ir under arrangement with their expected (ii) Provide emerger least every 2 years. (iii) Maintain docum (iv) Demonstrate sta procedures. All new and assigned speci the CORF's emerger their first workday. include instruction i alarm systems and equipment. (v) If the emerger	aff knowledge of emergency 35.68(d):](1) Training. The of the following: ining in emergency ies and procedures to all new individuals providing services , and volunteers, consistent roles. ncy preparedness training at					

If continuation sheet Page 6 of 151

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION		E SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			PLETED
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
E 037	Continued From pa	ge 6	E 0	37			
	*IFor CAHs at 8485	5.625(d):] (1) Training program.					
	The CAH must do a						
		emergency preparedness					
		lures, including prompt guishing of fires, protection,					
	and where necessa	ry, evacuation of patients,					
		sts, fire prevention, and efighting and disaster					
		engriting and disaster					
		g services under arrangement,					
	and volunteers, con roles.	isistent with their expected					
		ncy preparedness training at					
	least every 2 years.						
		entation of the training. aff knowledge of emergency					
	procedures.						
		cy preparedness policies and nificantly updated, the CAH					
		ng on the updated policies and					
	procedures.	0 1 1					
	*IFor CMHCs at 8/	85.920(d):] (1) Training. The					
		e initial training in emergency					
		ies and procedures to all new					
		ndividuals providing services , and volunteers, consistent					
	with their expected						
		ne training. The CMHC must					
		nowledge of emergency after, the CMHC must provide					
	•	edness training at least every 2					
		NT is not met as evidenced					
	by: Based on interview	<i>i</i> and document review, the			1. It is the expectation of the facilit	, to	
		elop a system to provide new			develop a system to provide new	y 10	
		n on the policies and			employee education on the policies	and	

		AND HUMAN SERVICES			ON		APPROVE 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	SURVEY PLETED
		245313	B. WING _			(08/2	C 27/2021
NAME OF	PROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/E CARE CENTER	2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
E 037	procedures for the preparedness plan deficient practice h residents who curre Findings include: A review of the faci Care Center manua conducted with the confirmed the findin various topics whic active shooter and the manual lacked provide new emplo and procedures for preparedness plan On 8/31/21, emerg were provided by th the following: -Director of Nursing employee emerger 8/30/21. -Registered nurse employee emerger 8/31/21. During an interview stated she had bee approximately a few Review of a facility	facility's emergency for 2 out of 3 employees. This ad the potential to affect all 25 ently resided in the facility. lity Meadow Lane Restorative al, updated October 2020, administrator present and she ngs. The manual included h included bomb threat, fires, natural disasters. However, documentation of a system to yee education on the policies the facility's emergency ency preparedness certificates he administrator and identified g (DON) completed the new hey preparedness education on (RN)-A completed the new hey preparedness education on on 8/27/21, at 9:53 a.m. RN-A en working at this facility for w months. staff record on 08/27/21, at	E 03	37	procedures for the facility's emerger preparedness plan. It was identified that the facility lack providing new hire education timely out of 3 employees who were review emergency preparedness training. was at the facility for a few months k completing her training on 8/21/202 DON hire date was 3/30/2021, how she did not begin employment at the facility until 5/5/2021, and her trainin completed on 8/30/21. Both had no completed their orientation within th expected 5 days of starting employn at facility, but since have completed 2. All employees are expected to ha completed emergency preparedness training timely. All new hires were reviewed to ensure compliance with emergency preparedness training requirements. No further employee found to be out of compliance. 3.To enhance currently compliant operations and under the direction of Administrator, an all-staff training is provided on 10/4/21 which includes re-education and review of the train EP policies and procedures. 4. Effective 10/1/2021, a quality assurance program was implement under the supervision to ensure on compliance with new hire orientation training. The Director of Clinical Education will audit current employee	ed for 2 wed for RN-A before 1. ever e ng ot e ment ave as of the being ing of ed strator going n and ees	
	approximately a few Review of a facility 10:37 a.m. identifie 3/30/21.	w months.			compliance with new hire orientation training. The Director of Clinical	n and ees eekly hs.	

Facility ID: 00930

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	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	
		245313	B. WING			C	
NAME OF	PROVIDER OR SUPPLIER	240313		STREET ADDRESS, CITY, STATE, ZIP COL	•	27/2021	
	W LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
E 037	newly hired employ revised 5/2019, ide shall be conducted transfers from othe services under con volunteers. All new personnel/voluntee attend a 10 hour or first 5 days of hire. INITIAL COMMENT On 8/23/21, to 8/27 survey was conduc investigation was a was found to be NO requirements of 42 Requirements for L The following comp SUBSTANTIATED: H5313059C (MNO cited at F677. H5313061C (MNO cited at F677, and I AND The following comp UNSUBSTANTIATE H5313060C (MNO The facility's plan o as your allegation of Departments accep enrolled in ePOC, y at the bottom of the	Pees, transfers, volunteers, last entified an orientation program for all newly employees, r departments, those providing tractual agreements, and ly hired rs/transfers, contractors must ientation program within their TS 7/21, a standard recertification ted at your facility. A complaint lso conducted. Your facility DT in compliance with the CFR 483, Subpart B, ong Term Care Facilities. blaints were found to be 0055846), with a deficiency F689.	E 03	37 the monthly quality assurance for further review and ongoing			

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		AND HUMAN SERVICES				FORM	: 10/07/2021 APPROVED : 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	COM	E SURVEY IPLETED C	
		245313	B. WING 08/22					
	PROVIDER OR SUPPLIER	/E CARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2009 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	onsite revisit of you validate that substa regulations has bee Resident Rights/Ex CFR(s): 483.10(a)(§483.10(a) Residen The resident has a self-determination, access to persons a outside the facility, this section. §483.10(a)(1) A fac with respect and dig resident in a manne promotes maintena her quality of life, re- individuality. The fa promote the rights of §483.10(a)(2) The fa access to quality ca severity of condition must establish and provision of service	acceptable electronic POC, an r facility may be conducted to initial compliance with the en attained. ercise of Rights 1)(2)(b)(1)(2) ht Rights. right to a dignified existence, and communication with and and services inside and including those specified in ility must treat each resident gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's cility must protect and	F C				10/11/21	
	§483.10(b) Exercise The resident has th rights as a resident or resident of the U	e of Rights. e right to exercise his or her of the facility and as a citizen nited States.						
	resident can exerci	facility must ensure that the se his or her rights without on, discrimination, or reprisal						

Facility ID: 00930

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE SURV COMPLETED C	
		245313	B. WING	;			_ 27/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
MEADO	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 550	Continued From pa from the facility.	ge 10	F	550			
	free of interference, reprisal from the fac- rights and to be sup exercise of his or his subpart. This REQUIREMEN by: Based on observat review the facility fa- utilizing a mechanic periods of time for 3 R21) who were dep of daily living and re- mechanical lift for the Findings include: R14 R14's quarterly MD R14 had severe con- diagnoses which in- poly-arthritis and lyr indicated R14 requi- bed mobility, transfe one staff for person R14's care plan rev had physical function impairment. The car staff assistance with for transfers and uti- mobility. During observations	S dated 7/13/21, indicated gnitive impairment and cluded: depression, mphedema. The MDS red two staff assistance with ers, dressing, toileting, and			 It is the expectation of the faci promote dignity while utilizing a mechanical lift sling for residents were dependent on staff for activi daily living and required the use of mechanical lift for transfers. R14 R21 were observed and reviewed ensure that their slings were not v their room or wheelchair, regardle they we or weren to in either; corr actions were reviewed and in place To promote dignity, all resident require the use of a mechanical lift not have their sling left visible in t room or wheelchair. All residents use a mechanical lift for transfers reviewed and appropriate interven place. No other residents were a affected. To enhance currently compliar operations and under the direction Director of Nurses, a nursing in-s training is planned on 10/4/21 wh includes re-education and honorin with residents including those why slings. Education provided include resident bill of rights, dignity and the 	who ties of f a , R1 and to visible in ess of if ective ce. s who ft should heir who were ntions in adversely theof the ervice ch ng dignity o use es	

Facility ID: 00930

If continuation sheet Page 11 of 151

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA				
	CONTRECTION	IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION		E SURVEY PLETED
					(0
		245313	B. WING		•	27/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2209 UTAH AVENUE	DE	
MEADOW	LANE RESTORATIV	E CARE CENTER		BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 550	Continued From pa	ae 11	F 5	50		
	•	's mechanical lift sling was		pertains to residents, their ro	oms/home,	
	visibly draped over	the sides and back of her		and audits implemented. Po	licies	
		s not tucked in around her or sat in her wheel chair.		reviewed include Quality of L dated 3-17-21.	ife: Dignity	
	Terrioved write she					
		s on 8/24/21, at 10:02 a.m.		4. Effective 10/1/2021, a qua		
		her wheel chair in her room	14's mechanical lift sling ad over the sides and back under the supervision of the Director of Nursing to monitor supervision to ensur			
		nd was not tucked in around		ongoing compliance with promoting		
		le she sat in her wheel chair.		dignity. The Director of Nurs		
		was out in the activity room I chair with other residents		will audit residents 2 times a weeks and then once a week		
		ere playing family feud. R14's		Any identified deficiencies wi		
	mechanical lift sling	remained the same.		corrected, and all findings bro		
		was out in the activity room I chair with other residents		monthly quality assurance co		
		ere playing bingo. R14's		further review and ongoing m	ionitoring.	
		remained the same.				
	During observations	s on 8/25/21, at 8:52 a.m.				
		IA-B) went out into the hallway				
		e and returned to R14's room,				
		hanical lift over R14, hooked /hile trained medication aid				
		e room. NA-B and TMA-A				
	transferred R14 via	mechanical lift from her bed				
		unhooked the lift from the sling				
		I her hands and immediately -B applied foot peddles to				
		placed her feet on the peddles,				
		and covered R14's legs with it.				
		wheeled R14 out of her room, wards the dining room area,				
		ble with other residents in the				
	area and immediate	ely left. R14's mechanical lift				
		aped over the sides and the				
		hair and was not tucked in wed while she sat in her wheel				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT	E SURVEY IPLETED
		245313	B. WING				C 27/2021
NAME OF	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	1 000	
MEADO	W LANE RESTORATIV			2	2209 UTAH AVENUE		
WILADO				I	BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550	chair. - at 9:36 a.m. R14 r room area with othe have her mechanica the sides and back not observed to offer mechanical lift sling it while R14 sat in h On 8/25/21, at 9:14 above findings and sling with a mechar NA-B indicated the in out of site or rem dignity. On 8/27/21, at 9:36 member about dign member did not ans R1 Findings include: R1's quarterly Minin 8/17/21, identified F depression weakne (numbness/tingle in identified R1 had se and required extens of daily living (ADL's toileting and locomo used assistive device R1's care plan revis impaired cognition, required the use of	remained seated in the dining er residents and continued to al lift sling visibly draped over of her wheelchair. NA-B was er or attempt to tuck the j out of other's view or remove er wheel chair. a.m. NA-B confirmed the indicated R14 utilized the nical lift for all of her transfers. sling should have been tucked oved to maintain R14's a.m. attempted to call family ity with use of sling and family	F 5	550			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED B. WING NAME OF PROVIDER OR SUPPLIER 245313 B. WING 08/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE BENSON, MN 56215 08/27/2021 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETION DATE F 550 Continued From page 13 wheelchair and required extensive assistance with locomotion. R1's care plan lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. F 550 R1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance of two staff and the use of a full body mechanical lift to transfer. The care guide lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. No 8/23/21, at 6:08 p.m. R1 was observed seated in a wheelchair in the hallway, wheeled down the hall by nursing assistant (NA)-H towards the dining room, a blue mechanical lift transfer sling Image: slink transfer slink		-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
245313 B. WING				· /		E CONSTRUCTION	(X3) DATE	E SURVEY
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) COMPLETION DATE F 550 Continued From page 13 wheelchair and required extensive assistance with locomotion. R1's care plan lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. F 550 R1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance of two staff and the use of a full body mechanical lift to transfer. The care guide lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. F 1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance of two staff and the use of a full body mechanical lift to transfer. The care guide lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. On 8/23/21, at 6:08 p.m. R1 was observed seated in a wheelchair in the hallway, wheeled down the hall by nursing assistant (NA)-H towards the dining room, a blue mechanical lift transfer sling			245313					
MEADOW LANE RESTORATIVE CARE CENTER BENSON, MN 56215 Image: Construct of the state of	NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLÉTION DATE F 550 Continued From page 13 wheelchair and required extensive assistance with locomotion. R1's care plan lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. F 550 R1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance of two staff and the use of a full body mechanical lift to transfer. The care guide lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. On 8/23/21, at 6:08 p.m. R1 was observed seated in a wheelchair in the hallway, wheeled down the hall by nursing assistant (NA)-H towards the dining room, a blue mechanical lift transfer Sling	MEADOW	V LANE RESTORATIV	E CARE CENTER					
 wheelchair and required extensive assistance with locomotion. R1's care plan lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. R1's nursing assistant care guide dated 8/26/21, revealed R1 required extensive assistance of two staff and the use of a full body mechanical lift to transfer. The care guide lacked direction for placement of the sling used to transfer R1 with the full body mechanical lift. On 8/23/21, at 6:08 p.m. R1 was observed seated in a wheelchair in the hallway, wheeled down the hall by nursing assistant (NA)-H towards the dining room, a blue mechanical lift transfer sling 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
 hung over the back and sides of R1's wheelchair approximately five to six inches. R1 was wheeled to the dining room which held several residents, to a squared table next to another resident and NA-H walked away. On 8/24/21, at 8:50 a.m. R1 was observed seated in a wheelchair in the dining room at a squared table next to another resident. R1 was observed seated on a blue mechanical lift transfer sling which hung over the back and sides of R1's wheelchair approximately five to six inches. - at 11:32 a.m. R1 was observed seated in a wheelchair in the facility activity room with several other residents, a blue mechanical lift transfer lift sling hung over the back and the sides of R1's wheelchair approximately five to six inches. - at 11:36 a.m. R1 was observed seated in a wheelchair approximately five to six inches. - at 11:36 a.m. R1 was observed seated in a wheelchair approximately five to six inches. - at 11:36 a.m. R1 was observed seated in a wheelchair approximately five to six inches. - at 11:36 a.m. R1 was observed seated in a wheelchair, with a blue mechanical lift sling hanging over the back and sides of her wheelchair and NA-D wheeled R1 to her room 	F 550	wheelchair and requ with locomotion. R1 for placement of the the full body mecha R1's nursing assista revealed R1 requires staff and the use of transfer. The care of placement of the slit the full body mecha On 8/23/21, at 6:08 in a wheelchair in th hall by nursing assist dining room, a blue hung over the back approximately five to to the dining room w to a squared table r NA-H walked away. On 8/24/21, at 8:50 in a wheelchair in th table next to another seated on a blue m which hung over the wheelchair approxir - at 11:32 a.m. R1 w wheelchair, with a b hanging over the back	uired extensive assistance 's care plan lacked direction e sling used to transfer R1 with inical lift. ant care guide dated 8/26/21, ed extensive assistance of two a full body mechanical lift to guide lacked direction for ing used to transfer R1 with inical lift. p.m. R1 was observed seated he hallway, wheeled down the stant (NA)-H towards the mechanical lift transfer sling and sides of R1's wheelchair to six inches. R1 was wheeled which held several residents, hext to another resident and a.m. R1 was observed seated he dining room at a squared er resident. R1 was observed echanical lift transfer sling a back and sides of R1's mately five to six inches. vas observed seated in a cility activity room with several lue mechanical lift transfer lift back and the sides of R1's mately five to six inches.	F 5	50			

Facility ID: 00930

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		AND HUMAN SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MLII T	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` ´				PLETED
			_			(C
		245313	B. WING				27/2021
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
	V LANE RESTORATIV	E CARE CENTER		2	209 UTAH AVENUE		
	VEANE REDIORANI			E	BENSON, MN 56215		
(X4) ID			ID				(X5) COMPLETION
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
			1				
F 550	•	-	F 5	50			
		om. NA-C entered R1's room					
		chanical lift. NA-D and NA-C ical lift in front of R1, took hold					
		ap which R1 was seated on,					
		traps to the mechanical lift					
		to bed. NA-C and NA-D					
		nechanical lift sling from					
	underneath RT and	placed it in the wheelchair.					
	On 8/25/21, at 8:24	a.m. R1 was observed seated					
		er room, her eyes were					
		Ited back and her mouth was					
		ed on a blue full body sfer sling, which hung over the					
	sides and the back						
		was observed seated in a					
		s wheeled by trained					
		A)-A towards her room. into her room, obtained a full					
		t and the occupational therapy					
	assistant, they proc	eeded to gather the straps					
		rneath R1, attached the straps					
		ed R1 to transfer from her TMA-A removed the sling from					
		placed it into the wheelchair.					
		p					
		8 a.m. NA-C indicated R1 was					
		n staff for all ADL's and was					
		of her needs. NA-C stated /as kept underneath R1 when					
		he wheelchair for ease of use.					
		a.m. NA-E stated R1 was					
		for transfers and required the					
		echanical lift. NA-E indicated underneath her in the					
		s easier on R1 to leave the					
		er. NA-E indicated R1's sling					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG			
		245313	B. WING		C 08/27/202		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	E CARE CENTER			BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	and straps were usi her wheelchair. On 8/25/21, at 10:2 was dependent on s required the use of transfers into bed. T transfer R1 was left was in her chair and TMA-A indicated the R1 was usually visil her wheelchair. On 8/26/21, at 10:4 placed to R1's fami was left. R21 R21 R21's significant ch (MDS) dated 8/4/21 cognitive impairmer included Alzheimer' and thyroid disorder identified R21 requi transfers, and exter	ange Minimum Data Set , identified R21 had significant that and diagnoses which so disease, muscle weakness that and diagnose with her when she	F 5	50			
	R21's significant ch (CAA) dated 8/5/21 dementia and was r wants or needs. Th dependent on staff locomotion. R21's C	CAA identified R21 required we with bed mobility and					

Facility ID: 00930

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	R21's care plan rev required extensive a all transfers and ha related to Alzheime On 8/23/21, at 5:11 wheelchair in her ro visible from the hall sling was visibly dra of her wheelchair by was in the dining ro mechanical lift sling the sides and back On 8/24/21, at 11:5 wheelchair in her ro was visible from the lift sling was visibly back of her wheelch On 8/24/21, at 1:13 (LPN)-A was transp to her room. R21's visibly draped over wheelchair by 3-4 ir assistant (NA)-F an assisting R21 with a wheelchair to her be draped around R21 until they completed wheelchair to her be On 8/25/21, at 11:4 wheelchair and the visibly draped on be and shoulders. R21 other residents and	 ised 7/12/21, identified R21 assistance with full body lift for d impaired thought processes r's disease. p.m. R21 was in her pom with the door open and way. R21's mechanical lift aped over the sides and back y 3-4 inches. At 5:57 p.m. R21 pom in her wheelchair while the gremained visibly draped over of her wheelchair. 6 a.m. R21 was sitting in her pom with the door open and e hallway. R21's mechanical draped over the sides and hair. p.m. licensed practical nurse porting R21 down the hallway mechanical lift sling remained the sides and the back of the nches. At 1:36 p.m. nursing ad NA-G were in R21's room a mechanical lift from her ed. R21's sling had remained 's wheelchair sides and back d R21's transfer from her ed. 5 a.m. R21 was in her mechanical lift sling was oth sides and above her back was in the activity room with 	F 5	550			

Facility ID: 00930

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		AND HUMAN SERVICES & MEDICAID SERVICES				FO	TED: 10/07/2021 ORM APPROVED NO. 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		245313	B. WING	i			C 08/27/2021
NAME OF PR	OVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	LANE RESTORATIV	E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
U IA N V O () Fiint Star K r O O O O the seaves O () stho F E said a	eave them in the w NA-E said she tried vere not visible to c On 8/27/21, at 10:29 CM)-A confirmed n have been removed indicated the mecha- used were designed he wheelchair or be stated she expected be removed for all r ceeping them in the esidents' risk of de CM-A confirmed it v On 8/26/21, at 2:21 confirmed the above he resident was up should have remove ight so it was not v idministrator confirm when staff did not re- sight of others. On 8/27/21, at 9:50 DON) stated she e shing for transfers w he sling hidden or r lignity. Review of facility po Dignity dated 3/17/2 should be cared for and enhanced his o evel of satisfaction	 acchanical lift slings was to heelchair of the residents. to tuck them in so the slings others. 9 a.m. clinical manager mechanical lift slings should after each use. CM-A anical lift slings the facility d to be easily removed from ed after each use. CM-A d the mechanical lift slings to esidents and indicated e wheelchair increased the veloping skin tears or bruises. vas a dignity issue as well. p.m. the administrator e findings and indicated once and in their wheel chair staff ed or tucked the sling out of risible to others. The med it was a dignity issue emove or tuck the sling out of a.m. the director of nursing xpected residents who used a rith a mechanical lift to have removed in order to maintain blicy titled, Quality of Life 21, indicated each resident in a manner that promoted or her sense of well being, with life, feeling of self worth esidents were to be treated 	F	550			

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		AND HUMAN SERVICES	_			FORM	: 10/07/2021 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /		E CONSTRUCTION	CON	E SURVEY IPLETED C
		245313	B. WING				27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	Personal Privacy/C CFR(s): 483.10(h)(onfidentiality of Records 1)-(3)(i)(ii)	F 5	583			10/11/21
	The resident has a	and Confidentiality. right to personal privacy and s or her personal and medical					
	accommodations, r telephone commun and meetings of far	nal privacy includes nedical treatment, written and ications, personal care, visits, nily and resident groups, but e the facility to provide a ch resident.					
	residents right to per right to privacy in hi written, and electro the right to send an mail and other lette materials delivered	facility must respect the ersonal privacy, including the is or her oral (that is, spoken), nic communications, including d promptly receive unopened rs, packages and other to the facility for the resident, vered through a means other ce.					
	and confidential per (i) The resident has of personal and me provided at §483.70 federal or state law (ii) The facility must Office of the State I to examine a reside administrative recor- law.	resident has a right to secure rsonal and medical records. the right to refuse the release edical records except as D(i)(2) or other applicable s. t allow representatives of the Long-Term Care Ombudsman ent's medical, social, and rds in accordance with State					
	Based on observat	tion, interview and document ailed to provide privacy during			1. It is the expectation of the facility provide privacy to residents during	/ to	

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	0938-039 SURVEY
AND PLAN (OF CORRECTION	DENTIFICATION NUMBER:		G	COM	PLETED
		245313	B. WING			
	PROVIDER OR SUPPLIER	245313	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	08/2	27/2021
	V LANE RESTORATI	VE CARE CENTER		2209 UTAH AVENUE		
				BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 583	Continued From pa	age 19	F 58	3		
		3 of 7 residents (R2, R22, ing personal cares.		personal cares. R2, R22, R21 we reviewed, and staff educated to en	nsure	
	R2			compliance with providing privacyresidents during personal cares.2. All residents are expected to be		
	 8/18/21, identified I had diagnoses whi accident (CVA) (str one side of the boo on one side of the required extensive transfers. R2's care plan revi a physical function assistance of one side 	mum Data Set (MDS) dated R2 was cognitively intact and ch included: cerebrovascular roke), hemiplegia (paralysis on dy) and hemiparesis (weakness body). R2's MDS indicated R2 assistance with dressing and sed 7/12/21, identified R2 had ing deficit and required staff with dressing, personal erring while using a standing		 provided privacy and can be affected by the deficient practice. All residents were reviewed an no other incidents were identified. 3. To enhance currently compliant operations and under the direction of the director of nurses, a nursing in-service training is planned on 10/4/21 which includes re-education and review of facility policies and providing privacy reviewed. 4. Effective 10/1/2021, a quality assurance program was implemented under the supervision of the Director of Nursing to monitor supervision to ensure 		
	and nursing assista sitting position with mechanical lift out which was near R2 room. The privacy against the wall wh wheelchair facing F R2's pants were pu her brief was visibl her feet onto the lift legs and NA-E app waist. CM-A raised pants remained do bare thighs and bri facing R2 . CM-A a and R2's roommate repeatedly. CM-A a	B a.m. clinical manager (CM)-A ant (NA)-E assisted R2 to a the use of the sit to stand of the right side of the bed 2's roommate's side of the curtain was pulled back ille R2's roommate sat in her R2 and R2's side of the room. Illed down to her thighs and e. CM-A assisted R2 to place t, applied the strap around her lied the harness around her R2 up in the lift while R2's wn, continued to expose her ef and R2's roommate was and NA-E asked R2 questions e responded by saying yeah and NA-E moved R2 towards in the lift while her pants		ongoing compliance with providing privacy. The Director of Nursing/Designee will audit weekl weeks and then monthly for 3 mon Any identified deficiencies will be corrected, and all findings brough monthly quality assurance commin further review and ongoing monito	y for 6 nths. t to the ttee for	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 583	remained down and exposed and the fe inches away from F up R2's pants and 0 wheelchair with the R2 to put a sweat s the room in her whe On 8/26/21, at 1:54 roommate had been transfer and they ha of R2's roommate. assisted R2 to trans side which faced R2 room. NA-E stated transfer R2 when he room or to pull the p NA-E indicated R2 get her up and NA- not pull the privacy On 8/27/21, at 10:4 interview CM-A con privacy for R2 durin CM-A stated the pri pulled between R2 R2's transfer out of normal practice was between residents of was aware of the ne On 8/27/21, at 1:38 (DON) stated her en privacy to be assure privacy curtains and stated when a residents	d her thighs and brief were et of the lift were only a few 82's roommate. NA-E pulled CM-A lowered R2 to the use of the lift. NA-E assisted hirt on and assisted R2 out of belchair. a.m. NA-E indicated R2's an in the room during R2's ad pulled up R2's pants in front NA-E indicated they always sfer out of bed on her right 2's roommate's side of the her usual practice was to er roommate was not in the privacy curtain between them. had been hollering at her to E was in a hurry, so she did curtain. 1 a.m. during a phone firmed they had not provided to g her transfer out of bed. vacy curtain should have been and R2's roommate during bed. CM-A indicated her s to pull the privacy curtain during cares and indicated she	F 5	583			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
			A. BUILDIN	NG		C
		245313	B. WING		08/	27/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	V LANE RESTORATIV	E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 583	Continued From pa	ge 21	F 58	33		
	R22					
	(MDS) dated 8/6/21 cognitive impairmer included: dementia, (high blood pressur	ange Minimum Data Set , identified R22 had significant nt and diagnoses which arthritis and hypertension e). R22's MDS indicated R22 assistance with bed mobility, onal hygiene.				
	had an activities of performance deficit and limited mobility included extensive	vised 8/13/21, identified R22 daily living (ADL) self-care related to advanced dementia . R22's care plan interventions assistance of one staff for hygiene, and bed mobility.				
	bed and informed F with her cares. NA- sheet, which R22 d R22's sheet and pro gown, while R22 re right arm and hand. sheet, R22 laid exp down to her feet; wi sheet and blanket b Additionally, the priv provide privacy. NA R22's brief, checker R22's bed to the low sink and obtained F wash cloth and town her bed side table. her face and provid in the bed, uncover down to her feet wit	a.m. NA-B raised up R22's R22 she would be assisting her B asked R22 to let go of the id and NA-B pulled down beceded to remove R22's peatedly grabbed at NA-B's After NA-B pulled down the osed in her bed from her neck th only a brief on and her bunched down by her feet. vacy curtain was not pulled to -B unfastened the tabs of d R22's brief and lowered w position. NA-B went to the R22's basin of water, soap, el and placed it beside R22 on NA-B instructed R22 to wash ed assistance. R22 remained ed and exposed from her neck th only her brief on, while the aid bunched up at the foot of				

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MEADOW LANE RESTORATIVE CARE CENTER					209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 583	her bed. At 7:45 a.r knocked on the doo then said "laundry, NA-B assisted R22 arms, while R22 sa NA-B informed R22 brief and assisted F uncovered and exp her feet. NA-B pulle her perineal area in the closet to obtain fully exposed from I NA-B returned to R from under her, wa a new brief. At 7:48 door, began to oper laundry now could k answer HK-A, surve body in front of doo HK-A closed the do R22's shirt and at 8 socks and pants. On 8/25/21, at 10:0 had not provided R2 exposed from her n cares. NA-B stated privacy and provide residents. On 8/27/21, at 11:4. interview family me a very modest pers she was exposed d R22's bed was righ opened the door du exposed that would for R22. FM-A india	n, housekeeper (HK)-A br, opened the door slightly I will come back". At 7:46 a.m. by washing her hands and t up on the edge of the bed. 2 she would assist her with the R22 to lay back down, still osed from her neck down to ed R22's brief down, cleansed in the front, dried her, went to a new brief while R22 was her neck down to her feet. 22's bed, removed the brief shed her buttocks and applied 9 p.m. HK-A knocked on the in the door and asked if be delivered. NA-B did not eyor blocked view by moving or opening, answered no and bor. At 7:55 a.m. NA-B applied 8:00 a.m. NA-B applied R22's 46 a.m. NA-B confirmed she 22 privacy by leaving her neck down to her feet during it was expected staff provide a dignified experience for 2 a.m. during a phone mber (FM)-A stated R22 was on and she would not like it if luring cares. FM-A indicated t by the door and if someone uring cares while she was I be an undignified experience cated she expected the facility luring cares for R22.	F 5	583			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			
		245313	B. WING _				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	·	
MEADOV	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE SENSON, MN 56215		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 583	Continued From pa	ge 23	F 58	33			
	R21						
	(MDS) dated 8/4/21 cognitive impairmer included: Alzheimer and thyroid disorder R21 required total a	ange Minimum Data Set , identified R21 had significant nt and diagnoses which 's disease, muscle weakness r. R21's MDS further indicated assistance with transfers, he with bed mobility, dressing ne.					
	required extensive a personal hygiene and and was to be check R21's care plan ide	ised 7/12/21, identified R21 assistance with dressing, nd R22 did not use the toilet ked and changed periodically. ntified R21 had impaired related to Alzheimer's disease.					
	room. R21's door w on her bed, with her next to her bed. NA bed, pulled down R exposed her brief a pants had been pull checked her brief, t over her to cover her down around her th privacy curtain or sl R21's brief for incor exposed from the h	9 a.m. during a phone					
	interview CM-A con	firmed she expected staff to ivacy as possible for residents					
	On 8/27/21, at 12:5	4 p.m. NA-H stated he had					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED C
		245313	B. WING _			27/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE		
MEADOV	V LANE RESTORATIV	E CARE CENTER		BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 583 F 655 SS=D	afternoon. NA-H inc close R21's door wi incontinence. NA-H practice was to closs providing cares to p On 8/27/21, at 1:19 (DON) confirmed sl privacy and promote residents, which inc being bathed, etc. The facility policy tit Assisting the Resid 3/17/21, instructed a much privacy as po dressing or undress The facility policy tit Information And Pe identified the facility resident's privacy re care. Baseline Care Plan CFR(s): 483.21(a)(1) §483.21 Comprehe Planning §483.21(a) Baseline §483.21(a)(1) The f implement a baseline that includes the ins effective and person that meet professio The baseline care p	continence on 8/23/21, in the dicated he had forgotten to hen he checked her for indicated indicated the usual be resident's doors when provide privacy. p.m. director of nursing he expected staff to provide e dignity during cares for all cluded covering areas not led Dressing And Undressing, ent With Level II dated staff to allow the resident as ssible while he or she was sing. led Confidentiality of rsonal Privacy, dated 3/17/21, would strive to protect the egarding his or her personal 1)-(3) nsive Person-Centered Care e Care Plans facility must develop and he care plan for each resident structions needed to provide n-centered care of the resident nal standards of quality care.	F 58	3		10/11/21
	effective and person that meet professio The baseline care p (i) Be developed wit	n-centered care of the resident nal standards of quality care. blan must-				

Facility ID: 00930

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		AND HUMAN SERVICES				FORM	10/07/202 APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	`´CO№	E SURVEY IPLETED	
		245313	B. WING			C 08/27/2021		
	PROVIDER OR SUPPLIER	/E CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE BENSON, MN 56215	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 655	necessary to prope including, but not lin (A) Initial goals bass (B) Physician order (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recom §483.21(a)(2) The comprehensive car care plan if the com (i) Is developed with admission. (ii) Meets the require (b) of this section (at this section). §483.21(a)(3) The resident and their re- of the baseline care limited to: (i) The initial goals (ii) A summary of the dietary instructions. (iii) Any services at administered by the on behalf of the fac (iv) Any updated info of the comprehensi This REQUIREMEN by: Based on interview facility failed to pro- baseline care plan	mum healthcare information rly care for a resident mited to- ed on admission orders. s. es. mendation, if applicable. facility may develop a e plan in place of the baseline prehensive care plan- thin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the epresentative with a summary e plan that includes but is not of the resident. he resident's medications and nd treatments to be e facility and personnel acting	F€	\$55	1. It is the expectation of the fac ensure compliance with providing baseline care plan to the residen resident representative after they admitted. R26 no longer resides facility.	the t or have		

Facility ID: 00930

		AND HUMAN SERVICES				10/07/202 APPROVE <u>0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COM	E SURVEY PLETED
		245313	B. WING			_ 27/2021
NAME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO	•	
MEADOV	V LANE RESTORATIV	VE CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 655	Continued From pa	age 26	F 65	5		
	Continued From page 26 Findings include: R26's admission Minimum Data Set (MDS) dated 6/19/21, identified R26 was admitted to the facility on 5/28/21. The MDS indicated R26 was cognitively intact and had diagnoses which included: hypertension, diabetes mellitus and respiratory failure. The MDS indicated R26 required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. Review of the undated form titled Individual Resident Baseline Care Plan identified the form was completed by nursing staff. The form lacked any documentation R26 or R26's representative had received a copy of the care plan. Additionally, the form lacked a signature from R26 or R26's representative. On 8/27/21, at 11:09 a.m. clinical manager (CM)-A was interviewed via telephone. CM-A indicated the 24 hour care plan was to be completed right away upon admission and staff were to review it with the resident. CM-A indicated after reviewing it, staff were expected to have the resident sign it when completed and to provide them a copy of the baseline care plan.			2. All residents could be affer deficient practice, and other admissions were reviewed a residents were adversely aff 3. To enhance currently com operations and under the dir director of nurses, a nursing training is planned on 10/4/2 includes re-education of the policies and procedures for I plans to ensure ongoing con 4. Effective 10/1/2021, a qua assurance program was imp under the supervision of the Nursing to ensure compliand providing baseline care plan recently admitted. The Dire Nursing/Designee will audit weeks and then monthly for Any identified deficiencies w corrected, and all findings br monthly quality assurance co further review and ongoing r	recent ind no other ected. ipliant rection of the in-service 1 which facility baseline care npliance. ality blemented Director of ce with s for residents ector of weekly for 6 3 months. ill be rought to the pommittee for	
	(DON) confirmed the she expected staff plan within 48 hour	27 a.m. the director of nursing the above finding and indicated to complete the baseline care rs, review it with the resident or ative and provide them with a				
	On 8/27/21, request care plans and one	sted a policy regarding baseline was not provided.				

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		AND HUMAN SERVICES			F	ORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>´</i>		E CONSTRUCTION (X	COM	E SURVEY PLETED C
		245313	B. WING				27/2021
NAME OF F	ROVIDER OR SUPPLIER	1	<u> </u>	ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATI	/E CARE CENTER			209 UTAH AVENUE		
				D	ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From pa	qe 27	F 6	57			
	Care Plan Timing a CFR(s): 483.21(b)(nd Revision	F 6				10/11/21
		ehensive Care Plans mprehensive care plan must					
	 (i) Developed withir the comprehensive (ii) Prepared by an includes but is not I (A) The attending p (B) A registered nur resident. (C) A nurse aide wi resident. (D) A member of fo (E) To the extent pr 	interdisciplinary team, that imited to hysician. rse with responsibility for the th responsibility for the od and nutrition services staff. acticable, the participation of					
	An explanation mus medical record if th and their resident re not practicable for t resident's care plar (F) Other appropria disciplines as deter or as requested by	te staff or professionals in mined by the resident's needs					
	team after each as comprehensive and assessments. This REQUIREMEN by: Based on interview facility failed to ens	sessment, including both the d quarterly review NT is not met as evidenced v, and document review, the ure residents/resident			1. It is the expectation of the facility tensure residents/resident representat	ives	
		re allowed to participate in of 1 residents (R23) reviewed			are allowed to participate in the plann of care. R23 had not had an initial ca conference held within 72 hours of admission, but since has had a care conference and has participated in the	re	

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		AND HUMAN SERVICES			I	FORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION (>	COMF	E SURVEY PLETED
		245313	B. WING			08/2	, 27/2021
NAME OF	PROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	00/1	
MEADO	W LANE RESTORATIV	VE CARE CENTER			09 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	R23's quarterly Min 9/8/21, indicated R2 had diagnoses whis stroke, and hemiple indicated R23 was of daily living. On 8/23/21, at 3:00 attended any care of of and could not rea of and could not rea	himum Data Set (MDS) dated 23 was cognitively intact and ch included: diabetes mellitus, egia or hemiparesis. The MDS independent with all activities 0 p.m R23 indicated he had not conference that he was aware call anyone going over his plan ring a care conference are Conference Summary , to 8/27/21, revealed the are conference summary eted and care conference was	F 6	57	planning of his care. 2. All residents and their representati are allowed to participate in the plann of their care. All other residents were reviewed, no deficient practices foun 3. To enhance currently compliant operations and under the direction of director of nurses, a nursing in-servic training is planned on 10/4/21 which includes re-education of the facility expectations to ensure residents and their representatives are allowed to participate in the planning of care. 4. Effective 10/1/2021, a quality assurance program was implemente under the supervision of the Director Nursing to ensure compliance with providing participation of care plannin residents and their representatives. Director of Nursing/Designee will aud weekly for 6 weeks and then monthly months. Any identified deficiencies v corrected, and all findings brought to monthly quality assurance committee further review and ongoing monitorin	ning e id. f the ce d d of ng for The dit y for 3 will be o the e for	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245313	B. WING _) 2/80	C 27/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE		
				BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	care conferences o ensure everyone at including the reside On 8/26/21, at 2:07 (DON) confirmed th care conferences w admission and quare expected staff to hor required. On 8/27/21, reques conferences and or ADL Care Provided CFR(s): 483.24(a)(2) §483.24(a)(2) A res out activities of daily services to maintain personal and oral h This REQUIREMEN by: Based on observat review the facility far routine grooming w removal and oral car R11, R14, R6, R1, F dependent on facilit living (ADL's). Furth routine incontinence clothing for 1 of 1 re routine checking an Findings include:	expected staff to hold the n a regular basis and to tended the care conferences nt and his representative. p.m. the director of nursing he above finding and indicated vere to be held upon terly. The DON indicated she old the care conferences as ted a policy regarding care he was not provided. for Dependent Residents 2) ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview and document hich included facial hair ares for 7 of 7 residents (R18, R21, R22) who were cy staff for activities of daily her, the facility failed to provide e cares and changing of soiled esident (R6) reviewed for	F 65	7 7 1. It is the expectation of the facility with routine grooming which include facial hair removal and oral cares for residents that were dependent of st activities of daily living. It is also an expectation that routine incontinence cares are provided, and soiled cloth changed appropriately. Upon identification, R18, R11, R14, R6, R and R22 were reviewed and observe ensure compliance with facial hair removal and oral cares. R6 was rev to ensure clothing wasn □t soiled and	ed or caff for ce hing 21, R21 red to viewed nd to	10/11/21
	R18			observe compliance with routine ch and changing for cares.	eck	

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		AND HUMAN SERVICES				FORM	10/07/202 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURV COMPLETE C	
		245313	B. WING				_ 27/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIN	/E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 677	7/21/21, identified F impairment and had chronic obstructive and anxiety. The M independent with be dressing, toileting, of R18's care plan rev had physical function impairment and more plan indicated R18 for set up, assist as shower and person During observations was walking around independently with noted to be uncomb the back of her heat head. R18's hair wat the back side of her head. - at 4:32 p.m. R18 v independently with continued to be uncom- tion for the set of her head. - at 4:34 p.m. R18 v independently with continued to be uncom- 5:26 p.m. R18 wa independently with continued to be uncom- During observations was standing up at	imum Data Set (MDS) dated R18 had severe cognitive d diagnoses which included: pulmonary disease, arthritis DS indicated R18 was ed mobility, transfers, eating and personal hygiene. rised on 3/23/20, indicated R18 oning deficit related to self care obility impairment. The care required assistance from staff a needed and assist of one for al hygiene. s on 8/23/21, at 2:38 p.m. R18 d the nursing home her walker. R18's hair was bed and her hair was pasted to d and to the right side of her as also sticking straight up on r head and the right side of her walked out of her room her walker and her hair combed. lked into the dining room area her walker and her hair	F 6	577	 All resident s needing assistar routine grooming and routine incordicates have the potential to be affet the deficient practice. All residents reviewed and observed to ensure compliance; no other deficient prawere identified. The facility did rebody/facial hair trimming equipme ensure that it is available and funct properly. Processes were reviewe new admissions to ensure further compliance with ADL cares. Ongo review of resident s grooming, faskin, incontinence, and ADLs are reviewed during care conferences more frequently as needed. To enhance currently compliant operations and under the direction director of nurses, a nursing in-set training is planned on 10/4/21 which includes re-education of the facility policies to aid with assisting reside their activities of daily living. Effective 10/1/2021, a quality assurance program was implemented including but not limit include facial care, clothing, hair, fingernails, body, skin, teeth and incontinence cares for resident sincentine to some sident side the index of the some sident side the and incontinence cares for resident side the sident s	ntinence cted by s were ctices view the nt to tions d for ing cial hair, and of the vice ch / ent with	
	the back and left sid	air was uncombed, pasted to de of her head. R18's hair was on the left and back of her			dependent on staff for activities of living. The Director of Nursing/De will audit weekly for 6 weeks and t monthly for 3 months. Any identifi	signee hen	

Facility ID: 00930

		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED C
		245313	B. WING				27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		22	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	R18 walked down t her walker and sat entrance area. R18 to the back and left was sticking straigh of her head. - 11:39 a.m. R18 w area drinking pop a uncombed. During observation R18 walked down t her walker and her sticking straight up On 8/26/21, at 11:1 (NA)-A confirmed F and verbal reminder personal hygiene ta should have followed have ensured her p been completed an On 8/26/21, at 2:07 (DON) confirmed th indicated staff should care plan. The DON were for staff to ens properly groomed at R11 R11's annual MDS had severe cognitive diagnoses which in	s on 8/25/21, at 10:38 a.m. the hallway independently with down in a chair in the main d's hair was uncombed, pasted side of her head. R18's hair at up on the left and the back as seated in the dining room and her hair continued to be s on 8/26/21, at 11:13 a.m. the hallway independently with hair was uncombed and all over. 1 a.m. nursing assistant R18 needed staff assistance ers to complete ADL's and asks. NA-A indicated staff ed R18's care plan and should bersonal hygiene tasks had id her hair was combed. 7 p.m. the director of nursing the above findings and uld have been following the N indicated her expectations sure the residents were	F	577	deficiencies will be corrected, and findings brought to the monthly qua assurance committee for further re and ongoing monitoring.	ality	

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		AND HUMAN SERVICES					FORM	: 10/07/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION		CON	E SURVEY IPLETED C
		245313	B. WING					27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP 2209 UTAH AVENUE BENSON, MN 56215	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD	BE	(X5) COMPLETION DATE
F 677	transfers, dressing, hygiene. R11's care plan rev had ADL self care p confusion and impa- identified R11 requi- staff for dressing and During observation was seated in the of noted to be wearing blue snow flakes and shirt had several so chest area and her white spots on the - at 5:08 p.m. R11 v hallway with her was R11 wore a light blue inside of her legs, h entire buttocks area stain. The outer rin brown in color and down in her chair in Multiple flies flew a and her clothing. R on her chin and new approximately 1/4 t - at 6:42 p.m. R11 v independently with be wearing the sam facial hair remained During observation was seated in the a several other reside wearing the same of	independent with bed mobility, toileting, eating and personal rised on 2/10/21, indicated R11 berformance deficit related to aired balance. The care plan ired limited assistance from nd personal hygiene. s on 8/23/21, at 4:53 p.m. R11 chair in her room. R11 was g a white turtle neck shirt with nd a pair of blue shoes. R11's biled white/brown spots on the shoes had several soiled top of the shoes. walked independently in the alker and back to her room. ue pair of denim jeans and the nalf way to her knees and her a had a light brown colored g of the stain was darker no odor was noted. R11 sat n her room independently. round R11 and landed on her 11 had several white long hairs ck area measuring o 1/2 inch long. walked down the hallway her walker and continued to ne soiled shirt, pants and R11's		577				

Facility ID: 00930

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/07/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245313	B. WING	i			C 27/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MEADO	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	same. -at 1:34 p.m. R11 si her walker and walk R11 continued to w denim jeans and or way to her knees at light brown colored of the stain was dar odor was noted. - at 1:56 p.m. R11 v area and her clothin During observations R11 was seated in to to wear the same si pair of yellow pants be soiled and stained chest and belly area remained unchange During observations R11 walked independing room area. Fisame shirt from 8/2	a and facial hair remained the tood up up independently with ked around the nursing home. ear the same light blue pair of a the inside of her legs, half and her entire buttocks area a stain remained. The outer ring rker brown in color and no was seated out in the activity ag remained unchanged. s on 8/25/21, at 11:59 a.m. the dining room and continued hirt from Monday and had a on. R11's shirt continued to ed with red/brown spots on her a and R11's facial hair	F	677			
	to be soiled and sta her chest and belly remained. R11 cont shirt for four days a two days and had n On 8/26/21, at 11:2 required staff assist personal hygiene. N verbal reminders to should have superv	ined with red/brown spots on area and R11's facial hair tinued to wear the same soiled nd the same soiled pants for ot been shaved in four days. 1 a.m. NA-A confirmed R11 tance with ADL's, shaving and IA-A indicated R11 needed change her clothes and staff rised her to ensure her clothes n. NA-A indicated R11 had not					

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		AND HUMAN SERVICES				FORM	D: 10/07/2021 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		TE SURVEY MPLETED
		245313	B. WING			08	C 6/27/2021
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	V LANE RESTORATIV	VE CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 677	Continued From pa care plan.	age 34	F6	677			
	above findings and assistance with her she expected staff shaving, grooming, their clothes and st care plan. R14 R14's quarterly MD R14 had severe co diagnoses which in poly-arthritis, lymph R14 required two s mobility, transfers,	7 p.m. DON confirmed the indicated R11 needed staff ADL's. The DON indicated to assist residents with personal hygiene, changing of aff should have followed the OS dated 7/13/21, indicated gnitive impairment had cluded: depression, nedema. The MDS indicated taff assistance with bed dressing, toileting and one h personal hygiene and					
	had physical function impairment. The ca	iting. vised on 2/9/21, indicated R14 oning deficit related to mobility are plan indicated R14 required with oral care and personal					
	R14's hair uncomb head and sticking s head. R14 had sev approximately 1/4 i - at 5:45 p.m. R14 in the dining room	was seated in her wheel chair area with several other remain uncombed and her					
	was seated in her v	s on 8/24/21, at 8:18 a.m. R14 wheelchair in her room and several long white chin hairs					

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		AND HUMAN SERVICES				FOR	D: 10/07/2021 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		LE CONSTRUCTION		TE SURVEY MPLETED C
		245313	B. WING	i		08	B/27/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	•	
MEADO	W LANE RESTORATIN	/E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 677	in the activity room and her hair continu- of her head and stic- at 1:07 p.m. R14 y in the activity room and her hair continu- at 2:22 p.m. R14 y continued to have se approximately 1/4 if During observations was in bed on her b room and said good R14's covers and u brief. NA-B washe tucked R14's brief of wash R14's peri are the right while she y removed the wet so garbage. NA-B plac under R14, assisted applied the incontin closet and picked of - at 8:39 a.m. NA-B R14 chose what sh obtained R14's pan applied ace wraps to slippers on R14's fe applied deodorant a head. NA-B assisted the right while straig placing the lift sling - at 8:52 a.m. NA-B ask for assistance a NA-B positioned the hooked the sling to	nch long or longer. was seated in her wheel chair with several other resident ued to be matted to the back cking straight up. was seated in her wheel chair with several other residents ued to be the same. was in bed resting and R14 several long white chin hairs nch long. s on 8/25/21, at 8:17 a.m. R14 back and NA-B entered her d morning. NA-B removed inhooked R14's incontinent ed R14's hands and face, on the left side and began to ea. NA-B asked R14 to roll to washed her buttocks area, biled brief and threw it in the ced a clean incontinent brief d her to roll to the left and hent brief. NA-B walked to the but clothes for R14. B brought over the clothes and to her lower legs. NA-B placed bet, removed her gown, and donned her shirt over her ed R14 to roll to the left and to ghtening her clothes and	F	577			

Facility ID: 00930

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	-	AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPI	E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(0
		245313	B. WING			08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
1/10					DEFICIENCY)		
F 677		her bed to her wheel chair,	F 6	77			
		om the sling and TMA-A and immediately left R14's					
		I peddles to R14's wheelchair,					
		he peddles, combed her hair					
		ses on her face. NA-B linen, washed her hands, put					
		y and washed her hands					
	again at the sink. N	A-B grabbed a blanket and					
	covered R14's legs	with it. wheeled R14 out of her room					
		way towards the dining room.					
	Several residents w	vere seated in the dining room					
		d to have several long white					
		ately 1/4 inch long. NA-B was er or attempt to provide R14					
	oral cares or assist						
		remained seated in the dining					
		tinued to have several long proximately 1/4 inch long.					
	write chin hans app	noximately 1/4 mentiong.					
		a.m., NA-B confirmed the					
		indicated R14 required ADL's. NA-B confirmed she					
		provided R14 oral cares or					
	facial hair removal.						
	0						
		p.m. DON confirmed the indicated R14 required staff					
		ADL's. The DON indicated					
		to assist residents with					
		personal hygiene, grooming ve followed the care plan.					
		יט וטווטייטע נוופ טמופ צומוו.					
	50						
	R6						
		dated 5/27/21, indicated R6 ct and had diagnoses which					

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			()(0)			0.0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED	
			A. BOILDIN			С	
		245313	B. WING		08	0/27/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
MEADO	W LANE RESTORATI	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 677	schizophrenia. The extensive assistant mobility, toileting, p assistance with dre transfers. Further, f always incontinent incontinent of bladd bladder toileting pro R6's care plan revis had ADL self care p aggressive behavio and pain. The care one to two staff assist personal hygiene and During observation	mellitus, anxiety and MDS identified R6 required ce of one staff with bed bersonal hygiene, limited assing and supervision with the MDS identified R6 was of bowel and frequently der, and was not on a bowel or ogram. sed on 8/25/21, indicated R6 berformance deficit related to or, confusion, impaired balance plan identified R14 required sistance with dressing, nd toileting. s on 8/23/21, at 2:12 p.m. R6	F 67				
	wheelchair using a room with a cup of wanted to go to the NA-D wheeled R6 in her wheelchair a to drink. R6 was we flowers on it and th several soiled white - at 2:28 p.m. R6 w nursing home using her shirt remained - at 4:25 p.m. R6 w out in the front lobb piece of pizza. R6's - at 5:20 p.m. R6 w the dining room are be wet with several several flies buzzin the chest of her shi	as seated in her wheelchair by area and was asking for a s shirt remained the same. ras seated in her wheelchair in ea and her shirt continued to l soiled white spots. R6 had g around her and landing on					

Facility ID: 00930

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		TE SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	co	MPLETED
		245313	B. WING		C 08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
MEADO	V LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 677	Continued From pa	age 38	F 677	7		
	her shirt remained	g her feet to peddle herself and the same. Nursing staff were er or provide R6 with ge her soiled shirt.				
	was awake lying in her call light was w morning. - at 7:24 a.m. R6 re - at 7:25 a.m. R6 tu proceeded to trans R6 was wearing a g - at 7:27 a.m. clinic R6's room, asked F and R6 was noted odor of urine on he and informed R6 it and changed. R6 s four o'clock. CM-A	s on 8/25/21, at 7:03 a.m. R6 bed, covered up with blankets, ithin reach and she said good emained in bed. Irrned her call light on and fer herself to her wheelchair. gown and a sweater over it. al manager (CM)-A entered R6 if she needed assistance to have a very strong pungent r. CM-A washed her hands was time to get washed up tated she was last changed at retrieved a pair of pants out of ed them on R6 up to he knees				
	while she sat in her needed her beddin collect the linen. Re completely saturate buzzing around and bedding. R6's entir pungent odor of uri	wheelchair. CM-A said R6 g changed and began to 5's bed and bedding was ed with urine and flies were d landing on her bed and e room was noted to have a				
	R6 agreed after sta placed the gait belt in her wheelchair. - at 7:33 a.m. CM-A bathroom, CM-A ar	 R6 about using the bathroom. Iff encouraged her and CM-A around her waist while she sat A wheeled R6 into the nd NA-E placed gloves on their the R6 to stand while using the 				

Facility ID: 00930

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			FORM	10/07/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE COMF	E SURVEY PLETED
245313	B. WING		08/2	; 27/2021
NAME OF PROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MEADOW LANE RESTORATIVE CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
 F 677 Continued From page 39 R6's buttocks were wrinkled, pink in color and no skin breakdown was noted. R6's plastic wheelchair cushion was noted to have urine present on it. CM-A proceeded to cleanse R6's buttocks and peri area with wipes while NA-E wiped R6's plastic wheelchair cushion off with wipes and dried it with a paper towel. NA-E and CM-A placed a clean incontinent brief on R6, pulled up her pants and assisted her to sit in her wheelchair. R6 refused the rest of her morning cares and peddled herself out of her room. NA-E indicated she had not received report that morning from the night shift. NA-E and CM-A stated they were not aware when the last time R6 had been checked, changed or offered assistance with toileting. - at 7:41 a.m. CM-A reviewed R6's medical record (MR) to review the last time R6 had been checked and changed at 3:40 a.m. and was incontinent of urine at that time. R6's MR lacked any documentation of R6 being checked and changed by staff or offered toileting from 3:40 a.m. to 7:33 a.m. for a total of 3 hours and 53 minutes. On 8/25/21, at 9:24 a.m. NA-B confirmed R6 was routinely incontinent of bowel and bladder and needed to be checked/changed every two hours. NA-B indicated he thought she had last checked and changed R6 around 4:15 a.m. and thought she was dry at the time but could not remember. On 8/26/21, at 1:57 p.m. CM-A confirmed the above finding and indicated R6 was incontinent of bowel and bladder and changed R6 every two hours and indicated R6 was incontinent of bowel and bladder and change R6 every two hours and indicated with toileting. 				

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	O	MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW LANE RESTORATIVE CARE CENTER					209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From par she expected staff to On 8/26/21, at 2:07 above findings and assistance with her she expected staff hygiene, grooming a DON indicated staff and changing R6 per refused to re-appro R1 Findings include: R1's quarterly Minin 8/17/21, identified F depression weaknet (numbness/tingle in identified R1 had set and required extension of daily living (ADL's hygiene, and bathin no rejection of care period. R1's care plan revise impaired cognition, required extensive a hygiene, dressing a lacked direction for R1's nursing assista revealed R1 required personal hygiene.	ge 40 to follow her care plan. p.m. DON confirmed the indicated R6 needed staff ADL's. The DON indicated to assist R6 with personal and incontinence cares. The f should have been checking er her care plan and if she ach her at a later time. num Data Set (MDS) dated A1 had diagnoses of dementia, ass and peripheral neuropathy nextremities.) The MDS evere cognitive impairment sive assistance with activities s) of dressing, personal ag. The MDS identified R1 had s during the assessment sed 7/12/21, revealed R1 had function, thought process and assistance with personal and bathing. R1's care plan facial hair removal. ant care guide dated 8/26/21, ed extensive assistance with	F				
	in bed, eyes closed	p.m. R1 was observed lying , covered with a blanket from st. R1's hands were rested on					

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
	245313	B. WING				C 27/2021
NAME OF PROVIDER OR SUPPLI	ĒR	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW LANE RESTORA	TIVE CARE CENTER			209 UTAH AVENUE ENSON, MN 56215		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
dozen four (4) to thick black coars chin and jaw line (10) mm long wl corners of her m - at 6:08 p.m. R ⁻ wheelchair, whe assistant (NA)-H hair was sticking along the sides. dozen 4 to 5 mm hairs along her u had several 6- 1 hairs along both On 8/24/21, at 8 in a wheelchair i table next to and combed straight have several do coarse facial hai jaw line. R1 had wispy facial hair and chin. - at 11:32 a.m. F wheelchair in the other residents. dozen 4 to 5 mm hairs along her u had several 6- 1 hairs along both - at 11:36 a.m. F	ove the blanket. R1 had several five (5) millimeters (mm) long, se facial hairs along her upper lip, e. R1 had several six (6) to ten hite wispy facial hairs along both		.77			

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245313	B. WING				27/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIN	/E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	to transfer R1 into the provided R1 with the needed to go find the bed and NA-D exite R1 had remained s room, at that time N room and proceeded her cares. R1 was of provided her call lig left R1's room. R1 of dozen 4 to 5 mm lo hairs along her upp had several 6- 10 m hairs along both co On 8/25/21, at 8:24 in a wheelchair in h closed, head was ti open. R1 continued mm long, thick blad upper lip, chin and j mm long white wisp corners of her mou NA-E confirmed R1 did not have a razo - at 10:17 a.m. R1 w wheelchair, wheele (TMA)-A towards he assist R1 to transfe with a full mechanic several dozen 4 to 5 facial hairs along both co On 8/24/21, at 11:4	bed. NA-C entered R1's room, er call light and indicated she he other NA to assist R1 to ed R1's room. At 11:43 a.m. eated in her wheelchair in her NA-D and NA-C entered R1's ed to assist R1 to bed and with covered with a blanket, thand both NA-D and NA-C continued to have several and, thick black coarse facial her lip, chin and jaw line. R1 nm long white wispy facial rners of her mouth and chin. A.m. R1 was observed seated her room, her eyes were lted back and her mouth was d to have several dozen 4 to 5 ck coarse facial hairs along her jaw line. R1 had several 6- 10 by facial hairs along both th and chin. At that time, l's facial hair and indicated she r to remove her facial hair. Was observed seated in a d by trained medication aid er room. TMA- A proceeded to er from her wheelchair to bed cal lift. R1 continued to have 5 mm long, thick black coarse er upper lip, chin and jaw line. 10 mm long white wispy facial rners of her mouth and chin. 8 a.m. NA-C indicated R1 was n staff for all ADL's and was	F	\$77			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ST CONNECTION	IDENTIFICATION NONDER.	A. BUILD	ING			C
		245313	B. WING				27/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 43	F 6	677			
	On 8/25/21, at 8:30 assisted R1 with me removed R1's facia not have a razor to further indicated shi that morning to sha staffed that morning was not able to pro- due to insufficient s morning an NA did and a night aid had familiar with mornin On 8/25/21, at 10:2 was dependent on s felt R1 was not able TMA-A indicated R2 been removed as n R1 had a razor. TM did not have time for shaving, routinely d On 8/26/21, at 10:4 placed to R1's fami was left. On 8/26/21, at 2:32 dependent on staff included personal h indicated she oftent unshaved and felt th care staff available standard cares, suc provided to residem On 8/27/21, at 9:50 (DON) stated she e	a.m. NA-E stated she had orning cares and had not I hair. NA-E indicated R1 did remove the facial hair and e would not have had time ve R1 since they were short g. NA-E indicated she felt she vide R1 with standard cares taffing. NA-E indicated that not show up for the day shift stayed over that was not					

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	FORM	APPROVED						
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED		
		245313	B. WING				C 27/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 000		
MEADO	V LANE RESTORATIV	/E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETION DATE		
F 677	• • • • • • • • • • • • • • • • • • •	ge 44 or any other residents were in	F 6	577				
	R21							
	(MDS) dated 8/4/21 cognitive impairmer included Alzheimer' and thyroid disorder required total assist	ange Minimum Data Set I, identified R21 had significant nt and diagnoses which 's disease, muscle weakness r. R21's MDS indicated R21 tance with transfers, extensive d mobility, dressing and						
	required extensive a personal hygiene and but was to be check R21's care plan ide thought processes	rised 7/12/21, identified R21 assistance with dressing, nd R22 did not use the toilet, ked and changed periodically. ntified R21 had impaired related to Alzheimer's disease. not include specific al hair removal.						
	wheelchair in her ro wispy white hairs or	p.m. R21 was sitting in her bom. R21 had multiple long n her chin and neck ranging I-5 hairs up to 3/4 inches long.						
	wheelchair in her ro multiple facial hairs	a.m. R21 was sitting in her oom. R21 continued to have , white in color on her chin and 1/8 inch long to 3/4 inch long.						
	wheelchair in the ac residents and staff continued to have fa	5 a.m. R21 was in her ctivity room with multiple other members present. R21 acial hairs present as before, wispy hairs up to 3/4 inch long						

Facility ID: 00930

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING				C 27/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	on her chin and new On 8/25/21, at 12:0 (NA)-E indicated sh member with R21's NA-E stated she ha morning and indica provide a razor for t the female resident and thus staff were stated she had infor that morning of the was told the facility the female resident residents had their On 8/27/21, at 11:1 had been informed did not have any ra- administrator would facility would discus with family member On 8/27/21, at 11:3 interview family me to remove R21's fac ON 8/27/21, at 10:2 interview, clinical m expected all female hair removed. CM-/ obtaining razors for facial hair would be On 8/27/21, at 1:29 (DON) confirmed sl	 9 a.m. nursing assistant 9 a.m. nursing assistant e had assisted another staff cares earlier that morning. id noticed R21's facial hair that ted the facility needed to R21. NA-E indicated none of s in the facility had any razors unable to shave them. NA-E rmed clinical educator (CE)-A need to purchase razors and would obtain some razors for s. NA-E indicated all the male own razors. 6 a.m. CE-A confirmed she by staff the female residents zors. CE-A stated the be obtaining razors and the as the need to purchase razors a.m. during a phone mber (FM)-B stated she used cial hair for her. FM-B stated ial hair was important to her. 29 a.m. during a phone anager (CM)-A confirmed she residents to have their facial Aindicated they would work on the female residents so their removed. p.m. director of nursing ne expected staff to remove hair to maintain their dignity 	F 6	;77			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NONDER.	A. BUILDIN	G			C
		245313	B. WING			08/:	27/2021
NAME OF F	PROVIDER OR SUPPLIER			,	CITY, STATE, ZIP CODE		
MEADO	V LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENU BENSON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	ER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULD ERENCED TO THE APPROP) BE	(X5) COMPLETION DATE
	1		p.		DEFICIENCY)		
F 677	Continued From pa	ge 46	F 67	7			
	R22						
	(MDS) dated 8/6/21 cognitive impairmen included: dementia, (high blood pressur	ange Minimum Data Set I, identified R22 had significant nt and diagnoses which , arthritis and hypertension re). R22's MDS indicated R22 assistance with bed mobility, onal hygiene.					
	had an activities of performance deficit and limited mobility indicated R22 requi	rised 8/13/21, identified R22 daily living (ADL's) self-care related to advanced dementia . The care plan interventions ired extensive assistance of sing, personal hygiene and oral					
	assisted R22 with n her in her wheelcha cares were complet medication aide (TM washed her hands R22 out of the bed gait belt. TMA-A exi combed R22's hair. complete oral cares wheeled R22 in her into the hallway. Fro was observed prop- hallways and no ora provided during tha observed in the dini her. At 9:19 a.m. Cl hallway near the nu	a.m. to 8:16 a.m. NA-B norning cares and wheeled air into the hallway after the ted. At 8:09 a.m. trained MA)-A entered the room, and assisted NA-B to transfer into her wheelchair using a ited the room and NA-B . NA-B was not observed to s for R22. At 8:16 a.m. NA-B wheelchair out of her room om 8:16 a.m. to 8:40 a.m. R22 elling herself up and down the al cares were observed to be t time. At 9:06 a.m. R22 was ing room with CE-A feeding E-A assisted R22 to the ursing desk, where R22 began If in her wheelchair down the					

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			Pr		APPROVED	
	RS FOR MEDICARE	& MEDICAID SERVICES	. 		OI	OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245313	B. WING				C 27/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	V LANE RESTORATIV	/E CARE CENTER		22	209 UTAH AVENUE			
				В	ENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 677	Continued From pa	ge 47	F 6	77				
	typically did not per usually worked the	6 a.m. NA-B stated she form R22's morning cares and night shift. NA-B confirmed eted oral cares for R22 that						
	On 8/26/21, at 10:4 had not completed	4 a.m. NA-E confirmed she oral cares for R22.						
	interview, CM-A sta perform oral cares of been completed by toothettes. CM-A inc	9 a.m. during a phone ted she expected staff to on R22 which should have swabbing R22's mouth with dicated oral cares were t for R22 as she had the food.						
	expected staff woul DON indicated oral	4 p.m. DON confirmed she d complete oral cares on R22. cares were important to keep revent infections or sores, and						
	(ADLs), Supporting residents would be and services to ens diminish unless the clinical condition(s) ADLs are unavoidal that appropriate car provided for resider out ADLs independer resident and in accor which included: hyg	tled Activities Of Daily Living dated 3/17/21, identified provided with care, treatment sure that their ADLs did not circumstances for their demonstrate that diminishing ble. The policy also identified re and services would be nts who were unable to carry ently, with the consent of the ordance with the plan of care, giene (bathing, dressing, care), mobility, elimination, nication.						

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
		245313	B. WING				C 27/2021		
NAME OF F	PROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE						
	V LANE RESTORATIV	E CARE CENTER		2	209 UTAH AVENUE				
				E	BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 677	The facility policy tit dated 3/17/21, iden promote cleanlines: The policy instructed care plan to assess resident. The polic notify the superviso procedure or other the facility policy an practice. The facility policy tit Assisting The Resid 3/17/21, identified th was to assist the re dressing and undre The policy further in supervisor if the resion of the rinformation policy and profession The facility policy tit 3/17/21, identified th was to keep the resion mouth, and to preve equipment and sup necessary included emesis basin, and a The policy further in supervisor if the resion of the rinformation policy and profession The policy further in supervisor if the resion of the resion of the rinformation policy and profession Free of Accident Ha	the Shaving The Resident, tified the purpose was to s and to provide skin care. I staff to review the resident's of rany special needs of the y further instructed staff to information in accordance with d professional standards of the Dressing And Undressing, dent With Level II dated he purpose of this procedure sident as necessary with ssing to promote cleanliness. Instructed staff to notify the sident refused the procedure in accordance with the facility onal standards of practice. The Mouth Care dated he purpose of the procedure sident's lips and oral tissues and freshen the resident's ent oral infection. The plies listed that would be : toothbrush, toothpaste, applicators or gauze sponges. Instructed staff to notify the sident refused the mouth care in accordance with the facility onal standards of practice.	F 6				10/11/21		
	3/17/21, identified th was to assist the re- dressing and undre The policy further in supervisor if the res- or other information policy and profession The facility policy tit 3/17/21, identified th was to keep the res- moist, to cleanse an mouth, and to preve equipment and sup necessary included emesis basin, and a The policy further in supervisor if the res- or other information policy and profession Free of Accident Ha CFR(s): 483.25(d) Accident	he purpose of this procedure sident as necessary with ssing to promote cleanliness. Instructed staff to notify the sident refused the procedure in accordance with the facility onal standards of practice. Ited Mouth Care dated he purpose of the procedure sident's lips and oral tissues and freshen the resident's ent oral infection. The plies listed that would be : toothbrush, toothpaste, applicators or gauze sponges. Instructed staff to notify the sident refused the mouth care in accordance with the facility onal standards of practice. azards/Supervision/Devices 1)(2)	F 6	\$89			10/11/21		

Facility ID: 00930

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		AND HUMAN SERVICES			FORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245313	B. WING _			_ 27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	§483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREMED by: Based on observar review, the facility f comprehensive fall root cause, identify interventions for 1 of repeated falls. Furt routinely implemen further falls for 2 of who had repeated f remained at high ris Findings include: R16's significant ch Minimum Data Set identified R16 had dementia, polymya disorder causing m around the shoulde The MDS identified impairment and rec with activities of da mobility, transfers a indicated R16 had delirium. The MDS maintain her balance last MDS assessme	resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview and document ailed to conduct assessments to determine patterns of falls and effective of 1 resident (R16) who had her, the facility failed to t interventions to prevent 3 residents (R16 and R21) falls in the facility and sk for falls.	F 68	 It is the expectation of the fact conduct comprehensive fall asset to determine root cause, identify of falls and effective interventions residents who had repeated falls facility also is expected to routine implement interventions to prever falls for residents who have had falls. Comprehensive assessme interventions were reviewed and to ensure compliance residents I R21. All residents at risk for or who fallen have the potential to be affective interventions and under the deficient practice. All resider falls or at risk for falls were reviee ensure that they are receiving the necessary treatment/services. To enhance currently complain operations and under the direction Director of Nurses, policies were reviewed, and assessments were to further ensure compliance with comprehensive assessments an interventions to prevent further failentify patterns and to determinic cause. Procedures were revised ensure compliance with deficient A nursing in-service training is so on 10/4/21 which includes educarevised nursing assessments, approximation of the second context of second context of the second	essments patterns s for . The ely ent further repeated ents and revised R16 and have fected by nts with wed to e nt on of the e revised n d fall alls, e root d to c practice. cheduled ition of	

Facility ID: 00930

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE	0938-039
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		
		245313	B. WING _			C 27/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	•	
MEADO	W LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 689	7/15/21, identified F in her ability to perf and required exten referred to both occ therapies though R CAA's revealed R1 remained at risk for impaired mobility a ADL's. The CAA lis included, gripper so free of clutter and F reach. Review of R16's re form dated 8/21/21 form that listed sev conditions/factors v affect R16's fall risk form identified R16 conditions/risk fact confusion, 1-2 falls medications that ha could increase risk predisposing disea condition, etc. The score of 17, howev define what the sco fall risk. R16's care plan rev had cognitive impa required extensive used a full body me care plan listed var prevention which in R16's bed, gripper footwear and direct	R16 had a significant change form her ADL's independently sive assistance, had been cupational and physical 16 refused services. The 6 had one in the last quarter, r falls due to incontinence, nd need for assistance with ted fall interventions which bocks, keeping environment her call light was to be within sident fall risk assessment , identified a check list type eral headings and subsets of which had the potential to k. The checklist assessment	F 68	fall interventions, appropriate r documentation to ensure comp 4. Effective 10/1/21, a quality a program was implemented und supervision of the director of n monitor the delivery of care, to appropriate care and services implemented and to better ensi- implementation of treatment. Director of Nursing/Designee w weekly for 6 weeks and then m months. Any identified deficient corrected, and all findings brow monthly quality assurance com further review and ongoing mo	bliance. assurance der the ursing to ensure are ure The will audit nonthly for 3 ncies will be ight to the mittee for	

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	-	AND HUMAN SERVICES				FORM	1 APPROVED	
		& MEDICAID SERVICES		T 15			<u>MB NO. 0938-0391</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION G		TE SURVEY	
			A. BUILD		<u> </u>		с	
		245313	B. WING				0 /27/2021	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
	V LANE RESTORATIV	E CARE CENTER			2209 UTAH AVENUE			
					BENSON, MN 56215			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)	
PRÉFIX		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE	
IAG			IAG		DEFICIENCY)	110/01		
			l					
F 689	Continued From pa	ge 51	F 6	380	٥			
	Continuou r rom pu	9001	1.0					
	On 8/24/21, 9:07 a.	m. during a telephone						
		s family member (FM)-C, he						
		en declining overall in the last						
		llen a few days ago and had						
		on her forehead. FM-C stated						
		mentia, was not able to voice						
		rns and felt she was not able for help when she needed to						
		C stated he had visited R16						
	5	/21, at approximately 8:00						
		f hour long visit, R16 had						
		t of bed by placing her						
		e floor and attempting to pull						
	•	grab bar. He indicated R16						
		he had notified staff of R16's						
		of bed. FM-C stated staff was						
		equest for help, had come into						
		her legs back into bed and y laying down. FM-C indicated						
		ave fallen if she had been able						
		and stated he was not aware						
		vas currently doing to						
	decrease R16's risk							
		ls incident reports from						
	1/27/21, to 8/21/21,	revealed the following:						
	on 1/07/04 at 7.4	Enm the incident report						
		5 p.m. the incident report called for help and had been						
		nd by a trained medication aid						
		erring from toilet to the						
		port revealed R16 had						
		ad given out and she couldn't						
	stand. The incident	report revealed a check list						
	type assessment w	ith several areas to assess						
		uries, pain, mental status at						
	the time of the incid							
	predisposing enviro	nmental, physiological, and						

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING	<u> </u>			C 27/2021
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/E CARE CENTER			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	situational factors. confused, had a ga memory and had be - on 1/29/21, a follo would screen reside candidate and staff with laying down in lacked any analysis interventions, poter implemented interve R16's medical reco evaluation following - on 6/25/21, at 11:3 identified R16 had b from her room and near her bed. The r independent with tra had indicated she h from her bed to the revealed R16 had c one bare foot. The to person, place, tin was not able to wal and from the toilet v incident report reve however the report fall interventions, p implemented interve Review of R16's fall identified R16 was a make her needs kn from the fall in her n	The report revealed R16 was it imbalance, impaired een incontinent. w up note revealed therapy ent to see if she would be a would offer to assist resident the afternoon. The report of the fall, current fall tial patterns and newly entions. rd lacked any therapy g the fall on 1/27/21. 84 p.m. the incident report been heard calling for help had been found on the floor note revealed R16 was ansfers at the time of the fall, had tried to transfer herself wheelchair and fell. The note one gripper stocking on and report listed R16 was oriented ne, situation and revealed R16 k, but was able to transfer to without assistance. The aled R16 likely slid out of bed, lacked any analysis of R16's otential patterns or newly entions. I follow up note dated 6/27/21, alert, oriented, was able to own and had no complications room on 6/25/21. rd lacked a therapy evaluation	F 68	89			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	~		APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			PLETED
		()
245313 B. WING		08/2	27/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
MEADOW LANE RESTORATIVE CARE CENTER 2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR			(X5)
PREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTIONTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE JACK			COMPLETION DATE
DEFICIENCY)			
F 689 Continued From page 53 F 689			
F 009 Continued From page 35 F 069			
-on 8/21/21, at 7:20 p.m. the incident report			
identified R16 had been found on the floor of her room lying on her right side by the doorway. The			
incident report revealed R16 was last seen at			
approximately 6:30 p.m. when she wheeled			
herself out of the dining room following the evening meal, to her and had been waiting for			
staff to help her get ready for bed. The report			
identified R16 was alert, confused and was not			
able to identify what had happened. The report revealed R16 had a bump on her forehead, ice			
was applied and neurological checks were started			
(assessment of neurological status to help			
determine possible brain impact from a head injury.) The report identified R16 was recently			
started on a new medication of Ativan			
(anti-anxiety) and had received a dose at 7:00			
p.m. that day. The incident report lacked any			
analysis of R16's fall, interventions, potential patterns or newly implemented interventions.			
Boview of B16's progress potes from 5/20/24 to			
Review of R16's progress notes from 5/30/21, to 8/27/21, revealed the following:			
on 6/26/21, a follow up fall note revealed P16			
- on 6/26/21, a follow up fall note revealed R16 was alert, oriented and had no new injuries or			
complications from the fall on 6/25/21. The note			
revealed R16 had difficulties with moving from a			
lying to sitting position, with transfers and had been using her call light for assistance. The note			
revealed R16 needed a therapy evaluation.			
- on 6/28/21, a progress note revealed R16 was			
alert, oriented, had episodes of hallucinations and			
had not needed to call for help with transfers.			
-on 6/29/21, a progress note revealed R16 had troubles transferring, could not pick her bottom			

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	FCORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 689	note revealed a fax R16's primary provi -on 7/1/21, a progre primary physician h evaluation for R16's and transfers. -on 7/2/21, a progre continued having di needed assistance wheelchair to the to -on 7/5/21, a progre from the facility boa nursing side of the f confusion and need -on 7/14/21, a socia BIMS (test to asses declined from cogni cognitive impairment -on 7/15/21, a progre seen on a routine v increased confusion -on 7/28/21, a progre sent to the local em condition of lethargy not answering ques R16 was returned to emergency room w heart failure and wa (medication used to from the body)	of inches from the chair. The communication was sent to der for therapy evaluation. ess note revealed R16's ad ordered a therapy a difficulties with bed mobility ess note revealed R16 fficulty performing ADL's and with transferring from her ilet. ess note revealed R16 moved rd and care to the skilled facility due to increased ling more assistance. al service note revealed R16's is cognition) had significantly tively intact, to severe nt. ress note revealed R16 was isit by her primary doctor for n and diarrhea. ress note revealed R16 was ergency room for change of y, not able to transfer and was tions. A later note revealed o the facility from the ith a diagnosis of congestive as ordered diuretic medication o help released excess fluid	F 6	89			
	(medication used to from the body)						

Facility ID: 00930

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		AND HUMAN SERVICES				FOR	D: 10/07/2021 MAPPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		ATE SURVEY OMPLETED
		245313	B. WING	÷		0	8/27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 2209 UTAH AVENUE BENSON, MN 56215	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	sent to the local em difficulty breathing. -on 8/9/21, a progre returned to the facil receive hospice ser -on 8/10/21, a prog required total assist -on 8/19/21, a prog anxious, exit seekir an anti-anxiety med for twice daily and a -on 8/22/21, a prog fall in her room on 8 a painful bump on h the use of oxygen. checked on frequer -on 8/23/21, a prog been calm, the bum resolved and she h motion. A later note and was repositioned R16's progress note R16 had been asse recommendations h 1/27/21, and 6/25/2 On 8/23/21, at 2:35 on her back in a low affixed to the left sid doorway,) her bare of the bed, towards the floor next to her	hergency room for lethargy and ess note revealed R16 lity and was expected to rvices. ress note revealed R16 tance of 1-2 staff for all cares. ress note revealed R16 was ng, was seen by hospice and dication (Ativan) was ordered as needed for anxiety. ress note revealed R16 had a 8/21/21, at 7:20 p.m., R16 had her forehead and had required The note revealed R16 was ntly. ress note revealed R16 had ad no changes in her range of a revealed R16 had been calm ed every two hours. es lacked any documentation essed by therapy or any by therapy following her fall on	F	689			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING	-			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	V LANE RESTORATIV	E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	grab bar with both h attempted to pull he her bare feet toward was unable to pull h back and forth in a attempted to pull he R16 was not able to the bar and moved again. -at 2:38 p.m. R16 w her back in a low be assistant (NA)-G er barefooted feet into her bed and left the barefooted. -at 2:46 p.m. R16 w her back, R16 then grabbed onto the gr the side of the bed rocked back and fo her legs back into b -at 2:54 p.m. R16 w back, eyes were clo feet and remained a her legs and bare fe flooring. She made the side of her bed. the right side of her feet back into bed. -at 4:29 p.m. R16 w in a low bed, her ey was on. At that time picked up yellow gr	ge 56 h. R16 reached towards the her right and left hands and erself upwards while moving ds the laminate flooring. R16 herself up, she began to rock momentum type motion and erself up with the assist bar. b pull herself up, she let go of her legs in and out of the bed vas observed lying in bed on ed, at that time nursing hered the room, lifted R16's the bed, raised the head of room. R16 remained vas observed lying in bed on reached her left arm up and rab bar, moved her legs over and attempted to sit up. R16 rth several times. R16 moved bed and let go of the grab bar. vas observed lying on her bsed, blanket was off of her around her waist. R16 moved bet off the bed, towards the no attempt to grab the bar on R16 had a call light button on upper body. She moved her vas observed lying on her back tes were closed and call light a, NA-G entered R16's room, ipper socks from the floor and feet. R16's eyes remained	Fθ	\$89			

If continuation sheet Page 57 of 151

		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	closed, though she the grab bar, swung NA-G told R16, "yo NA-G indicated R16 following a fall over "comfort cares." NA and about on her ov recently moved to th facility. NA-G proce incontinent cares, p her chest and left h -at 5:55 p.m. R16 w her back, moved he bed towards the flow with her left hand al was unable to sit up her eyes. At that tim picked up the yellow indicated R16 was told the nurse about left the room and F bed. -at 5:59 p.m. R16 w reached her left arm her chest, took hold attempted to sit up, pillows and closed I remained hanging of -at 6:05 p.m. R16 w on her back, eyes w over the side of the At that time, NA-H of her legs and placed	moved her left arm towards g her legs out of the bed, u gotta stay in bed, it's okay." 6 had remained in bed the weekend and was on A-G indicated R16 had been up wn a few weeks ago, and had he skilled living side of the seded to assist R16 with blaced R16's flat call light on	F 6	;89			

If continuation sheet Page 58 of 151

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
				:	2209 UTAH AVENUE		
	V LANE RESTORATIV	E CARE CENTER		I	BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	 -at 6:37 p.m. R16 w on her back, eyes w covered with a shee lower body. -at 7:10 p.m. R16 w had a pillow tucked grab bar, her bare f within reach. On 8/24/21, at 8:35 in a low bed, on her on her right side, sh legs and body up to were exposed, no g -at 11:26 a.m. R16 w her back, pillows we left sides of R16. He covered from her fet -at 1:27 p.m. R6 wa back, her eyes were feet to her mid ches her room, asked if s blanket, looked at h gripper socks and c left R16's room. On 8/25/21, at 7:06 in bed on her back, were closed, she ha right and left sides a made no attempt to to try to sit up. -at 9:05 a.m. R16 w 	ge 58 vas observed lying in a low bed vere closed, her body was et, a pink blanket covered her vas observed lying in bed, she between her body and the eet were visible, call light was a.m. R16 was observed lying back, pillows were positioned he had a blanket covering her o her mid chest. R16's feet gripper socks were observed. was observed lying in bed on ere positioned on the right and er eyes were closed, she was bet to her mid chest. as observed lying in bed on her e closed, covered from her st, at that time NA-C entered she was alright, lifted up her her feet which revealed yellow covered R16 back up. NA-C a.m. R16 was observed lying covered with a sheet, eyes ad pillows placed on both her and underneath her legs. R16 o move her legs out of bed or vas observed lying in bed on e closed, pillows were placed	Fθ	689	9		
	in a low bed, on her on her right side, sh legs and body up to were exposed, no g -at 11:26 a.m. R16 her back, pillows we left sides of R16. He covered from her fe -at 1:27 p.m. R6 we back, her eyes were feet to her mid ches her room, asked if s blanket, looked at h gripper socks and c left R16's room. On 8/25/21, at 7:06 in bed on her back, were closed, she hav right and left sides a made no attempt to to try to sit up. -at 9:05 a.m. R16 w her back, eyes were	 back, pillows were positioned he had a blanket covering her of her mid chest. R16's feet gripper socks were observed. was observed lying in bed on her epositioned on the right and er eyes were closed, she was bet to her mid chest. as observed lying in bed on her e closed, covered from her est, at that time NA-C entered she was alright, lifted up her her feet which revealed yellow covered R16 back up. NA-C a.m. R16 was observed lying covered with a sheet, eyes ad pillows placed on both her and underneath her legs. R16 move her legs out of bed or 					

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	T CONNECTION	IDENTIFICATION NOMBER.	A. BUILDI	ING _			C
		245313	B. WING _				27/2021
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	'E CARE CENTER			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	nurse entered R16's hospice nurse remo- proceeded to assist positioned R16 on h that time, the hospic been kept in bed sir comfort per facility n On 8/23/21, at 5:55 NA-G, she stated R staff for all of her AI declining over the p indicated R16 had a and had remained i indicated she was n injuries or if there w of care other than k On 8/24/21, at 1:32 NA-C, indicated R1 staff for all of her ner recently fallen and h her comfort. NA-C in get out of bed at tim have the strength to anymore. NA-C furt prevention intervent socks and making s On 8/25/21, at 7:47 hospice nurse indic risk for falls and sho place, such as gripp get out of bed. How	aid (TMA)-A and hospice s room. TMA-A and the oved the blanket from R16 and t R16 with morning cares, her right side with pillows. At ce nurse indicated R16 had nce her fall on 8/21/21, for report. p.m. during an interview with R16 was totally dependent on DL's and had been rapidly past couple of weeks. NA-G a fall over the past weekend in bed since the fall. She not aware if R16 had any vere any changes with her plan teeping her in bed. p.m. during an interview with 6 was totally dependent on eds. NA-C indicated R16 had had been in bed since then for indicated R16 was not able to ds and indicated she needed positioning and checking and licated R16 would attempt to nes, though felt she did not o get out of bed on her own ther stated R16 had fall tions of a low bed, gripper sure her call light was by her. a.m. during an interview the tated she felt R16 remained at ould have fall interventions in per socks should R16 try to vever, the hospice nurse stated	F 68	89			
		6 had the strength to get out of					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		PLETED C
		245313	B. WING _			27/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 689	Continued From pa bed on her own in h On 8/25/21, at 11:4 occupational therap R16 was currently r not within the last fe had been referred i refused any treatme stated she could no been seen by thera On 8/26/21, at 10:2 licensed practical n had been declining and had recently fa R16 had been in be did not appear to be overall was not eati night R16 had faller what footwear R16 call light within reac R16's fall, she was and mobility, though and was unable at t LPN-A indicated fol frequent checks we the shift. LPN-A wa interventions had be fall. On 8/26/21, at 2:01 NA-E, indicated R1 staff for all of her Al been independent a	ge 60 her current state. 5 a.m. the certified by assistant (COTA) stated hot receiving therapy and had ew months. COTA stated R16 in the past, however she ent and likely evaluation. She it recall the last time R16 had	F 68	DEFICIENCY)	RIATE	DATE
	stated R16 had bee 8/21/21, was not su	ed help with her cares. NA-E en in bed since her fall on re if it was for her comfort or no longer hold herself up.				

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		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
and plan (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3		C
		245313	B. WING		•	/27/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
MEADO	W LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 689	NA-E indicated R16 get out of bed that lay back down. NA- nurse and the nurse to help her relax an to get out of bed. N to wear gripper soor position and have a for fall prevention. On 8/26/21, at 2:34 NA-F, indicated R2 staff for all ADL's at in her overall condi NA-F stated R16 ha and no longer was indicated she had t comfort and overall herself up anymore attempted to get ou morning, though wa sitting position. NA- R16 had the streng indicated R16 had gripper socks, low bed and call light w On 8/27/21, at 9:43 clinical manager (C back to work at the and on, and had no assessment. CM-A R16's fall to have b factors, review all fa-	6 had been observed trying to morning and was redirected to -E stated she had told the e had given something to R16 ind since she had not attempted A-E stated R16 was supposed eks, have her bed in the low a mat on the floor by her bed during an interview with 16 was totally dependent on ind had been rapidly declining tion in the last few weeks. ad fallen the past weekend helped out of bed. NA-F hought R16 was in bed for her I she was not able to hold be. She stated R16 still ut of bed, which occurred that as not able to get herself into a -F indicated she did not feel th to make it out of bed. NA-F fall interventions in place of bed, mat on the floor by her	F 68			

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	OF DEFICIENCIES F CORRECTION	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
	CONTECTION			G		C
		245313	B. WING _			/27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 2209 UTAH AVENUE BENSON, MN 56215	Ξ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	-	F 68	9		
		to wear gripper socks when in ase R16 was able to get g position.				
	interview with R16's doctor (MD)-A, she rapidly declining with had been notified of She indicated she if evaluation following feel R16 would be on previous attemp R16. She indicated to look at other inter been complaints with footwear in place the further stated she with complete a compre- R16's falls to help of	97 a.m. during a telephone s primary physician, medical indicated R16 had been thin the last few weeks and of R16's two falls since June. had ordered a therapy g the fall in June, but did not compliant with therapy based ots from therapy to work with she would expect the facility erventions that R16 would have th, and felt R16 should have hat prevents slipping. She would expect the facility to shensive assessment following determine causative factors, terventions post fall.				
		nange Minimum Data Set				
	cognitive impairme included Alzheimer and thyroid disorde identified R21 requ transfers, and exte mobility, dressing a MDS identified R21	1, identified R21 had significant nt and diagnoses which 's disease, muscle weakness r. R21's MDS further ired total assistance with nsive assistance with bed and personal hygiene. R21's I's balance during surface to as not steady, and unable to				

Facility ID: 00930

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		AND HUMAN SERVICES				FORM	D: 10/07/2021 MAPPROVED D: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION		TE SURVEY MPLETED
		245313	B. WING			08	B/27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP COI 2209 UTAH AVENUE BENSON, MN 56215	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	identified R21 had a assessment. R21's Care Area As 8/5/21, identified R2 a history of falls sin dependent on staff lift for all transfers. required extensive repositioning. R21's included gripper so care plan. R21's care plan rev required extensive personal hygiene a assistance with trar all transfers. R21's impaired thought pr Alzheimer's disease R21 was at high ris interventions includ ensuring R21 wore footwear when tran wheelchair and R2: during periods of w R21's kardex dated interventions for sa wore appropriate for transferring or mob to be up in wheelch wakefulness. R21's Resident Fal 8/4/21, identified R2 times, had 3 or mot	man assistance. R21's MDS no falls since prior assessment (CAA) dated 21 was at risk for falls and had ce admission and was for all transfers with a full body R21's CAA identified R21 assistance from staff for all as CAA indicated interventions cks and to proceed to R21's rised 7/12/21, identified R21 assistance with dressing, nd required extensive nsfers using a full body lift for care plan identified R21 had rocesses related to e. R21's care plan indicated k for falls and the following led: bedside mat during naps, appropriate footwear no skid sferring or mobilizing in 1 was to be up in wheelchair akefulness.	F€	589			

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STATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	· /	LE CONSTRUCTION	(X3) DA	D. 0938-039	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>	0	MPLETED	
		245313	B. WING		08/27/20		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
MEADO	V LANE RESTORAT	VE CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 689	Continued From p	age 64	F 689				
	score was 19, whi	ch was high risk for falls.					
		9 p.m. R21 was observed lying ly onto her right side, covered					
	with a sheet and b	lanket, with her feet hanging					
		e bed, trained medication aide R21's room, with a glass of ice					
		d R21 to put her feet back onto					
		d was in low position, had a					
		with a mat on the floor next to					
		pen, alert, informed TMA-B who	0				
		1's room. TMA-B asked R21 if					
		up, or was uncomfortable and it her feet back into bed. R21's					
		B could not be heard. At 2:26					
	p.m. R21's eyes w	ere open and her feet were					
		next to her bed and the head of					
		ly elevated. At 2:30 p.m. R21 ght side, her head resting on					
		with blanket and sheet and					
		pain noted to be out of the bed.					
		ft arm to her mouth and back in \t 2:34 p.m. nursing assistant					
		21's room, told her she was					
	going to put her fe	et up, then quickly moved					
		ed, while R21 said "ow" and sroom. At 2:41 p.m. R21's feet					
		and she was in a partial sitting					
		ered the room and told R21 it					
		t up. NA-H raised R21's bed					
		ould come to get her when it , pulled R21's sheet down,					
		placed R21's bed back in					
	place, raised up h	er head of bed slightly and					
		ack down. NA-H told R21 he					
		to check on her and instructed					
		t to get up on her own. At 2:54					

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ΤΔΤΕΜΕΝΤ	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· ,			· · ·	MPLETED
							С
		245313	B. WING			80	8/27/2021
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CC	DE	
MEADOV	V LANE RESTORATI	VE CARE CENTER			9 UTAH AVENUE NSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	age 65	F 6	89			
		and were hanging from the					
		1's eyes were noted to be					
		lying on her right side. NA-H ss the hallway however did not					
	look into R21's roo	m. At 2:55 p.m. NA-G entered					
		if she could turn her again and to the bed. R21 made a noise					
		eep her feet up, asked her if it					
	hurt and R21 said r	my legs. NA-G raised R21's					
		e bottom of her bed slightly and					
		A-G was not observed nplaint of pain to nurse or					
		eet out of bed after incident. At					
		red her feet off of the bed,					
		21's room twice and did not NA-H was observed looking					
		ain, said Oh, getting down					
	again. At 3:05 p.m	. NA-H entered R21's room					
		he was going to put her feet sted her to put feet back into					
		gled her sheets from around					
		At 3:08 p.m. NA-H told R21 he					
		on her again then left the					
		NA-H entered R21's room, al lift and TMA-B. NA-H told					
		getting R21 up for supper,					
	then closed the doo	or. At 4:39 p.m. R21 was					
	U	eelchair with her feet on the in her room. R21 had no socks					
		et had leg ace wraps, (elastic	,				
		for dressings and swelling of					
		15 a.m. R21 was in the activity					
	room sitting in per	wheelchair, no slipper socks					

Facility ID: 00930

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		AND HUMAN SERVICES				FORM	: 10/07/2021 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245313	B. WING	;			C / 27/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
MEADO	W LANE RESTORATIN	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	usually did not take aware if she had ar mat by her bed, but her leg wraps. On 8/26/21, at 10:3 not usually work wit put her feet out, and to make sure she with kept putting her feet her up at that time. On 8/26/21, at 12:5 interview, NA-H stat of bed on 8/23/21. feet back into bed, at that time. NA-H the night shift, and out in bed, and his include getting her was awake. NA-H socks on, before he stated on 8/23/21, If feet while she was they were not on af wheelchair. NA-H sincontinence at one her feet out of the b at that time. On 8/27/21, at 11:4 remembered R21 a 8/23/21. NA-G said would readjust her NA-G indicated she R21's interventions she was awake. Na was to have gripped	ge 66 care of R21 and was not by falls. NA-E stated R21 had a c did not wear any socks, just 7 a.m. NA-F stated she did th R21, but stated she does d NA-F said she would check vas dry. NA-F stated if R21 t out of he bed, she would get 4 p.m. during a phone ted yes, R21 kept getting out NA-H said he kept putting her and no, he did not get her up indicated he usually worked he would just straighten R21 usual intervention did not up from her bed when she said R21 was to have gripper e got her out of bed. NA-H R21's socks would fall off her in bed and was the reason ter she was up in her stated he had checked R21 for e time 8/23/21, when R21 had bed but had not gotten her up 7 a.m. NA-G stated she attempted to get out of bed on d R21 kept getting up, so they and check on her more often. was not aware that one of included to get her up when A-G said she was aware R21 r socks on over her wraps, but did not have them on.	F	689			

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		AND HUMAN SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ΓIΡΙ	LE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
						0	C
		245313	B. WING _			08/2	27/2021
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	V LANE RESTORATIV	/F CARE CENTER			2209 UTAH AVENUE		
				E	BENSON, MN 56215		
(X4) ID			ID	,	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	`	CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
=	_						
F 689	Continued From pa	ge 67	F 68	89			
	On 9/26/21 at 2:42	n m licenced practical purce					
		p.m. licensed practical nurse 's interventions for falls					
	()	ways low, check on her often					
	and keep her door of	open. LPN-A sated R21 was					
		socks on, but R21 did not					
		I if R21 kept trying to get up ould get R21 up, and if she					
		t out of the bed, R21 should					
		n, discomfort or incontinence					
		sitioned. LPN-A stated for					
		wing R21's care plan he					
	she could roll out of	no leave her in bed, because f the bed					
		9 a.m. during a phone					
		anager (CM)-A indicated R21					
		er feet over the bed, floating in d if R21 was awake, and					
		, they should address R21's					
		and not tell R21 to stay in bed.					
		e would expect R21 to have					
	slipper socks when also.	she was up in the wheelchair					
	aiso.						
	On 8/27/21, at 1:29	p.m. director of nursing					
		21's care plan in her electronic					
		N confirmed R21's care plan					
		be up in wheelchair during less and R21 was to have					
	•	hen she was up in her					
	wheelchair. DON s	tated she expected staff to					
		an. DON stated she was					
		I a history of falls, but indicated as had no falls since she					
	began at the facility						
	gan at the raolity						
		nt report identified R21 was					
	observed lying on the	he floor next to her bed in low					

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	1	X3) DATE COM	E SURVEY PLETED
		245313	B. WING	;) (80) 27/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			-
MEADO	W LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD E		(X5) COMPLETION DATE
F 689	Continued From pa	ge 68	F	689				
	position on 3/27/21, noted at time of inc (IDT) reviewed the included a new inte- bed while occupied R21's facility incider found by staff lying on 3/30/21, at 3:32 of incident. IDT rev- included an interver assist with fall risk, day for activities. A intervention implem R21's facility incider found by staff sitting 4/7/21, at 9:44 p.m. incident. Notes on identified interventio (pain medication) to Noted resident likes bed. R21's primary phys 4/1/21, identified R2 falls out of bed, and concave mattress to R21's primary phys 4/15/21, identified F	at 11:00 a.m., no injuries ident. Interdisciplinary team fall dated 3/30/21, and rvention for a fall mat next to		009				
	apparent pattern. F identified the facility methods and were multiple falls occurr bed.	ere at different times with no R21's physician note further had tried multiple prevention trying a concave mattress as red when R21 rolled out of 4 a.m. during an interview, the						

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	V LANE RESTORATIV	E CARE CENTER		2	209 UTAH AVENUE		
				E	BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689 F 692 SS=D	plan, fall prevention the floor, call light w free of clutter and d socks/non-skid foot stated since R16 wa bed, she would exp She indicated with F not feel R16 had the her own and felt R1 uncomfortable vs w bed. The DON state staff to ask R16 wh she attempted to ge incidents were revie confirmed R16's me comprehensive and 6/25//21, and 8/21/2 record lacked any of followed up by thera The facility's physic for interview. A facility policy titled Managing, dated 3/ staff would identify resident's specific r prevent the residen minimize complicat directed facility staff centered fall prever subsequent falls an information on a co Nutrition/Hydration CFR(s): 483.25(g)(1	DON) confirmed R16's care interventions included mat to <i>vithin</i> reach, keep environment irected staff to ensure gripper wear was worn. The DON as no longer getting out of ect gripper socks to be worn. R16's current state, she did e strength to get out of bed on 6 may have been anting to get up and out of ed she would have expected at she was trying to do when et out of bed. R16's fall ewed with the DON, she edical record lacked a alysis of R16's falls on 1/27/21, 21, further R16's medical locumentation R16 was apy after her fall on 6/25/21. al therapist was not available d, Falls and Fall Risk 17/21, identified the facility interventions related to the isks and causes to try to t from falling. The policy f to implement resident otion plan and monitoring for d fall risk. The policy lacked mprehensive fall assessment. Status Maintenance	F 6				10/11/21
SS=D							

		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION ()	(X3) DATE SURVEY COMPLETED C 08/27/2021		
		245313	B. WING	i				
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/2		
MEADO	W LANE RESTORATIN	/E CARE CENTER			209 UTAH AVENUE SENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 692	Continued From pa	ge 70	F6	692				
	(Includes naso-gas both percutaneous percutaneous endo enteral fluids). Bas comprehensive ass ensure that a reside §483.25(g)(1) Main of nutritional status desirable body weig balance, unless that preferences indicat §483.25(g)(2) Is off maintain proper hyd §483.25(g)(3) Is off	tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and sed on a resident's sessment, the facility must ent- tains acceptable parameters , such as usual body weight or ght range and electrolyte e resident's clinical condition this is not possible or resident e otherwise; fered sufficient fluid intake to dration and health; fered a therapeutic diet when I problem and the health care						
	This REQUIREMEN by: Based on observat review, the facility facomprehensive nut interventions were in significant weight for reviewed for significant Findings include: R6's admission Min 2/24/21, indicated F impairment and have diabetes mellitus, a MDS indicated R6 m of one staff with tra personal hygiene, lit	NT is not met as evidenced tion, interview and document ailed to ensure a ritional assessment and implemented to prevent oss for 1 of 1 residents (R6)			 It is the expectation of the facility ensure that comprehensive nutritional assessment and interventions were implemented to prevent significant w loss for residents reviewed for weigh loss. R6 was reviewed and staff edu to ensure compliance with assessme and interventions in place were appropriate. All residents have the potential to affected by the deficient practice; resident s assessments and weight were reviewed, and no other residen were identified to have been affected Clinical morning meetings have beer updated to include review of weight 	al reight it icated ents be s ts ts d. n		

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OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	0938-039
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED
	245313	B. WING			C 27/2021
PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COI	•	
V LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE
identified R6's mos pounds (lbs) and he MDS further indicat symptoms of a swa had a five (5) perce last month and/or h six months. R6's admission Cat dated 2/24/21, iden impairment and hav anemia, diabetes m CAA indicated R6 r of staff for transfers hygiene, limited ass supervision with ea had no swallowing height was 66 inche (5) percent or more and/or had 10% we months. The CAA in any nutritional appr the nutritional statu related to R6's bod person's weight in screen for weight of health problems but body fatness or hea identified R6's BMI in an overweight ra R6's advanced age weight." The CAA in	t recent weight was 168 er height was 66 inches. The ted R6 had no signs or illowing disorder and had not ent or more weight loss in the had 10% weight loss in the last re Area Assessment (CAA) tified R6 had severe cognitive d diagnoses which included: nellitus and schizophrenia. The equired extensive assistance s, dressing, toilet use, personal sistance with bed mobility and ting. The CAA indicated R6 disorders, weight was 168 lbs, es and R6 had not had a five e weight loss in the last month eight loss in the last six dentified R6 was not receiving oaches. The CAA indicated s care area was triggered y mass index (BMI) (a kilograms divided by the meters). BMI can be used to ategories that may lead to t it is not diagnostic of the alth of an individual. The CAA was 27.1 which identified RR nge, however, indicated with a, she was at a "healthy ndicated R6 received a	F 69	 decrease in appetite, change and ensuring proper notificati dietician and MD as needed a required for ongoing assessment/interventions. 3. To currently enhance compoperations and under the dire Director of Nurses, a nursing training is scheduled on 10/4/ includes education of the poli procedures to ensure nutrition assessments are completed a appropriate interventions are prevent significant weight loss 4. Effective 10/1/21, a quality program was implemented ur supervision of the director of ensure compliance with the e of completing comprehensive assessments and completing interventions to maintain nutri determined necessary by thei individualized assessment. T of Nursing/Designee will audi weeks and then monthly for 3 Any identified deficiencies wil corrected, and all findings bro- monthly quality assurance compliance completing server assurance compliance completing weeks 	ons to and as plaint ction of the in-service 21 which cies and al and in place to s. r assurance nder the nursing to xpectations nutritional appropriate tion as r he Director t weekly for 6 months. l be pught to the mmittee for	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L identified R6's mos pounds (lbs) and he MDS further indicat symptoms of a swa had a five (5) perce last month and/or h six months. R6's admission Cal dated 2/24/21, iden impairment and had anemia, diabetes m CAA indicated R6 r of staff for transfers hygiene, limited ass supervision with ea had no swallowing height was 66 inche (5) percent or more and/or had 10% we months. The CAA in any nutritional appr the nutritional appr the nutritional statu related to R6's bod person's weight in square of height in screen for weight c health problems bu body fatness or hea identified R6's BMI in an overweight ra R6's advanced age weight." The CAA in consistent carbohy	DF CORRECTION IDENTIFICATION NUMBER: 245313 PROVIDER OR SUPPLIER X LANE RESTORATIVE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 71 identified R6's most recent weight was 168 pounds (Ibs) and her height was 66 inches. The MDS further indicated R6 had no signs or symptoms of a swallowing disorder and had not had a five (5) percent or more weight loss in the last month and/or had 10% weight loss in the last	PROVIDER OR SUPPLIER A. BUILDIN 245313 B. WING _ PROVIDER OR SUPPLIER JUDENTIFICATION NUMBER: V LANE RESTORATIVE CARE CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 71 identified R6's most recent weight was 168 pounds (lbs) and her height was 66 inches. The MDS further indicated R6 had no signs or symptoms of a swallowing disorder and had not had a five (5) percent or more weight loss in the last month and/or had 10% weight loss in the last six months. F 69 R6's admission Care Area Assessment (CAA) dated 2/24/21, identified R6 had severe cognitive impairment and had diagnoses which included: anemia, diabetes mellitus and schizophrenia. The CAA indicated R6 required extensive assistance of staff for transfers, dressing, toilet use, personal hygiene, limited assistance with bed mobility and supervision with eating. The CAA indicated R6 had no swallowing disorders, weight was 168 lbs, height was 66 inches and R6 had not had a five (5) percent or more weight loss in the last six months. The CAA identified R6 was not receiving any nutritional approaches. The CAA indicated the nutritional approaches. The CAA indicated the nutritional approaches. The CAA indicated to health problems but it is not diagnostic of the body fatness or health of an individual. The CAA identified R6's BMI was 27.1 which identified RR in an overweight range, however, indicated with R6's advanced age, she was at a "healthy weight." The CAA indicated R6 received a consistent carbohydrate diet, consumed 75 plus	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245313 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL VLANE RESTORATIVE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP COL SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) PREVIX Continued From page 71 F 692 identified R6's most recent weight was 168 pounds (lbs) and her height was 66 inches. The MDS further indicated R6 had no signs or symptoms of a swallowing disorder and had not had five (5) percent or more weight loss in the last six months. F 692 R6's admission Care Area Assessment (CAA) Tade afive (5) percent or more weight loss in the last six months. S. To currently enhance compoperations and under the dire Director of Nurses, a nursing training is scheduled on 10/4/1 includes education of the politiv and supervision with eating. The CAA indicated R6 had not had a five (5) percent or more weight loss in the last six months. The CAA identified R6 mas not receiving any nutritional approaches. The CAA indicated R6 had not had a five (5) percent or more weight loss in the last six months. The CAA identified R6 mas not receiving any nutritional approaches. The CAA indicated R6 had not had a five (5) percent or more weight was 168 lbs, height was 66 inches and R6 had not had a five (5) percent or more weight mas (2000) 4. Effective 10/1/21, a quality program was implemented ur supervision of the director of 1 meters). BMI can be used to screen for weight categories that may lead to heal	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMI 245313 B. WING COMI PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE SUMMARY STATEMENT OF DEFICIENCIES BENSON, MN 56215 COMI (EACH DEFCIENCY WEIL TO FDEFCIENCIES PROVIDERS PLAN OF CORRECTION PREVIDENTIFY AND OF CORRECTION (EACH DEFCIENCY WEIL TO FDEFCIENCIES PREVIDENTIFY AND OF CORRECTION PREVIDENTIFY AND OF CORRECTION (EACH DEFCIENCY WEIL TO FDEFCIENCIES PREVIDENTIFY AND OF CORRECTION PREVIDENTIFY AND OF CORRECTION (Continued From page 71 TAG COMICAL TO FORMEDIA AND OF CORRECTION (Continued From page 71 TAG COMICAL TO FORMEDIA AND OF CORRECTION (Continued From page 71 TAG COMICAL TO FORMEDIA AND OF CORRECTION (Continued From page 71 Continued From page 71 Continued From page 71 Continued From page 71 (Continued From page 71 Continued From page 71

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DA) <u>. 0938-039</u> TE SURVEY MPLETED C
		245313	B. WING		80	/27/2021
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
MEADO	W LANE RESTORATIN	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 692	included: diabetes i schizophrenia. The extensive assistance mobility, toileting, p assistance with dre transfers. The MDS independent with ea only from staff. The recent weight was inches. The MDS ic symptoms of a swa unknown if R6 had weight loss in the la weight loss in the la weight loss in the la Review of R6's adm dated 1/26/21, iden was 170 lbs and he completion of the fo assessment reveal weight, did not use averaged 65 plus % R6's nutritional asse estimated nutrition (kilocalorie (Cal or I protein 90-95 gram needs were 2000 m R6's medical record nutritional assessm Review of R6's sign an order dated 8/4/, 100 milligrams (mg day for urinary tract supplement 120 mi	act and had diagnoses which mellitus, anxiety and MDS indicated R6 required be of one staff with bed ersonal hygiene, limited ssing and supervision with 5 identified R6 was ating and required set up help e MDS indicated R6's most 168 lbs and her height was 66 dentified R6 had no signs or illowing disorder and was a five (5) percent or more ast month and/or had 10% ast six months. nission Nutritional Data form tified R6's admission weight er weight at the time of the form was 170 lbs. The ed R6 had no change in her adaptive equipment and 6 of her meal intakes per day. essment revealed her needs as 1500 to 1600 kcal kcal) per day, estimated s per day and estimated fluid hilliliters (mI) per day. d (MR) lacked any further	F 6	92		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			
		245313	B. WING				C 27/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 692	Review of R6's sign dated 8/5/21, revea discontinue R6's Me Simvastatin, Sitagli not improving due t weight loss and hyp Review of R6's Prof revealed staff had n requesting an order assist R6 with eatin order on 8/9/21, for treated by occupatie equipment. The MR lacked any evaluation being co Review of R6's med (MAR) from 8/1/21, following: - R6 had received h supplement everyda during this time. R6's care plan revis had a nutritional pro problem and was at altered state of min The care plan indica as ordered by medi intake, monitor for si dehydration, record facility protocol and The care plan ident from staff for eating	ned Order Summary Report led an order was received to etformin, Fosamax, ptin and to consult hospice if to diagnoses of dementia with boalbumenia. blem Sheet dated 8/7/21, notified R6's primary doctor r for adaptive dining utensils to ng. R6's primary doctor gave R6 to be evaluated and onal therapy (OT) for adaptive v documentation of an OT ompleted. dication administration record to 8/25/21, revealed the ner 120 ml of 2 Cal ay and had refused it twice sed on 8/25/21, indicated R6 oblem or potential nutritional t risk for dehydration with an id, age and decrease mobility. ated staff were to follow diet ical doctor, monitor fluid signs and symptoms of I daily intake, weights per I snacks per R6's preference. tified R6 required set up help g. ghts from 2/17/21, to 8/23/21,	F 69	92			

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		AND HUMAN SERVICES				FORM	APPROVED
	CS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		LE CONSTRUCTION		<u>0938-0391</u> e survey
	OF CORRECTION	IDENTIFICATION NUMBER:	` '				IPLETED
						(С
		245313	B. WING			08/:	27/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	W LANE RESTORATIV	/E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 602	0						
F 092	Continued From pa	-	F 6	92			
	- 2/17/21, - 168 lbs - 5/3/21, - 168 lbs						
	- 8/4/21, - 140.8 lbs	5					
	- 8/16/21, - 141.6 lb)S					
	- 8/23/21, - 142 lbs						
	R6's MR lacked an	y weights from 5/3/21, to					
	8/4/21.						
	Paview of R40's pro	ogress notes from 8/4/21, to					
	8/10/21, revealed th						
	- 8/4/21, medical do	octor noted having increased					
		oor appetite. R6 was weighed					
		28 lbs in the last 2 months. had refused nourishments					
		and was increasingly					
	confused. R6 had a	a strong odor to her urine and					
		rie malnutrition. Difficult to					
		behaviors, start Doxyclycline v to cover pulmonary and					
		and start 2 Cal supplement 120					
	ml by mouth twice a						
	0/1/21 D6 seen h	visures prestitioner for rounds					
		y nurse practitioner for rounds ondition, more tired, confused,					
		ting as well. Suspected urinary					
	tract infection, R6 h	ad lost 30 lbs since January					
		. New orders received for					
		g twice a day for 7 days for element 120 ml by mouth twice					
	a day for weight los						
	- 8/7/21 R6 had tro	ouble feeding herself and					
		neals. Tried lipped plate with					
	sippy cup and work	ed well. Faxed medical doctor					
		evaluate and treat for					
	adaptive dining uter	15115.					
	- 8/10/21, R6 refuse	ed to eat.					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DAT	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER		l 	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	2209 UTAH AVENUE		
MEADOV	V LANE RESTORATIV	E CARE CENTER		E	BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 692	Continued From pa	ge 75	F 6	92	2		
	unplanned signification her admission, 16.4 the last 6 months. During observations was seated at the d lunch. Dietary staff it down in front of he any help, R6 decline	y other documentation of R6's nt weight loss of 28 lbs from 7% of her body weight within s on 8/26/21, at 12:09 p.m. R6 lining room table waiting for brought R6 a plate of food, set er, asked her if she needed ed and said she was ok. R6 otatoes, country fried steak					
	with gravy on her pl of tea. R6 began to independently with - at 12:22 p.m. R6 c with gravy independ - at 12:25 p.m. licer came over and ask R6 responded ok. L him to cut up her st cut up her fried stea wanted a cola, LPN brought R6 a can o to eat and drink her - at 12:28 p.m. dieta like a piece of cake said she wanted ca piece of chocolate o cake independently	a silver spoon. continued to eat her fried steak dently. need practical nurse (LPN)-A ed R6 how she was doing and .PN-A asked R6 if she wanted eak, R6 agreed and LPN-A ak for her. R6 indicated she I-A went to the kitchen and f cola back while R6 continued food independently. ary staff asked R6 if she would or pudding for dessert and R6 ke. Dietary staff brought R6 a cake and she began to eat her r. R6 ate all of her potatoes, and approximately 75% of her					
	indicated nutritional completed on admi significant change. reviewed daily in the	p.m., dietary manager (DM)-A assessments were to be ssion, quarterly and with a DM-A stated weights were e MR and the reports would ight loss in one month or 10%					

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		AND HUMAN SERVICES				FORM	D: 10/07/2021 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED C
		245313	B. WING	i		08	B/27/2021
_	PROVIDER OR SUPPLIER	/E CARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 692	in 6 months. DM-A registered dietician facility until recently DM-A stated when was identified, the of contact the RD. On 8/25/21, at 12:3 via phone R6's MR DM-A verified R6 re- received 120 ml of and started the sup weight loss. DM-A of weight loss from M DM-A reported the 24 lbs from Februa was a 15% weight confirmed the last r completed in Janua admitted and verifie assessments had b time. DM-A stated re have been complet quarterly and with a condition. DM-A stated re have been complet guarterly and with a condition. DM-A stated re have been complet quarterly and with a completed as indica normal process wa doctor of any change the residents on a s the above findings staff to complete R day and to notify th weight loss is ident	indicated he believed (RD)-A was covering the when the facility hired RD-B. a significant weight change expectation was for staff to 7 p.m. in a follow up interview was reviewed with DM-A. eceived a diabetic diet, 2 Cal supplement twice a day oplement on 8/4/21, due to confirmed R6 had a significant ay 2021, to August 2021. MR had revealed R6 had lost ry 2021, to August 2021, which loss in 6 months. DM-A nutritional assessment was ary 2021, when R6 was ed no other nutritional been completed since that nutritional assessments should ed on R6 upon admission, any significant change of ated he believed R6's weight en identified sooner if the R6's weights had been ated. DM-A indicated the s to notify the RD and the ges in weight loss and to start supplement. DM-A confirmed and indicated he expected 6's weights weekly on her bath e nurses, DM whenever a		592			

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		X3) DATE COM	E SURVEY PLETED
		245313	B. WING	i) 08/2	C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
MEADOW	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD B		(X5) COMPLETION DATE
F 692	Continued From pa hygiene and toiletin feed herself after st supervised her. NA had good intake an received snacks du was not aware if R6 supplements. On 8/25/21, at 12:0 required extensive ADL's and sometim times when she wa was independent w to supervise and er indicated R6 receiv and additionally rec ml twice a day. LPN supplement the ma refuse at times. LPI refused the suppler re-approach her or stated staff were ex on their weekly bath loss is identified or weight. On 8/25/21, at 1:56 phone RD-A indicate facility. On 8/25/21, at 2:01 indicated she was a a little input, worked and as a result did facility's RD or cons		1	692				
	loss. RD stated she RD for recommend	e expected staff to contact the ations, provide supplements a week when a weight loss						

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		AND HUMAN SERVICES				FORM	: 10/07/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	`´co∧	E SURVEY IPLETED C
		245313	B. WING				27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		22	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 692	had been identified staff would be com monitoring intakes findings. RD-B state meals, it was exper- supplement. The R assessments shoul admission by the D thereafter. RD-B st notified RD of R6's interventions in play which would include for four weeks. In a 8/27/21, at 11:03 a. no written contract dietician services. On 8/25/21, at 2:15 confirmed R6 had r and stated she had evaluate R6. OTA-/ assistant (PTA)-A r nursing staff and P need to evaluate ar On 8/26/21, at 10:2 (MDSC) spoke with confirmed PT-A wa evaluate and treat I stated OT would ev On 8/26/21, at 10:2 phone PTA-A confit treated R6 yet for u equipment and had be completed on 8/ On 8/26/21, at 1:57	. RD-B indicated she expected pleting weekly weights, daily and to document the ed if a resident had refused cted staff would start nutritional D-B indicated nutritional Id have been completed on M and quarterly after ated the DM should have weight loss and put ce to stabilize the weight loss e completing weekly weights i follow up interview on m. RD-B confirmed she had with the facility to provide 6 p.m. OT assistant (OTA)-A not been receiving OT services not received any orders to A indicated Physical therapist eceived the orders from TA-A then communicated the nd treat residents. 27 a.m., MDS consultant n PTA-A via the phone and s not aware of the order to R6. MDSC indicated PTA-A valuate R6 on 8/30/21. 27 a.m., during an interview via rmed OT had not evaluated or use of adaptive eating I scheduled the evaluation to	F 6	92			

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). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION		TE SURVEY MPLETED
						С
		245313	B. WING _		08	/27/2021
NAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COL		
MEADO	W LANE RESTORATIN	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIOI DATE
F 692	CM-A indicated R6 would spill her food issues with her plat were obtained for the the order in the con- therapy staff the ner- were expected to p OT should have ev- ensure R6 received needed to eat her r On 8/27/21, at appr call medical doctor assumed the role of confirmed R6 had r loss. MD-A stated F dementia with schiz caused her weight had a poor appetite been progressing to MD-A stated she ha 120 ml twice a day expected OT to eva from the order. MD and the RD to com- monitor her weights any changes. On 8/27/21, at 12:3 (DON) confirmed the indicated she was j significant weight lo expected staff to m- , to report nutritional team and MD. The staff to monitor weights	of her activities of daily living. would miss the spoon and l on herself due to having e. CM-A stated when orders herapy, nursing staff placed nputer and would email w order. CM-A indicated staff rocess orders immediately and aluated R6 soon after to d the adaptive equipment she	F 69			

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		AND HUMAN SERVICES			FORM	: 10/07/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT COM	E SURVEY IPLETED
		245313	B. WING	 		27/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		-
MEADO	V LANE RESTORATIN	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	medications and fin problem. The DON evaluate and treat h ordered. The DON have RD on staff a the facility. Review of facility po Assessment dated assessment, which status and risk facts should have been of The policy identified with the nursing sta were to conduct a r resident upon admit change in condition risk for impaired nur resident nutritional the following compo- current height and w preferences, usual general appearance resident usual routi residents current co to be assessed, the care plan was to be minimize further nur Sufficient Nursing S CFR(s): 483.35(a) (§483.35(a) Sufficient the appropriate com provide nursing and resident safety and	ritional assessment, review ad out the root cause of the verified R6's OT order to had not been processed as indicated the facility did not and RD-B was trying to assist blicy titled, Nutritional 3/17/21, identified a nutritional included current nutritional ors for impaired nutrition, conducted for each resident. d the dietician in conjunction off and healthcare practitioners, nutritional assessment for each ssion, and as indicated a that placed the resident at trition. The policy revealed assessments included at least onents: usual body weight, weight, usual intake, food meal and intake patterns, e and clinical conditions and ne. The policy revealed onditions and risk factors were en analyzed and an individual e developed to address and tritional complications. Staff 1)(2)	F 6			10/11/21

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		STRUCTION	(X3) DATE COM	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
MEADOW	V LANE RESTORATIV	/E CARE CENTER			AH AVENUE DN, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 725	well-being of each in resident assessment and considering the diagnoses of the far accordance with the at §483.70(e). §483.35(a)(1) The in by sufficient number types of personnel nursing care to all in resident care plans (i) Except when wan this section, license (ii) Other nursing per limited to nurse aid §483.35(a)(2) Except paragraph (e) of this designate a license nurse on each tour This REQUIREMENT by: Based on observation review, the facility for staffing to provide in activities of daily liv personal hygiene a residents (R1, R18, R22) who required dependent on staff practice had the po- who resided in the Findings include: R1	resident, as determined by nts and individual plans of care a number, acuity and cility's resident population in a facility must provide services ers of each of the following on a 24-hour basis to provide residents in accordance with : ived under paragraph (e) of ed nurses; and ersonnel, including but not es. ept when waived under is section, the facility must ed nurse to serve as a charge of duty. NT is not met as evidenced tion, interview and document ailed to ensure sufficient outine assistance with ing (ADL's) of grooming, nd dressing for 7 of 7 , R11, R14, R6, R1, R21 and assistance and were for ADL's. This deficient tential to affect all 25 residents	F 7	1. I ens prov ADL wer furth patt nee 2. / affe staf inpu imp	t is the expectation of the fa ure sufficient staffing is in pl vide routine assistance with s who required assistance e dependent on staff for AD 8, R11, R14, R6, R1, R21 an e reviewed, and input provid her make adjustments with erns in order to meet all res ds in a timely manner. All residents have the potent cted by staffing. Facility pol f were reviewed, staff and re ut gathered; changes were lemented to ensure complia icient staffing. Clinical man	ace to resident⊡s e and who Ls. R1, id R22 ded to staff ident tial to be icies for esident unce with	

Facility ID: 00930

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY
			A. BUILDING	3		C
		245313	B. WING			
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO\	V LANE RESTORATIN	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 725		-	F 72			
	depression weakned (numbness/tingle ir identified R1 had se and required extension of daily living (ADL' hygiene, and bathin R1's care plan revision impaired cognition, required extensive hygiene, dressing at lacked direction for On 8/23/21, at 1:43 in bed, eyes closed her feet to mid chest her abdomen about dozen four (4) to five thick black coarse at chin and jaw line. Fe (10) mm long white corners of her mout On 8/24/21, at 8:50 in a wheelchair in the table next to another combed straight to have several dozer coarse facial hairs at and chin. On 8/25/21, at 8:24 in a wheelchair in the combed straight of the several dozer coarse facial hairs at and chin.	sed 7/12/21, revealed R1 had function, thought process and assistance with personal and bathing. R1's care plan facial hair removal. 6 p.m. R1 was observed lying l, covered with a blanket from st. R1's hands were rested on e the blanket. R1 had several <i>y</i> e (5) millimeters (mm) long, facial hairs along her upper lip, R1 had several six (6) to ten e wispy facial hairs along both th and chin. 0 a.m. R1 was observed seated her dining room at a squared er resident. R1's hair was her head and she continued to a 4 to 5 mm long, thick black along her upper lip, chin and veral 6- 10 mm long white long both corners of her mouth a.m. R1 was observed seated her room, her eyes were lited back and her mouth was		retrained on additional duties to ongoing the day to day staff patt reporting and processes were et to more closely monitor staffing Clinical managers were also ass additional rotating oversight on o to ensure that there was further observation and evaluation of flo based on resident input, staff an 3. An all staff in-service training for 10/4/2021 which includes eva and reviewing ongoing staffing p and input in order to meet reside in a timely manner, including rev policies and procedures for staff 4. Effective 10/1/2021, a quality assurance program was initiated the direction of the Director of N ensuring sufficient staffing to pro routine assistance with activities living. Audits are being conducted observe for timely and completed meeting needs of residents base individualized plan of care. Aud completed weekly for 6 weeks a monthly for 3 months to ensure compliance in this area. Any de will be corrected immediately; re brought to, and recommendation provided through to the monthly assurance committee team for f review and ongoing monitoring.	erns, and hhanced patterns. igned coverage or staff d family. is planned aluating atterns ent needs iewing ing. I under ursing for ovide of daily ed to care and ed on their ts nd ficiencies sults is quality	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING			C 08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	mm long white wisp corners of her mour nursing assistant (N hair and indicated s remove her facial h On 8/25/21, at 8:30 assisted R1 with mo removed R1's facia not have a razor to further indicated sh that morning to sha staffed that morning was not able to pro- due to insufficient s morning an NA did and a NA from the n was not familiar with On 8/25/21, at 10:2 (TMA)-A indicated F all of her ADL's and verbalized her need hair should have be was not aware if R1 she felt the NA's did cares, such as shar sufficient staff. TMA	aw line. R1 had several 6- 10 by facial hairs along both th and chin. At that time, VA)-E confirmed R1's facial she did not have a razor to air. a.m. NA-E stated she had orning cares and had not I hair. NA-E indicated R1 did remove the facial hair and e would not have had time ve R1 since they were short g. NA-E indicated she felt she vide R1 with standard cares taffing. NA-E indicated that not show up for the day shift hight shift had stayed over that h morning cares. 1 a.m. trained medication aid R1 was dependent on staff for felt R1 was not able to ds. TMA-A stated R1's facial een removed as needed and I had a razor. TMA-A indicated d not have time for routine ving, routinely due to lack of A-A stated she would help on	F 7	25			
	pass and when the the facility had been few months which h stated this past wee	s able between medication re were call ins. She indicated n using pool staff for the past had been helpful. TMA-A ek, they had a call in and had not been able to find					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED	
245313 B. WING 08/2	; 7/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW LANE RESTORATIVE CARE CENTER 2209 UTAH AVENUE BENSON, MN 56215		
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BETAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATEDEFICIENCY)DEFICIENCY)DEFICIENCY	(X5) COMPLETION DATE	
 F 725 Continued From page 84 R18's quarterly Minimum Data Set (MDS) dated 7/21/21, indicated R18 had diagnoses of chronic obstructive pulmonary disease, arthritis, anxiety and was severely cognitively impaired. The MDS indicated R18 was independent with bed mobility, transfers, dressing, toileting, eating and personal hygiene. R18's care plan revised on 3/23/20, indicated R18 had a physical functioning deficit related to self care impairment and mobility impairment. The care plan indicated R18 equired assistance from staff for set up, assist as needed and assist of one for shower for personal hygiene. During observations on 8/23/21, at 2:38 p.m. R18 was walking around the nursing home independently with her walker. R18's hair was pasted to the back of her head and to the right side of her head. R18's hair was also sticking straight up on the back side of her head and to the right side of her head. R18's hair was sticking straight up on the laft and back of her head. R18's hair was sticking straight up on the laft and back of her head. R18's hair was sticking straight up on the laft and back of her head. R18's hair was sticking straight up on the back and left side of her head. During observations on 8/25/21, at 10:38 a.m., R18 was sticking straight up on the hallway independently with her walker and set down to achir in the main entrance area. R18's hair was uncombed, pasted to the back and left side of her head. R18's hair was sticking straight up on the left and back of her head. 		

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL	E CONSTRUCTION		E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		245313	B. WING_			C 08/27/2021	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	V LANE RESTORATIV	/E CARE CENTER			209 UTAH AVENUE		
				B	ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 85	F 72	25			
	R18 walked down t	s on 8/26/21, at 11:13 a.m. he hallway independently with 3's hair was uncombed and t up all over.					
	(NA)-A indicated sh and was not familia she had access to r were stored at the r NA-A attempted to unable to locate it a indicated that day s medical records to in. NA-A located R facility's electronic r and indicated R18	1 a.m. nursing assistant he worked as a casual NA-A ir with R18's needs. She stated resident care guides which nurses station in a binder. retrieve the binder, and was at the nurses station. NA-A she had been pulled from work on the floor due to a call 18's plan of care in the medical record (MR) system, required staff assistance with t identify why R18 was not hing that morning.					
	had diagnoses which depression, muscle cognitively impaired independent with be	dated 6/11/21, indicated R11 ch included seizure disorder, e weakness and was severely d. The MDS indicated R11 was ed mobility, transfers, eating and personal hygiene.					
	had ADL self care p confusion and impa indicated R11 requi	ised on 2/10/21, indicated R11 performance deficit related to aired balance. The care plan red limited assistance from nd personal hygiene.					
	was seated in the c	s on 8/23/21, at 4:53 p.m. R11 hair in her room, wore a white e snow flakes and a pair of					

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245313	B. WING			C 08/27/2021	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	'E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	 blue shoes. R11's s white/brown spots of shoes had several s of the shoes. - at 5:08 p.m. R11 w hallway with her wa R11 wore a light blu light brown colored her legs, half way to entire buttocks area was darker brown in noted. R11 sat dow independently, while flies buzzed around clothing. R11 had s chin and neck area to 1/2 inch long. - at 6:42 p.m. R11 w independently with the same soiled shi hair remained the s During observations was seated out in th with several other re- clothing from yester soiled red/brown sp area and facial hair During observations R11 was seated in to wear the same s with a pair of yellow to be soiled and state 	walked independently in the liker and back to her room. We pair of denim jeans with stain noted on the inside of the knees and over her a. The outer ring of the stain in color and no odor was in in her chair in her room e visiting with her, multiple and landed on her and her everal white long hairs on her measuring approximately 1/4 walked down the hallway her walker, continued to wear it and pants and R11's facial ame. s on 8/24/21, at 1:09 p.m. R11 he activity room playing bingo esidents. R11 wore the same rday, her shirt had several bots on her chest and belly remained the same. s on 8/25/21, at 11:59 a.m. the dining room and continued hirt from Monday, 8/23/21, pants. R11's shirt continued ined with red/brown spots on area and R11's facial hair	F 7	25			

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245313	B. WING			C 08/27/2021	
NAME OF	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIN	/E CARE CENTER			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	During observations R11 walked independining room area, of shirt from Monday & yellow pants. R11's and stained with rea and belly area and same. R11 was observed for four days and the days and had not b On 8/26/21, at 11:2 worked as an NA of familiar with R11's r access to resident of at the nurses station had been pulled from the floor due to a cas of care in the facility indicated R11 requi- ADL's. NA-A did no assisted with groom R14 R14's quarterly MD R14 had diagnoses poly-arthritis, lymph and was severely c indicated R14 requi- bed mobility, transfe staff for personal hy- eating.	s on 8/26/21, at 12:20 p.m. ndently with her walker to the continued to wear the same 8/23/21, with the same pair of shirt continued to be soiled d/brown spots on her chest R11's facial hair remained the to wear the same soiled shirt he same soiled pants for two een shaven in four days. 1 a.m. NA-A indicated she in a causal basis and was not needs. She stated she had care guides which were stored n in a binder. NA-A attempted er, and was unable to locate it n. NA-A indicated that day she im medical records to work on all in. NA-A located R11's plan y's electronic MR system, and iired staff assistance with t identify why R11 was not	F 7	25			

Facility ID: 00930

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
		BERTHIO, CHOR HOWBER.	A. BUILDIN	ING		C
		245313	B. WING _		08/	27/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	had physical function impairment. The car one staff to assist we hygiene. During observations was noted to have I the back of her heat chin hairs approxime During observations was seated in her we R14 continued to ha hairs approximately During observations was in bed on her be began to make R14 straightened up the and soiled linen. NA garbage and soiled hallway on the othe NA-B entered the u and garbage in the hands. During an observation was the eled R14 hallway towards the to have several long approximately 1/4 in observed to offer or to R14. On 8/25/21, at 9:14 required assistance indicated she forgor	a on 8/23/21, at 5:05 p.m. R14 ber hair uncombed, matted to d and sticking straight up on d. R14 had several long white hately 1/4 inch long. s on 8/24/21, at 8:18 a.m. R14 wheel chair in her room and ave several long white chin of 1/4 inch long. s on 8/25/21, at 8:17 a.m. R14 wheel chair in her room, and ave several long white chin of 1/4 inch long. s on 8/25/21, at 8:17 a.m. R14 wheel chair in her room, and ave several long white chin of 1/4 inch long. s on 8/25/21, at 8:17 a.m. R14 wheel chair in her room, and ave several long white chin of 1/4 inch long. s on 8/25/21, at 8:17 a.m. R14 wheel chair in her room, and ave several long white chin of 1/4 inch long. s on 8/25/21, at 8:17 a.m. R14 wheel chair in her room, and ave several long white chin of the nursing home. tility room, placed the linen proper bins and washed her fon on 8/25/21, at 9:03 a.m. out of her room, down the e dining room. R14 continued	F 72			

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED C 08/27/2021	
		245313	B. WING			
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD		
MEADO	W LANE RESTORATIV	VE CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIOI DATE
F 725	stayed over from the was short staffed. S with morning care difficulty finding sup such as oral cares R6 R6's quarterly MDS had diagnoses white anxiety, schizophre The MDS indicated assistance of one s personal hygiene, I dressing and super R6's care plan revis had ADL self care p aggressive behavio and pain. The care one to two staff assis personal hygiene a During observation was seated in her r strong, pungent, he permeating from he bedding were comp a strong odor of uri Manager (CM)-A at incontinent brief wh with urine and had buttocks were wet, with markings note and transferred R6 refused the rest of	A contract of the second states of the second state	F 72	5		

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		AND HUMAN SERVICES				F	ORM.	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(>	(X3) DATE SURVEY COMPLETED C	
		245313	B. WING	i		08/27/2021		
	PROVIDER OR SUPPLIER	/E CARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP C 2209 UTAH AVENUE BENSON, MN 56215	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 725	night shift and state Both NA-E and CM when the last time I changed or offered - at 7:41 a.m. CM-A last time R6 had be CM-A reported R6 I changed at 3:40 a.n time of urine. R6's MR lacked an R6 had last been cl 3:40 a.m R21 R21's significant ch (MDS) dated 8/4/21 cognitive impairment included: Alzheiment and thyroid disorde required total assist extensive assistant and personal hygie R21's care plan rev required extensive personal hygiene a however was expect changed periodical R21 had impaired total R21 had impaired total R21's care plan rev required extensive personal hygiene a however was expect changed periodical R21 had impaired total R21 had impaired total R21 had impaired total R21 had impaired total R21 had impaired total R21 had impaired	A reviewed R6's MR, to see the enchecked and changed. A reviewed R6's MR, to see the enchecked and changed. had last been checked and m. and was incontinent at that y further documentation when hecked and changed since hange Minimum Data Set I, identified R21 had significant nt and diagnoses which r's disease, muscle weakness r. R21's MDS indicated R21 tance with transfers and ce with bed mobility, dressing	F	725				

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLI	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	۱G _			PLETED
		245313	B. WING _				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER	I	·	S	IREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	V LANE RESTORATIV	/E CARE CENTER			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE
1			1		· · · · ·		
F 725	-	-	F 72	25			
	neck ranging from 7 3/4 inches long.	1/8 inch with 4-5 hairs up to					
		a.m. R21 was observed					
		Ichair in her room. R21 nultiple facial hairs, white in					
	color on her chin ar	nd neck, ranging from 1/8 inch					
	long to 3/4 inch long	g.					
		5 a.m. R21 was observed					
		Ichair in the activity room with ents and staff members					
	present. R21 conti	nued to have facial hairs					
		with multiple white wispy hairs on her chin and neck.					
		9 a.m. nursing assistant					
		he did not usually assist R21 had helped another staff					
		cares that morning.					
	R22						
		ange Minimum Data Set					
	. ,	I, identified R22 had significant nt and diagnoses which					
	included: dementia,	, arthritis and hypertension					
		e). R22's MDS further ired extensive assistance with					
		ng, and personal hygiene.					
	R22's care plan rev	rised 8/13/21, identified R22					
	had an activities of	daily living (ADL) self-care					
		related to advanced dementia R22's care plan interventions					
	included extensive	assistance of one staff for					
	uressing, personal	hygiene and oral care.					
	On 8/25/21, at 7:36	a.m. to 8:16 a.m. NA-B					

Facility ID: 00930

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RS FOR MEDICARE					
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	TE SURVEY MPLETED
		A. BOILDING			С
	245313	B. WING		08/27/2021	
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	
V LANE RESTORATI	/E CARE CENTER				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETIO DATE
assisted R22 with r her wheelchair out were completed. D had not completed On 8/25/21, at 9:37 NA-B indicated her night shift, 10:30 p. within the last few v care staff calling in their morning shifts several residents w urine and would rec which included R1, residents. NA-B inci- been struggling with had improved some couple of months a again the last seven the facility had a car morning shift, either would stay or the d one NA. NA-B indic patterns would inclu- shift. She stated the within the last few r alone at night and co on the day and eve occurred most rece indicated she was t night. NA-B indicate was expected she	norning cares, then assisted in into the hallway after the cares uring the observation, NA-B oral cares for R22. Y a.m. during an interview, typical shift was working the m. to 6:00 a.m., however weeks the facility had direct sick or just not showing up for a. NA-B stated upon shift start, were routinely saturated with quire complete bed changes, R6 and several other dicated she felt the facility had h staffing for several months, e when pool staff came in a go and had been worsening ral weeks. She indicated when all in or a no show for the er someone from the night shift ay shift would work with only cated the usual staffing ude at least two NA's on each ere had been several times months when she had to work other NA's had worked alone ning shifts. NA-B stated this ently as the week prior and the only NA scheduled for that ed when she worked alone, it would provide care for	F 725	5		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L assisted R22 with r her wheelchair out were completed. D had not completed On 8/25/21, at 9:37 NA-B indicated her night shift, 10:30 p. within the last few v care staff calling in their morning shifts several residents w urine and would rea which included R1, residents. NA-B indic been struggling wit had improved some couple of months a again the last seve the facility had a car morning shift, either would stay or the d one NA. NA-B indic patterns would inclu- shift. She stated the within the last few r alone at night and co on the day and eve occurred most rece indicated she was to night. NA-B indicated	IDENTIFICATION NUMBER: 245313 PROVIDER OR SUPPLIER V LANE RESTORATIVE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 92 assisted R22 with morning cares, then assisted in her wheelchair out into the hallway after the cares were completed. During the observation, NA-B had not completed oral cares for R22. On 8/25/21, at 9:37 a.m. during an interview, NA-B indicated her typical shift was working the night shift, 10:30 p.m. to 6:00 a.m., however within the last few weeks the facility had direct care staff calling in sick or just not showing up for their morning shifts. NA-B stated upon shift start, several residents were routinely saturated with urine and would require complete bed changes, which included R1, R6 and several other residents. NA-B indicated she felt the facility had been struggling with staffing for several months, had improved some when pool staff came in a couple of months ago and had been worsening again the last several weeks. She indicated when the facility had a call in or a no show for the morning shift, either someone from the night shift would stay or the day shift would work with only one NA. NA-B indicated the usual staffing patterns would include at least two NA's on each shift. She stated there had been several times within the last few months when she had to work alone at night and other NA's had worked alone on the day and evening shifts. NA-B stated this occurred most recently as the week prior and indicated she was the only NA scheduled for that night. NA-B indicated when she worked alone, it was expected she would provide care for	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245313 B. WING	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245313 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO 209 UTAH AVENUE BENSON, NM 56215 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 92 assisted R22 with morning cares, then assisted in her wheelchair out into the hallway after the cares were completed. During the observation, NA-B had not completed oral cares for R22. F 725 On 8/25/21, at 9:37 a.m. during an interview, NA-B indicated her typical shift was working the night shift, 10:30 p.m. to 6:00 a.m., however within the last few weeks the facility had direct care staff calling in sito. or just not showing up for their morning shifts. NA-B stated upon shift start, several residents were routinely saturated with urine and would require complete bed changes, which included R1, R6 and several other residents. NA-B indicated she feit the facility had been struggling with staffing for several months, had improved some when pool staff came in a couple of months ago and had been worsening gapain the last several weeks. She indicated when the facility had a call in or a no show for the morning shift, either someone from the night shift would stay or the day shift would work with only one NA. NA-B indicated the usual staffing patterns would include at least two NA's on each shift. She stated there had been several times within the last few months when she had to work alone at night and other NA's had worked alone on the day and evening shift	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING Cold 245313 B. WING 08 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, NN 56215 SUMMARY STATEMENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USE DENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION HOULD BE CROSS-REFERENCED TO THE PROPRIATE DEFICIENCY) Continued From page 92 assisted R22 with morning cares, then assisted in her wheelchair out into the hallway after the cares were completed. During the observation, NA-B had not completed oral cares for R22. F 725 On 8/25/21, at 9:37 a.m. during an interview, NA-B indicated her typical shift was working the night shift, 10:30 p.m. to 6:00 a.m., however within the last few weeks the facility had direct care staff calling in sick or just not showing up for their morning shifts. NA-B stated upon shift start, several residents were routinely saturated with urine and would require complete bed changes, which included R1, R6 and several months, had improved some when pool staff carea in a couple of months ago and had been worsening again the last several weeks. She indicated when the facility had a call in or a no show for the morning shift. NA-B indicated the usual staffing patterns would include at least two NA's on each shift. She stated there had been several itmes within the last few months when she had to work alone at night and other NA's had worked alone on the day and evening shifts. NA-B stated this occurred most recently as the week prior and indicated she was the only NA scheduled for that night. NA-B indicated when she worked alone, it was expected she would provide

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DEPARTMENT OF HEALTH AND HUM CENTERS FOR MEDICARE & MEDICA					FORM	10/07/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVID	ER/SUPPLIER/CLIA ICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED	
	245313	B. WING _			C 08/27/2021	
NAME OF PROVIDER OR SUPPLIER		· [REET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW LANE RESTORATIVE CARE CE	ENTER			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID SUMMARY STATEMENT OF D PREFIX (EACH DEFICIENCY MUST BE PR TAG REGULATORY OR LSC IDENTIFYI	ECEDED BY FULL	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725 Continued From page 93 indicated she had spoken with administration and the director as recently as that day regardi sufficient staffing and had bee facility was working on a soluti On 8/25/21, at 10:06 a.m. duri interview, NA-B stated she typ perform R22's morning cares a with her morning routine. NA-E had not completed oral cares f morning, but indicated her usu be to complete oral cares. NA had stayed over from the night due to a no call no show. On 8/24/21, at 1:32 p.m. durin NA-C indicated the facility usu and two nurses each shift. NA the last few weeks, there had in the schedule and they would short nursing assistants. NA-C daily, when they started their s would be soaked with urinary i felt the prior shift was not able cares with one NA. NA-C state take a break during their eight would be no one to answer res NA-C indicated they made sur repositioned but when they we they would not be able to give and cares and essential cares such as repositioning and toile indicated shaving, showering a not generally be included in es indicated the charge nurse and of the staffing concerns and as day, had indicated they were w	r of nursing (DON) ng concerns with n informed the on. ng a follow up ically did not and was unfamiliar 3 stated no, she for R22 that al practice would A-B indicated she t shift that morning g an interview ally had two NA's -C indicated within been call-ins, holes d end up working c stated almost shift, residents ncontinence and to keep up routine ed they would not hour shift, as there sident call lights. e residents were ere short staffed residents baths would be provided, eting. NA-C and hair care would esential cares. NA-C d DON were aware s recently as that	F 72	25			

Facility ID: 00930

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		0. 0938-039 TE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		ING		COMPLETED		
		245313	B. WING			C / 27/2021		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,				
MEADO	W LANE RESTORATIV	VE CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE		
F 725	On 8/24/21, at 2:32 NA-G stated the us on each shift and the there were several they would be resp alone. NA-G stated were able, but often for getting residents cares. NA-G indica as that week and the felt residents did not times when they we they did they best the facility had pool state ago, which had hel occurred, usually withey had reported the concerns with staffin had been told the facility withey were working changes with staffin indicated the facility within the last few mistaffin indicated the facility within the last few mistaffin anagement/leaded was currently using been using the server The administrator states their board and car the skilled nursing splace in the board and car	2 p.m. during an interview, sual staffing was for two NA's wo nurses. NA-G indicated times an NA had called in and onsible for working the floor I the nurses would help as they ntimes they were responsible s up for meals and all routine ted this occurred as recently ne week prior. NA-G stated she of receive quality of care during ere short staffed, however felt hey could. NA-G stated the eff come in several months ped though call-ins still <i>v</i> ith the NA's. NA-G indicated to the DON and charge nurse ing as recently as that day and acility was working on it. By p.m. the facility d the facility schedule was elf and the DON and stated through significant process ng currently. The administrator y had a high staff turnover months, with several long term et go and shifts in ership. She indicated the facility g pool agency staff and had vice for the past few months. stated they had moved all of re residents up to one wing of side while renovations took and care, which also helped to ff. She indicated within the last		725				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
	FORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	NG		C
		245313	B. WING			8/27/2021
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
MEADOV	V LANE RESTORATIN	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETIO DATE
F 725	entry and posting/s	uge 95 who was responsible for data taff notification of open shifts. ndicated she was aware of the	F 72	25		
	current weeks staff	ing shortages and had shifts with licensed staff and				
	licensed practical n day an NA had calle	1 a.m. during an interview, urse (LPN)-A indicated that ed in for the day shift, al manager had helped on the				
	floor in the morning arrived early. LPN-, daily, the prior day	until one of the evening NA's A stated this occurred almost the facility had a no call no nad been a problem off and on				
	time, the facility wa stay from the previo in, though there we	s. LPN-A indicated most of the s able to mandate an NA to bus shift when there was a call re occurrences when there				
	also worked the evithose days, he felt the quality of care t	om nights and that NA had ening shift. He indicated on residents would not receive hey would like and may not s or medications timely. LPN-A				
have state resid suffic conc as re able cares	stated he had receive residents or family sufficient staffing he	wed no complaints from members regarding lack of owever staff had voiced ident care due to lack of staff,				
	able to help answer cares at times how	day. LPN-A indicated he was r call lights and assist with ever he was expected to tions in a timely manner as				
	well. LPN-A stated	he had voiced concerns to the sistant director of nursing				

Facility ID: 00930

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STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
	SI CONNECTION	245313	A. BUILDIN B. WING	NG		С
	PROVIDER OR SUPPLIER	240313	D. WING _	STREET ADDRESS, CITY, STATE, ZIP COD	•	/27/2021
	W LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215	L	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 725	indicated the facility NA's was two per s NA's had not show that occurred week scrambled to find s NA-F indicated the where upon starting one NA on the prior had appeared to ha including R1. NA-F recently as the day within the last few r not have sufficient in a timely manner. that day, they had s administrator and E calling in for shifts a NA-F indicated the indicated they were working to resolve On 8/26/21, at 2:01 NA-E indicated the work with her that of shown up for work help. NA-E indicated the work with her that of shown up for work help. NA-E indicated every time she wor times when an NA shift, the facility wa then the facility wa then the facility had work the floor. NA- for work in the mor including R6, R9, F and required comp she felt it occurred on the night shift. S patterns for NA's w stated more freque	y's usual staffing pattern for hift and that day one of the n up for her shift. NA-F stated ly and the facility routinely taff to piece a shift together. re had been several occasions g her shift there had been only r shift and several residents ave not gotten out of bed at all stated it had occurred as prior. NA-F stated she felt months the facility routinely did staff to provide resident cares NA-F indicated as recently as spoken with the facility DON regarding staff routinely and/or not showing up at all. facility management had a ware of the issue and were	F 72	25		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245313	B. WING _		08	C / 27/2021
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CC		
MEADO	V LANE RESTORATIV	E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 725	DON and administr recently as that day start looking up soc On 8/26/21, at 3:15 director (AD) stated the floor that day ar facility was short sta not routinely schede maintained her NA to help when neede On 8/27/21, at 9:53 (CM)-A indicated th no shows for direct and was responsibl assisting with cares worked the floor at concerned for the s required to work alo not received any co family members reg several staff memb residents cares wer such as incontinent and bathing. She st would piece shifts, show up for work, s aid would stay and evening NA to come up the whole shift. O was only one NA or worked the evening stay for the day shift to help on the floor. the facility DON as	ation regarding staffing as and had been told "things will on." p.m. the facility activity I she had been asked to work ad on prior days when the affed. She indicated she was uled on the floor, though had certification so she was able ed. a.m. the clinical manager e facility had frequent ill calls/ care staff or NA's routinely e for filling the shift and on the floor. CM-A stated she a minimum of weekly and was cheduled NA's who were one. CM-A indicated she had omplaints from residents or garding staffing however ers voiced concerns that re not being routinely provided ce cares, grooming, oral cares ated oftentimes the facility for example if a day NA did not such as the day prior, the night they would try to get an e in early, or find one to pick CM-A stated at times there on nights who had already g shift and would not be able to ft, then the CM was expected CM-A indicated she spoke to recently as the day prior ufficient staffing and had been	F 72	25		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		CO	MPLETED
		245313	B. WING			08	C / 27/2021
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CO	•	
MEADO	W LANE RESTORATI	VE CARE CENTER			9 UTAH AVENUE NSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 725	On 8/27/21, at 10:7 interview, the AD s floor approximately times due to lack of indicated she felt th DON had been doi staff and they conti to help meet reside On 8/27/21, at 11:4 with the facility adm administrator state facility staffing com- process of hiring d indicated she felt th improved within the indicated this past challenge with call schedule. The adm had implemented of responsible for the staffing and were r in the event of a ca administrator state nurse was also res the shift. The admi several months the staff hired, they we and then never car facility was current positions and had I in place for for staff The DON stated sh a management/lea clinical managers, overall workflow we	13 a.m. during a follow up tated she helped out on the a few times a week at varying f direct care staff. She he facility administrator and ng all they could to hire new inued to use agency pool staff	F 7	25			

Facility ID: 00930

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM APPROV OMB NO. 0938-03				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED			
		245313	B. WING				C 27/2021			
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
MEADOW	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 725	identified:	-	F 7:	25						
	12 hour shifts 5:00 6:00 a.m. to 2:00 p.	nsed staff were scheduled for a.m. to 5:00 p.m., a TMA from m. and two NA's from 5:30 oal with full census would be								
	licensed nurse) and	0 p.m. to 10:30 p.m. (or I two NA's from 1:30 p.m. to th full census would be three								
		urse 5:00 p.m. to 5:00 a.m. 10:00 p.m. to 6:30 a.m.								
	confirmed the facilit identified required s resident cares durin both stated they felt	ninistrator and the DON ty did not routinely have the staff on each shift available for ng the week of survey, though t it was a fluke and staffing g within the last few months.								
	stated he had just s coordinator, was pro- the facility administra- staffing pattern and the month. The staff posted the opening- up. He indicated he open shifts caused indicated it was the to find a replacement	p.m. the staffing coordinator started the role of staffing ovided the staffing data from rator and DON, such as developed the schedule for fing coordinator indicated he s for the month for staff to pick was not responsible for filling by a call in or a no show, and e charge nurses responsibility nt in those situations.								
		y staffing schedule from identified the following								

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		AND HUMAN SERVICES				FORM): 10/07/2021 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245313	B. WING			08	C 6/27/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	V LANE RESTORATIV	VE CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 725	-8/22/21, revealed NA shift. -8/25/21, revealed NA shift. Review of the facili of survey 8/17/21, t following unfilled sh -8/17/21, revealed NA shift	unfilled 5:30 a.m. to 2:00 p.m. unfilled 1:30 p.m. to 10:00 p.m. ty daily schedule for the week to 8/27/21, identified the	F 7	725			
	TMA shift	unfilled 6:00 a.m. to 2:00 p.m. unfilled 6:00 a.m. to 2:00 p.m.					
	NA shift	unfilled 10:00 p.m. to 6:30 a.m. unfilled 10:00 p.m. to 6:30 a.m.					
	p.m., one night NA	call in NA on 5:30 a.m. to 2:00 stayed from previous shift, o 10:00 p.m. NA shift and a a.m. NA shift.					
	p.m., CM was pulle	call in NA on 5:30 a.m. to 2:00 ed to the floor, and evening NA filled 10:00 p.m. to 6:30 a.m.					
	-8/27/21, revealed	unfilled 5:30 a.m. to 2:00 p.m.					

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		AND HUMAN SERVICES				FORM	: 10/07/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	CON	E SURVEY IPLETED C
		245313	B. WING				27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		22	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	NA shift, one night I Review of Meadow facility assessment the facility was licer beds, 19 board and beds, had an avera facility assessment plan: -day shift, two licent hours and one for s eight hours and thre -evening shift, two I each and one for ei and three NA's for eig Drug Regimen Rev CFR(s): 483.45(c)(1) §483.45(c)(1) The of must be reviewed a licensed pharmacis §483.45(c)(2) This of the resident's me facility's medical dir and these reports n (i) Irregularities inc drug that meets the	NA stayed from previous shift. Lane Restorative Care Center updated 7/25/21, identified nsed for 37 skilled nursing care beds, for a total of 56 ge daily census of 34. The identified the following staffing sed nurses, one for eight six and a half hours, TMA for ee NA's for eight hours each. icensed nurses for four hours ght hours, TMA for eight hours eight hours each. insed nurse for eight hours ght hours each. iew, Report Irregular, Act On 1)(2)(4)(5) egimen Review. drug regimen of each resident at least once a month by a it.	F 7				10/11/21

Facility ID: 00930

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	COM	E SURVEY PLETED C
		245313	B. WING	G			
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		-
MEADO	V LANE RESTORATIN	/E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 756	(ii) Any irregularities during this review n separate, written re attending physician director and directo minimum, the resid and the irregularity (iii) The attending p resident's medical n irregularity has bee action has been tak be no change in the physician should do the resident's medical §483.45(c)(5) The f maintain policies and drug regimen review	s noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical r of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. hysician must document in the record that the identified n reviewed and what, if any, sen to address it. If there is to a medication, the attending pocument his or her rationale in	F	756			
	when he or she ide requires urgent acti This REQUIREMEN by: Based on interview facility failed to ens (PC) identified and to the lack of a ratio (GDR) for a psycho residents (R10 and laboratory for 1 of unnecessary medic Findings include: R10's quarterly Min 6/11/21, identified F included cerebral va	eps the pharmacist must take ntifies an irregularity that ion to protect the resident. NT is not met as evidenced and document review, the ure the pharmacy consultant reported an irregularity related onal for gradual dose reduction otropic medication for 2 of 5 R22,) and physician ordered 5 residents (R10) reviewed for eations.			 It is the expectation of the far ensure the pharmacy consultant identified and reported an irregurelated to the lack of a rational f dose reduction (GDR) psychotra medication, and physician order laboratory reviewed for unnecess medications. R10 and R22 s regime was reviewed to ensure compliance with monitoring of recommendations. All residents have the potent adversely affected by the deficies practice. Facility policies and private to ensure the reviewed and revised to ensure the potent adversely affected by the deficies of the practice. 	t (PC) Ilarity for gradual opic red ssary drug ial to be ent rocedures	

Facility ID: 00930

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		OMB NO.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION	COM	E SURVEY IPLETED
		245313	B. WING _			C 27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		STREET ADDRESS, CITY, STATE, 2209 UTAH AVENUE BENSON, MN 56215	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 756	identified R10 had and required exten of daily living (ADL' received daily antip medications and id reduction had not b quarter. R10's care plan rev had behavior proble depression and che various interventior administering medi monitor/document R6's care plan reve antidepressants, ps listed several interv pharmacy review m R10's Consultant F Review dated 6/9/2 taking a current do (mg) at bedtime sir require at least qua sedatives/hypnotics dose reduction con suggested course of R10 for continued to bedtime for sleep. appropriate at the to for continuing current the form on 7/15/2 underline of "contin above. The form la current dose. The f nursing (DON) on 5	severe cognitive impairment sive assistance with activities (s.) The MDS revealed R10 osychotic and antidepressant entified a gradual dose been attempted in the last vised 7/12/21, revealed R10 ems (alcohol abuse) related to ronic pain. The care plan listed as which included: cations as ordered, side effects and effectiveness. ealed R6 received sychotropic medications and ventions which included nonthly or per protocol. Pharmacist's Medication enterly assessment of s for continued need and trial isideration. The form's of action included to assess use of Trazodone 50 mg at f a dose reduction was not ime, provide clinical rational ent dose. The physician signed 1, with a handwritten "ok", and buing current dose" in message acked a rationale for continuing form was signed by director of 7/20/21.	F 75	 proper monitoring of phrecommendations. Recover reviewed to ensure medication reviews. A nursing in-service for 10/4/2021 which incomportance of the preview. Effective 10/1/2021, assurance program was the direction of the direction of the direction review basis to ensure compliance with recompliance with recompliance with recompleted weekly for 6 monthly for 3 months to compliance with recompleted through the quality assure for further review and on the second second	commendations re compliance with training is planned ludes education of harmacist⊡s a quality s initiated under ctor of nursing to /s on a regular ance. Audits weeks and o ensure mendations. Any rected immediately, and monitored urance committee	

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION		(X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	i			PLETED
		245313	B. WING					C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
MEADOW	V LANE RESTORATIV	E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD I	BE	(X5) COMPLETION DATE
F 756	Continued From pa	ge 104	F7	756				
		pressant medication) 50 mg e related to insomnia, start						
		dministration Record (MAR) revealed R10 had received ations:						
		by mouth one time daily at ia, started 12/12/19.						
	had received orders panel (CMP) and co draws to check pati	e dated 5/26/21, revealed R10 s for comprehensive metabolic omplete blood count (CBC) lab ents liver and heart function abdominal girth and pain.						
	fax communication primary physician, i received for labs of The DON stated sh labs to be done at t would have been th confirmed the pharn have R10's Trazodo not been sufficiently physician.	5 a.m. the DON confirmed a had been sent to R10's n response an order had been a CBC and CMP to be drawn. e would have expected the he next available visit, which ie following day. The DON macy consultants request to one reviewed for a GDR had y addressed by R10's primary						
	coordinator, confirm had not been addre	1 a.m. the regional MDS ned R10's GDR for Trazodone essed by R10's primary cated an "ok" was not sufficient ued use.						
	interview R10's prin	4 a.m. during a telephone nary physician stated she had s on 5/24/21, and would have						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			PLETED
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	remembered to che have expected R10 during the next ava stated she had not gradual dose reduc On 8/27/21, at 1:37 interview, the PC st recommendations t 60 days after being been seen by psych months and she ha one of R10's provid GDR. The PC state response to a GDR had voiced this to th management in the not aware of R10's CBC and CMP. The	 ck on them, however would 's labs to have been drawn ilable visit. R10's physician felt R10 was a candidate for a tion for his Trazodone. p.m. during a telephone ated she expected her o be addressed within 30 to written. She stated R10 had hiatry within the last few d reminded the facility to have ers address his Trazodone d she did not feel an "ok" in was a sufficient rationale and he facility nursing past. The PC stated she was lab order on 5/25/21, for a e PC confirmed had she been ders and she would have 	F 7	756			
	(MDS) dated 8/6/21 cognitive impairment included: dementia, (high blood pressur indicated R22 requi- bed mobility, dressi	ange Minimum Data Set , identified R22 had significant nt and diagnoses which arthritis and hypertension e). R22's MDS further red extensive assistance with ng, and personal hygiene. ed R22 received antipsychotic					

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		AND HUMAN SERVICES			FORM): 10/07/202 1 APPROVE). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245313	B. WING		08	/27/2021
	PROVIDER OR SUPPLIER	VE CARE CENTER		STREET ADDRESS, CITY, STATE, Z 2209 UTAH AVENUE BENSON, MN 56215	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETIO DATE
F 756	and antidepressant days. R22's care plan rev had an activities of performance defici and limited mobility included: extensive dressing, personal R22's care plan ide antidepressant me (antidepressant) re behavioral disturba R22's care plan ind psychotropic medic (antipsychotic) rela R22's Consultant F Review dated 6/9/2 taking current dose bedtime since 2/20 at least quarterly as sedatives/hypnotics dose reduction con suggested course of R22 for continued bedtime for sleep. appropriate at the t for continuing curret the form on 7/15/2 underline of "contin above. The form la	t medications 7 of the last 7 vised 8/13/21, identified R22 daily living (ADL) self-care t related to advanced dementia 7. R22's care plan interventions assistance of one staff for hygiene, and bed mobility. entified R22 received dication, Trazodone elated to dementia with ance and an aid to sleep. dicated R22 received cations, risperidone ted to behavior management. Pharmacist's Medication 21, identified R22 had been e of Trazodone 25 mg at 121. CMS guidelines required ssessment of s for continued need and trial hsideration. The form's of action included to assess use of Trazodone 25 mg at If a dose reduction was not time, provide clinical rational ent dose. The physician signed 1, with a handwritten "ok", and huing current dose" in message acked a rationale for continuing form was signed by director of	F 75	6		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/07/2021 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
n h d 	ate of 8/23/21. risperidone (antips) ng. Give 1 mg by m bedtime related to u behavioral disturbar Trazodone hydroch ng by mouth at bed lementia with beha of 12/4/20. R22's physician pro dentified R22 was of the bedtime, and if R lay it would be disc continued use of Tra- borders to discontinue Dn 8/27/21, at 1:19 expected the PC to gradual dose reduct ecommendations of poy her primary phys should have gotten DON stated R22's p specific on pharmad and indicated the fa conversation with R dentified the facility ollow-up of pharma lune. DON confirme ecommendations to ohysician's respons o contact the physic	e 0.5 mg by mouth every 6 r anxiety and agitation, start ychotic medication) tablet 1 nouth every morning and at inspecified dementia with nce, start date of 2/18/21. hloride (HCI) tablet. Give 25 ltime related to unspecified vioral disturbance, start date gress note dated 4/15/21, currently on Trazodone 25 mg 22 appeared fatigued the next ontinued. No rationale for azodone was included and no e Trazodone were found. p.m. DON indicated she review medications and tions. DON reviewed R22's from 6/9/21, and the response ician of "Ok" and said nursing clarification from the doctor. primary physician was not very by recommendation follow ups cility needed to have a 22's primary physician. DON was inconsistent with their rey recommendations prior to ed she expected the PC's o be followed up on and if the e was unclear, nursing were	F 7	756			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
/		245313	A. BUILDIN B. WING	G		c
NAME OF	PROVIDER OR SUPPLIER	245515	D. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE	08/2	27/2021
	V LANE RESTORATIV	E CARE CENTER		2209 UTAH AVENUE		
				BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756 F 758 SS=D	interview PC-A con for the facility to foll recommendations w indicated she was r and had noted on 7 they would have ha physician documen on 8/13/21, howeve documentation. PC the required rationa Trazodone during h PC-A stated a response physician of "ok" wa for continued use. Free from Unnec PC CFR(s): 483.45(c)(3 §483.45(c)(3) A psy affects brain activiti processes and beha but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprese resident, the facility §483.45(e)(1) Reside psychotropic drugs unless the medicati specific condition as in the clinical record	firmed her expectation was ow up on her within 30-60 days. PC-A eviewing her documentation /15/21, the facility identified d R22's primary care t about the recommendation er could not locate the C-A stated she planned to add le for continuing R22's er next visit in September. onse from R22's primary care as not an acceptable rationale sychotropic Meds/PRN Use 3)(e)(1)-(5) tropic Drugs. /chotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following	F 75			10/11/21

		AND HUMAN SERVICES			FORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION	COM	E SURVEY PLETED C
		245313	B. WING			27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2209 UTAH AVENUE BENSON, MN 56215	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	drugs receive gradu behavioral interven contraindicated, in drugs; §483.45(e)(3) Resin psychotropic drugs unless that medicated diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 da §483.45(e)(5), if the prescribing practitic appropriate for the beyond 14 days, he rationale in the resi indicate the duration §483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practitic the appropriateness. This REQUIREMEN by: Based on interview facility failed to ens (GDR) was attempt which clinically con psychotropic medic residents (R10) rev medications. R10's quarterly Min 6/11/21, identified F included: cerebral	ual dose reductions, and tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented	F 7	1. It is the expectation of th ensure a gradual dose redu was attempted, or provider clinically contraindicated a 0 psychotropic medication wa R10□s drug regime was rev ensure compliance with unr psychotropic medications/P 2. All residents on psychotr have the potential to be affer deficient practice. Facility p procedures were reviewed a	ction (GDR) rationale which GDR, for a is completed. viewed to necessary RN use. ropic meds acted by the policies and	

Facility ID: 00930

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STATEMENT	OF DEFICIENCIES	KOMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				-		(C
		245313	B. WING			08/2	27/2021
	PROVIDER OR SUPPLIER	VE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 758	and required exten of daily living (ADL' received daily antip medications and id reduction had not b quarter. R10's care plan rev had behavior probl depression and chi various intervention administering medi monitor/document R6's care plan reve antidepressants, pe listed several intervention pharmacy review n R10's Consultant F Review dated 6/9/2 taking a current do (mg) at bedtime sin required at least qu sedatives/hypnotics dose reduction con suggested course of R10 for continued to bedtime for sleep, appropriate at the t for continuing current the form on 7/15/2 underline of "contin above. The form la current dose. The f nursing (DON) on 1	severe cognitive impairment sive assistance with activities (s.) The MDS revealed R10 osychotic and antidepressant entified a gradual dose been attempted in the last vised 7/12/21, revealed R10 ems (alcohol abuse) related to ronic pain. The care plan listed as which included: ications as ordered, side effects and effectiveness. ealed R6 received sychotropic medications and ventions which included: nonthly or per protocol. Pharmacist's Medication 21, identified R10 had been se of Trazodone 50 milligrams foce 12-2019. CMS guidelines uarterly assessment of s for continued need and trial usideration. The form's of action included to assess use of Trazodone 50 mg at If a dose reduction was not time, provide clinical rational ent dose. The physician signed 1, with a handwritten "ok", and nuing current dose" in message cked a rationale for continuing form was signed by director of 7/20/21.	F 75	58	on psychotropics were reviewed to that compliance with GDRs was completed; no further concerns we identified. 3. A nursing in-service training is pl for 10/4/2021 which includes educa the facilities policies and procedure unnecessary psychotropic medications/PRN use. 4. Effective 10/1/2021, a quality assurance program was initiated ur the direction of the director of nursi audit residents on psychotropic medications/PRN use and review of compliance. Audits completed wee 6 weeks and monthly for 3 months ensure compliance with recommendations. Any deficiencie be corrected immediately, findings brought to and monitored through t quality assurance committee for fur review and ongoing monitoring.	re anned ation of es for nder ng to of GDR ekly for to es will he	
	R10's signed Orde identified the follow	r Summary dated 6/3/21, /ing orders:					

		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED
		245313	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/2	21/2021
MEADOV	V LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM			
F 758	Continued From pa	ge 111	F 75	58		
	-Trazodone (antidepressant medication) 50 mg by mouth at bedtime related to insomnia, start date 12/12/19 R10's Medication Administration Record (MAR) for August of 2021, revealed R10 had received the following medications;					
	for August of 2021,	revealed R10 had received				
		by mouth one time daily at ia, started 12/12/19.				
	pharmacy consultan Trazodone reviewe	5 a.m. the DON confirmed the nts request to have R10's d for a GDR had not been ed by R10's primary physician.				
	interview, R10's phy	4 a.m. during a telephone ysician stated she had not felt te for a gradual dose reduction				
	interview, the pharm she expected her re addressed within 30 written. She stated psychiatry within the reminded the facility providers address h stated she did not for GDR was a sufficie	p.m. during a telephone nacy consultant (PC) stated ecommendations to be 0 to 60 days after being R10 had been seen by e last few months and she had y to have one of R10's his Trazodone GDR. The PC eel an "ok" in response to a nt rationale and had voiced ursing management in the				
		requested for psychotropic tions and one was not				

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245313	B. WING	;			27/2021
NAME OF I	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIN	/E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 770	Continued From pa	ge 112	F	770			
	Laboratory Services CFR(s): 483.50(a)(F	770			10/11/21
	laboratory services residents. The facil and timeliness of th (i) If the facility prov services, the servic requirements for lal of this chapter. This REQUIREMEN by: Based on interview facility failed to ens laboratory monitorin residents (R10) rev medication use. Findings include: R10's quarterly Min 6/11/21, identified F included: cerebral v chronic pain, arthrit identified R10 had s and required extens of daily living (ADL's Review of R10's ph dated 5/25/21, iden due to abdominal b problems. The fax of hand written order f (CBC) and compret (CMP) for a diagno	facility must provide or obtain to meet the needs of its ity is responsible for the quality he services. vides its own laboratory les must meet the applicable boratories specified in part 493 NT is not met as evidenced v and document review, the ure physician ordered ng was completed for 1 of 5 iewed for unnecessary			 It is the expectation of the facility ensure compliance with physician of laboratory monitoring. R10 has sin been reviewed to ensure compliance physician ordered labs. All residents have the potential t affected by the deficient practice. F and procedures were reviewed and residents with lab orders to ensure compliance with laboratory services A nursing in-service training is p for 10/4/2021 which includes educat the policies and procedures for ensi- compliance with physician ordered laboratory services. Effective 10/1/2021, a quality assurance program was initiated un the direction of the director of nursi- audit residents who have routine and physician ordered laboratory orders. Director of Nursing/Designee will at weekly for 6 weeks and then month months. Any identified deficiencies corrected, and all findings brought to monthly quality assurance committed 	nder ng to nder ng to nd new s. The udit nly for 3 s will be to the	

Facility ID: 00930

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245313	B. WING			C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 770	R10's progress note had received orders to check patients liv increased in abdom	e dated 5/26/21, indicated R10 s for CMP and CBC lab draws /er and heart function due to	F 77	0 further review and ongoing monito	ring.	
	(DON) confirmed a sent to R10's prima an order had been to CMP to be drawn. have expected the	fax communication had been ry physician and in response received for labs of a CBC and The DON stated she would abs to be done at the next h would have been the				
	interview R10's prin not ordered the labs remembered to che	4 a.m. during a telephone hary physician stated she had s on 5/24/21, and would have eck on them, however she ed R10's labs to have been ext available visit.				
	interview, the pharm was not aware of R a CBC and CMP. T been aware of the la	p.m. during a telephone nacy consultant stated she 10's lab order on 5/25/21, for he PC confirmed had she ab orders, however she would d the facility obtain them.				
F 801 SS=F	A facility policy was services and was n Qualified Dietary St CFR(s): 483.60(a)(aff	F 80	11		10/11/21
	appropriate compet	nploy sufficient staff with the encies and skills sets to carry the food and nutrition service,				

Facility ID: 00930

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/27/2021	
		245313	B. WING			
NAME OF	PROVIDER OR SUPPLIER	2-0010		STREET ADDRESS, CITY, STATE, ZIP CODE		/2//2021
MEADO	V LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 801	taking into consider individual plans of o and diagnoses of th in accordance with required at §483.70 This includes: §483.60(a)(1) A qua- clinically qualified n full-time, part-time, qualified dietitian or nutrition profession (i) Holds a bachelor a regionally accred United States (or al with completion of a program in nutriti- recognized for this (ii) Has completed supervised dietetics supervised dietetics supervised of a reg- professional. (iii) Is licensed or co- nutrition profession services are perform provide for licensur- will be deemed to h or she is recognize the Commission or successor organiza requirements of pa- this section. (iv) For dietitians hi November 28, 2016	ration resident assessments, care and the number, acuity ne facility's resident population the facility assessment D(e) alified dietitian or other nutrition professional either or on a consultant basis. A r other clinically qualified al is one who- r's or higher degree granted by ited college or university in the n equivalent foreign degree) the academic requirements of on or dietetics accredited by onal accreditation organization purpose. at least 900 hours of s practice under the gistered dietitian or al by the State in which the med. In a State that does not re or certification, the individual nave met this requirement if he d as a "registered dietitian" by n Dietetic Registration or its ation, or meets the ragraphs (a)(1)(i) and (ii) of red or contracted with prior to 5, meets these requirements rs after November 28, 2016 or	F 80			

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		AND HUMAN SERVICES			FORM	: 10/07/202 ⁻ 1 APPROVEI . 0938-039 ⁻
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION	COM	TE SURVEY MPLETED C
		245313	B. WING			/27/2021
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, S		
MEADO	V LANE RESTORATI	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 801	clinically qualified n employed full-time, person to serve as nutrition services w (i) For designations meets the following years after November after November 28, (A) A certified dieta (B) A certified dieta (B) A certified dieta (C) Has similar nati service manageme certifying body; or D) Has an associat service manageme course study includ management, from higher learning; and (ii) In States that has food service manage meets State require managers or dietar (iii) Receives freque from a qualified die qualified nutrition p This REQUIREMEN by: Based on observat review, the facility f person to serve as oversee the dietary a full time dietitian.	ualified dietitian or other utrition professional is not the facility must designate a the director of food and ho- s prior to November 28, 2016, requirements no later than 5 per 28, 2016, or no later than 1 er 28, 2016 for designations 2016, is: ry manager; or service manager; or onal certification for food nt and safety from a national e's or higher degree in food nt or in hospitality, if the es food service or restaurant n an accredited institution of d we established standards for gers or dietary managers, ements for food service y managers, and ently scheduled consultations titian or other clinically rofessional. NT is not met as evidenced tion, interview and document ailed to designate a qualified the director of food service to department in the absence of This had the potential to affect itors and staff who consumed	F8	1. It is the expect designate a qualif the director of foo dietary departmer full-time dietitian. procedures were Dietary Manager H qualifications for t 2. All residents ha	reviewed to ensure the nas the proper	

Event ID:RSG411

Facility ID: 00930

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STATEMEN	OF DEFICIENCIES OF CORRECTION	KOMPANY CALL CALL CALL CALL CALL CALL CALL CAL	. ,	PLE CONSTRUCTION G	Сом	E SURVEY PLETED
		245313	B. WING			C 27/2021
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CO	•	
MEADO	W LANE RESTORATION	VE CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 801	(DM)-A and DM-By manager of the foo On 8/23/21, at 12:5 the kitchen, DM-A it trained in by him to the kitchen. On 8/24/21, at 2:47 above findings and (RD)-A was coverin RD. DM-A explained every two weeks to RD-B recently assufacility. On 8/25/21, at 12:3 DM-A confirmed sh On 8/25/21, at 7:56 was not certified ar employee training. On 8/25/21, at 1:56 indicated she recer and was not overses she had offered to RD however the fa- her regarding the o On 8/25/21, at 2:01 indicated she was of facility a little input indicated she work	able to provide any support dietary manager were certified to be the ad service position. 50 p.m. during the initial tour of indicated DM-B was being take over the DM position in 7 p.m. DM-A confirmed the indicated registered dietician og for the facility until they hired ad RD-A came to the facility b assess the residents and umed this role to cover for the 87 p.m. in a follow up interview he was not certified to be a DM. 6 a.m. DM-B confirmed she and was in the midst of new 85 p.m. via phone call RD-A htly resigned from the facility being the facility. RD-A stated fill in until the facility hired a cility had not followed up with	F 80	 to serve as the director of fo oversee the dietary departm absence of a full-time dietitia current dietary manager has enrolled into the Certified Die program and has a precepto with assistance. Under the director of the an IDT training was help on review the facility policies an requirements for director of t to oversee dietary departme 4. Effective 10/1/2021, a qua assurance program was initi the direction of the administr monitor systems to ensure of compliance with designating person to oversee the dietar The Administrator/Designee weekly for 6 weeks and then months. Any identified defic corrected, and all findings br monthly quality assurance of further review and ongoing r 	ent in an. The since been etary Manager or assigned Administrator, 10/1/2021 to d food service nt. ality ated under rator to ongoing a qualified y department. will audit o monthly for 3 iencies will be rought to the pommittee for	

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		AND HUMAN SERVICES			FORM	: 10/07/2021 APPROVED . 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	CON	TE SURVEY MPLETED
		245313	B. WING			C / 27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		STREET ADDRESS, CITY, STATE, Z 2209 UTAH AVENUE BENSON, MN 56215	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	On 8/26/21, at 12:0 confirmed the above and DM-B were not verified the facility h RD-B and that it was between the owner On 8/27/21, at 11:3 RD-B confirmed the between her and th Review of facility po and Nutrition Service indicated the direct services would be n foods to all individu Food Procurement, CFR(s): 483.60(i)(1) §483.60(i) Food sat The facility must - §483.60(i)(1) - Proc approved or consid state or local autho (i) This may include from local producer and local laws or re (ii) This provision d facilities from using gardens, subject to safe growing and fo (iii) This provision c from consuming foo §483.60(i)(2) - Stor	 7 p.m. the administrator re findings and indicated DM-A t certified. The administrator and no written contract with as only a verbal agreement and RD-B. 30 a.m. in a follow up interview ere was no written contact re facility. blicy titled, Director of Food ces Responsibility undated, or of food and nutritional responsible for providing safe als. Store/Prepare/Serve-Sanitary)(2) fety requirements. cure food from sources ered satisfactory by federal, rities. a food items obtained directly rs, subject to applicable State egulations. oes not prohibit or prevent produce grown in facility compliance with applicable pod-handling practices. loes not procured by the facility. e, prepare, distribute and dance with professional 	F 8			10/11/21

Facility ID: 00930

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		AND HUMAN SERVICES			FORM	10/07/202 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED C
		245313	B. WING			_ 27/2021
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STA		
MEADO	V LANE RESTORATIN	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 812	by: Based on observat review, the facility f and sanitary manne cross contamination the potential to affe currently resided in from the Blue Horiz Findings include: During observations dietary cook (DC)-A from the steam tab area. DC-A had her plate, placed a score on the turkey and a plate. DC-A grabbe her gloved hand, pl set the plate on the - DC-A proceeded the r gloved hands, g the package setting placed it on the plate steam table to be d - at 6:05 p.m. DC-A top of the steam tal grabbed a plate, grathe package, place tongs to place hotd	NT is not met as evidenced tion, interview and document ailed to serve food in a safe er to prevent the spread of n. This deficient practice had oct all 13 residents who the facility and received food con kitchenette. s on 8/23/21, at 6:01 p.m. A was serving the supper meal le in the main dining room r hands gloved, she grabbed a op of turkey, a scoop of gravy a scoop of baked beans on the ed a handful of raw carrots with aced them on the plate and e steam table to be delivered. to touch the menu slips with grabbed a hot dog bun out of g on the back counter and te. DC-A grabbed the tongs, the bun, put a scoop of the	F 8	 1.It is the expectation serve food in a safe to prevent the spread contamination. This is the potential to affect currently reside and the Blue Horizon kito. 2. All residents have affected by this defice service policies and reviewed by the Adm Nursing to ensure the sanitary manner. 3. Under the direction and Dietician, an Ins for dietary staff on 10 compliance with the procedures of servin sanitary manner. 4. Effective 10/1/202 assurance program the direction of the amonitor systems to e compliance with servin servin sanitary manner. 	and sanitary manner d of cross deficient practice had t all residents who received food from thenette. the ability to be ient practice; food procedures were hinistrator/Director of at food is served in a n of the Administrator ervice is being held D/2/2021 to ensure facility policies and g food in a safe and 1, a quality was initiated under dministrator to ensure ongoing ving food in a safe . The mee will audit s and then weekly for hly for 3 months. Any s will be corrected, ght to the monthly mmittee for further	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		(X3) DATI	E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			IPLETED C
		245313	B. WING				27/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From par set the plate on top served. - at 6:08 p.m. DC-A dirty gloves on the b carrots, buns and c plastic container of gloved her hands, g cereal into it. DC-A bowl of cereal on it, the steam table to b menu slips off the to gloved hands and b proceeded to grab a pureed turkey on the the turkey, obtained set them on the cou- removed her gloves the back counter ne chips. DC-A gloved pureed beans in a b placed a scoop of p a scoop of gravy ar steam table to be d - at 6:11 p.m. DC-A scoop of pureed beans gravy and mashed placed it on top of the DC-A proceeded to dog bun out of the p and used tongs to p	ge 119 of the steam table to be removed her gloves, set the pack counter near her raw hips. DC-A then grabbed a cereal out of the cupboard, grabbed a bowl and poured grabbed a plate, placed the set the plate down on top of be served. DC-A grabbed the op of the steam table with her began to review them. DC-A a plate, place a scoop of e plate, a scoop of gravy on a bowls out of cupboard and unter behind her. DC-A s and set the dirty gloves on ear the raw carrots, buns and her hands, put a scoop of powl, set the bowl on a plate, pureed turkey on the plate with ad placed it on top of the	F 8	312	DEFICIENCY)		
	was done serving a On 8/24/21, at 4:41	t 6:31 p.m. p.m. dietary manager (DM)-A					

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		AND HUMAN SERVICES			FORM	: 10/07/2021 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY NPLETED	
		245313	B. WING			27/2021	
	PROVIDER OR SUPPLIER	/E CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE) TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 812 F 840 SS=F	confirmed the abov were expected to con- hands and start over when contaminated slips were complete indicated the slips were indicated dietary start touching the menu- touching ready to en- stated staff were ex- serve with and to no Review of facility por Preparation and Ha- hands should never directly. Food would served with clean to spatulas, or other s- manual contact of p- Use of Outside Res- CFR(s): 483.70(g)(1) §483.70(g)(1) If the qualified profession service to be provide must have that service person or agency of arrangement descri- Act or an agreement (2) of this section. §483.70(g)(2) Arran- section 1861(w) of pertaining to service resources must spa- assumes responsite	e findings and indicated staff hange gloves, wash their er with a clean pair of gloves I. The DM-A stated the menu ed in the resident rooms and were contaminated. DM-A aff should not have been slips while serving food and at foods thereafter. DM-A cpected to use utensils to ou use dirty gloved hands. blicy titled, General Food andling undated, indicated bare r touch ready to eat raw food d have been prepared and ongs, scoops, forks, spoons, uitable implements to avoid orepared foods. sources 1)(2) butside resources. facility does not employ a lal person to furnish a specific led by the facility, the facility vice furnished to residents by a utside the facility under an ibed in section 1861(w) of the nt described in paragraph (g)	F 8			10/11/21	

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		AND HUMAN SERVICES			FORM	10/07/202 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	Сом	E SURVEY PLETED C
		245313	B. WING			_ 27/2021
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
MEADOV	V LANE RESTORATIN	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 840	Continued From pa standards and princ	-	F 84	40		
		ding services in such a facility;				
	This REQUIREMEN	NT is not met as evidenced			e 1114 -	
	facility failed to ensure a written registered ensure a w agreement		1. It is the expectation of the ensure a written registered die agreement is in place. A facil written contract was obtained	tician ity specific		
		ct all 25 residents currently the registered dietician one identified that it was not in		the registered dietician once it identified that it was not in place 2. All residents have the poten	was ce.	
	Findings include:			affected by the facility not havi agreement with a registered d	ng a written ietician.	
	confirmed the abov	p.m. dietary manager (DM)-A re findings and indicated		The contract with the dietician obtained. Policies and proced	ures were	
	facility until they hire	(RD)-A was covering the ed a RD. DM-A indicated RD-A y every two weeks to assess		reviewed by the Administrator compliance with the expectation 3. An all staff in-service education	ons.	
		D-B recently assumed		planned for 10/4/2021 which in education regarding the requir outside resources; specifically	ncludes rements of	
		p.m. requested a copy of a n RD-B and one was not		registered dietician. 4. Effective 10/1/2021, a qual assurance program was initiat the direction of the administration	ity ed under	
	indicated she had r and had resigned b	p.m. via phone call with RD-A not been overseeing the facility pack in January 2021. RD-A pred to fill in until the facility		monitoring for compliance with agreements. Audits complete for 6 weeks and monthly for 3 ensure monitoring for complia	n written ed weekly months to	
	hired a RD howeve follow-up from the f	r had not received any facility regarding coverage.		Findings will be brought to and through the quality assurance for further review and ongoing	l monitored committee	
	indicated she had b facility a little input a stated she worked	p.m. via phone call RD-B been asked to provide the and to help them out. RD-B full time at another facility and vide coverage as their RD or				

		AND HUMAN SERVICES			FORM): 10/07/202 / APPROVEI). 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245313	B. WING		08	C 6/27/2021	
	PROVIDER OR SUPPLIER	/E CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2209 UTAH AVENUE BENSON, MN 56215	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	11:03 a.m. RD-B co contact with the fac On 8/26/21, at 12:0 confirmed the abov facility had no writte indicated there was between the owner Infection Prevention CFR(s): 483.80(a)(§483.80 Infection O The facility must es infection prevention designed to provide comfortable environ development and tr diseases and infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys reporting, investiga and communicable staff, volunteers, vis providing services of arrangement based conducted accordin accepted national s	ow up interview on 8/27/21 at onfirmed there was no written cility for dietician services. 7 p.m. the administrator re findings and verified the en contract with RD-B and s only a verbal agreement and RD-B. n & Control 1)(2)(4)(e)(f) Control tablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable tions. n prevention and control stablish an infection prevention n (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following	F 84			10/7/21	
		program, which must include,					

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		AND HUMAN SERVICES					FORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(COM	E SURVEY PLETED C
		245313	B. WING	;				27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP C 2209 UTAH AVENUE BENSON, MN 56215	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 880	 (i) A system of surv possible communic infections before th persons in the facilit (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pr (iv)When and how in resident; including if (A) The type and do depending upon the involved, and (B) A requirement the least restrictive post circumstances. (v) The circumstance must prohibit emploid disease or infected contact with resider contact with resider	eillance designed to identify sable diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility by ees with a communicable skin lesions from direct t the disease; and ne procedures to be followed direct resident contact. estem for recording incidents facility's IPCP and the aken by the facility. ndle, store, process, and as to prevent the spread of	F	880				

					0938-039	
	IDENTIFICATION NUMBER:	. ,		()	E SURVEY IPLETED	
			°		С	
	245313	B. WING			27/2021	
ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE		
V LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 5621	15		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORR	ECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE	
Continued From pa	ae 124	F 88	0			
Based on observation	tion, interview and document			ented.		
personal protective properly which had residents who reside the facility failed to hygiene and glove with incontinence c infection for 2 of 5 observed during per MASK USE On 8/25/21, at 7:19 was in the hallway which hung below f HK-A's mask would a.m. HK-A entered both R21 and R6 w	equipment (PPE) was worn the potential to affect all 25 led in the facility. In addition, assure appropriate hand use while providing assistance ares to prevent the spread of residents (R22, R14) pronal cares. a.m. housekeeper (HK)-A with his mask worn loosely, his nose. While HK-A spoke, d drop down to below. At 7:20 R21's and R6's room when vere in the room while his mask		ensure appropr and hand hygie aiding with inco the spread of in observed during of deficient prace reviewed and s providing perso further infection Facility policies were reviewed compliance. In re-educated sta on proper hand	iate PPE is worn properly ine and glove use while intinence cares to prevent ifection for residents g cares. Upon identification ctice, R22 and R14 were taff observations of inal cares to ensure no in control deficient practices. , procedures and systems to ensure system fection Preventionist aff and competencied staff washing and PPE use, to		
walked to R6's side who was in bed, wh her room. HK-A co room and gathered cart outside the doo stood next to R21 w when clinical mana HK-A's mask rema spoke to CM-A whi fitted on his face ar while he spoke. At the hallway towards his cart away, walk entered the door. H loosely down below HK-A entered room	e of the room and spoke to R6 hile he removed garbage from ontinued to walk around the supplies periodically from the orway. At 7:27 a.m. HK-A who was in bed in her room, ger (CM)-A entered the room. ined below his nose. HK-A le his mask remained loosely of falling below his mouth 7:28 a.m. HK-A walked down is the housekeeping closet, put ked to the basement door and IK-A's mask continued to hang y his nose. At 11:36 a.m. 147, while R13 was sitting in		affected by defi prevention and handwashing, g were competen observations of completed on a orientation pack include comple new hires and a The DON and I reviewed proce handwashing, g compliance with control practice	cient practices of infection control, specifically gloving and PPE. Staff icied and re-educated, the delivery of cares were ill applicable employees, kets were reviewed to tion of competencies for all annually for all employees. nfection Preventionist sses and procedures of gloving and PPE to ensure n infection prevention and s.		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Based on observar review, the facility f personal protective properly which had residents who resid the facility failed to hygiene and glove with incontinence c infection for 2 of 5 observed during per MASK USE On 8/25/21, at 7:19 was in the hallway which hung below f HK-A's mask would a.m. HK-A entered both R21 and R6 w continued to hang f walked to R6's side who was in bed, wh her room. HK-A co room and gathered cart outside the doo stood next to R21 w when clinical mana HK-A's mask rema spoke to CM-A whii fitted on his face ar while he spoke. At the hallway towards his cart away, walk entered the door. H loosely down below HK-A entered room his room. HK-A's r	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245313 PROVIDER OR SUPPLIER V LANE RESTORATIVE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 124 Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn properly which had the potential to affect all 25 residents who resided in the facility. In addition, the facility failed to assure appropriate hand hygiene and glove use while providing assistance with incontinence cares to prevent the spread of infection for 2 of 5 residents (R22, R14) observed during personal cares.	F CORRECTION IDENTIFICATION NUMBER: A. BUILDIN 245313 B. WING _ PROVIDER OR SUPPLIER JUNNARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 124 Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn properly which had the potential to affect all 25 residents who resided in the facility. In addition, the facility failed to assure appropriate hand hygiene and glove use while providing assistance with incontinence cares to prevent the spread of infection for 2 of 5 residents (R22, R14) observed during personal cares. MASK USE On 8/25/21, at 7:19 a.m. housekeeper (HK)-A was in the hallway with his mask worn loosely, which hung below his nose. While HK-A spoke, HK-A's mask would drop down to below. At 7:20 a.m. HK-A entered R21's and R6's room when both R21 and R6 were in the room while his mask continued to hang loosely below his nose. HK-A walked to R6's side of the room and spoke to R6 who was in bed, while he removed garbage from her room. HK-A continued to walk around the room and gathered supplies periodically from the cart outside the doorway. At 7:27 a.m. HK-A stood next to R21 who was in bed in her room, when clinical manager (CM)-A entered the room. HK-A's mask remained below his nose. HK-A spoke to CM-A while his mask remained loosely fitted on his face and falling below his mouth while he spoke. At 7:28 a.m. HK-A walked down the hallway towards the housekeeping closet, put his cart away, walked to the basement door and entered the door. HK-A's mask continued to hang loosely down below his nose. HK-A spoke to CM-A while his mask remained loosely fitted on his face and f	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245313 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, OT V LANE RESTORATIVE CARE CENTER STREET ADDRESS, OT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER (EACH ORR Continued From page 124 Based on observation, interview and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn properly which had the potential to affect all 25 residents who resided in the facility. In addition, the facility failed to assure appropriate hand hygiene and glove use while providing assistance with incontinence cares to prevent the spread of infection for 2 of 5 residents (R22, R14) observed during personal cares. F 880 MASK USE On 8/25/21, at 7:19 a.m. housekeeper (HK)-A was in the hallway with his mask worn loosely, which hung below his nose. While HK-A spoke, HK-A's mask would drop down to below. At 7:20 a.m. HK-A entered R2's and R6's room when both R21 and R6 were in the room while his mask continued to hang loosely below his nose. HK-A spoke to CM-A while he removed garbage from her room. HK-A continued to walk around the room and gathered supplies periodically from the cart outside the doorway. At 7:27 a.m. HK-A spoke to CM-A while his mask remained loosely fitted on his face and falling below his nose. HK-A spoke to CM-A while his mask continued to hang loosely down below his nose. At 11:36 a.m. HK-A entered room 147, while R13 was sitting in his room. HK-A's mask continued to hang loosely All residents ha affected by defin prevention and norientation pade c	F CORRECTION IDENTIFICATION NUMBER: A BUILDING COM 245313 B. WING B. WING 087 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2209 UTAH AVENUE 2209 UTAH AVENUE SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTIVE ACTION NUMBER:) ID PREVIDER OR SUPPLIER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTIVE ACTION SHOULD BE (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ID PREVIDER OR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 124 Based on observation, interview and document review, the facility failed to assure appropriate hand hygiene and glove use while providing assistance with incontinence cares to prevent the spread of infection for 2 of 5 residents (R22, R14) observed during personal cares. F 880 DASE/S1/1, at 7.19 a.m. housekeeper (HK)-A was in the hallway with his mask worn loosely, which hung below his nose. HK-A sonthued to hang loosely below his nose. HK-A was in the hallway with his mask worn loosely, which hung below his nose. HK-A southene to R21 who was in bed in her room, HK-A's mask remained book his nose. HK-A spoke to CM-A while he removed garbage from her room. HK-A continued to hang hosely below his nose. HK-A spoke to CM-A while he removed garbage from her room. HK-A continued to walk around the room and gathered supplese periodically from the cart outside the doorway. At 7:27 a.m. HK-A spoke to CM-A while he removed garbage from hene failed on hasuce (CM)-A entered the rooom. HK-A's mask continued	

		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		245313	B. WING				C 27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER	1	22	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE SENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	various items in R1 in his room. On 8/25/21, at 11:5 HK-A's mask contir nose. When HK-A s below his mouth HH his nose. HK-A stat was below his nose and fogging up his residents stated the him when his mask said he had receive week about proper he pulled it down si HK-A confirmed he 19 vaccination yet. On 8/26/21, at 9:29 (HM)-A confirmed to stated he had remin nose and mouth co indicated it was imp pandemic concerns R22 R22's significant ch (MDS) dated 8/6/21 cognitive impairment included: dementia (high blood pressur indicated R22 requi bed mobility, dressi R22's care plan rev	3's room while R13 remained 0 a.m. during an interview nued to hang down below his spoke his mask fell down K-A positioned his mask up to ted he was aware his mask and indicated it kept falling glasses. HK-A indicated some ey had a difficult time hearing twas over his mouth. HK-A ed education this week and last mask use however indicated nce it fogged up his glasses. had not received the COVID 0 a.m. housekeeping manager here had been concerns of the by staff. HM-A indicated his to slip down as well. HM-A nded his staff to keep their overed with the mask and portant due the COVID-19		380	audits on all shifts implemented ar compliance must be achieved for before any changes, any deficience be corrected, findings brought to a monitored through the quality assu committee for further review and o monitoring.	7 days ies will and ırance	

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION). 0938-039 TE SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED	
		245313	B. WING _		08	C / 27/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•		
MEADO	W LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 880	Continued From pa	age 126	F 88	30			
	and limited mobility included: extensive	t related to advanced dementia r. R22's care plan interventions assistance of one staff for hygiene, and bed mobility.					
	entered R22's roon provide R22's morr observed to comple	a.m. nursing assistant (NA)-B n and informed R22 she would ning cares. NA-B was not ete hand hygiene when she					
	in the sink and star while R22 sat on th gown was removed	n. NA-B filled a basin of water ted to remove R22's gown e edge of the bed. After R22's I, NA-B assisted R22 to lie					
	NA-B folded the bri placed her bare ha	ed the tabs on R22's brief. ef down between her legs and nd onto the brief to check for oggles were noted to be on the					
	was not observed t lowered R22's bed	d not covering her eyes. NA-B o perform hand hygiene. NA-B , walked to the counter and multiple drawers. While NA-B					
	was opening the dr drawer handles and NA-B located some	awers, NA-B touched the d multiple items in the drawers. e towels and socks and placed					
	into the basin of wa placed the basin of	er top. NA-B put the washcloth ater, returned to R22's bed and water on the bed side table A-B began to wash R22's face					
	NA-B pulled R22's inside of her brief v	wash her hands and arms. brief back down, touched the vith her bare hands and blete perineal cares with her					
	bare hands. NA-B the handle of the cl	walked to the closet, touched oset, removed a new brief and red. NA-B assisted R22 to turn					
	R22's soiled brief a her. At this point, N	d R22's buttock, removed and placed the new brief under A-B placed gloves on, applied ment to R22's buttocks and					

Facility ID: 00930

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	. ,	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	co	MPLETED	
		245313	B. WING _		08	C 6/27/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
MEADO	W LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 880	perineal area. NA-E fastened the tabs of her gloves and was hands. NA-B's gog her head during the R22. NA-B walked closet door handle, removed R22's cloi assisted R22 to sit socks and shoes. No opened multiple dra stated she was sea located the gait bel attempted to transfineeded assistance attempt, opened R2 medication aid (TM entered the room, Na-B to her wheelchair. the sink once the ta the room. NA-B ren rinsed out R22's ba R22's comb, combo hair in a bun. At 8: hands in the sink for goggles remained of the entire time. NA room for 39 minute On 8/25/21, at 9:32 confirmed she had she began R22's ca have washed her h about it due to the for cares. NA-B stated shift when she was opened up she was	³ pulled up R22's brief and on the sides. NA-B removed a not observed to sanitize her gles remained on the top of a time cares were provided to to the closet, touched the opened the door and thing. At 7:55 a.m. NA-B up, applied R22's shirt, pants, NA-B went to the counter, awers and the closet and urching for the gait belt. NA-B t on top of R22's chair, er R22 her self and stated she . NA-B stopped the transfer 22's door and asked trained IA)-A for assistance. TMA-A washed her hands in the sink to transfer R22 from her bed TMA-A washed her hands in ask was completed and exited noved R22's gait belt and usin in the sink. NA-B wet ed her hair and placed R22's 16 a.m. NA-B washed her or the first time. NA-B's on top of her head throughout A-B was observed in R22's	F 88				

Facility ID: 00930

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED	
		245313	B. WING		08	C 3/27/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•		
MEADO	V LANE RESTORATI	VE CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 880	••••••	-	F 88	80			
	wearing gloves and stated should have worn gloves when she worked on perineal cares for R22. NA-B d indicated she had been "called on it" in the past when she had not work gloves while providing cares. NA-B stated about 50% of the time she wore gloves when providing incontinence cares at night since the staff she worked with at night worked very quickly. NA-B confirmed she had touched multiple items in R22's rooms without washing her hands after perineal cares and indicated she was aware that action breach in infection control practices. NA-B confirmed she had only washed her hands after she was done with R22's morning cares. NA-B confirmed she had worn her goggles on the top of her head during R22's cares as they kept fogging up.						
	interview clinical m expected hand hyg staff entered reside worn during perine have been washed removed. CM-A in	19 a.m. during a phone anager (CM)-A confirmed she jiene to be completed when ent's rooms, gloves were to al cares and hands should or sanitized after gloves were dicated proper hand hygiene e important to prevent the					
	MASK USE						
	west hallway towar facemask was und into resident room seated in a wheelc HK-A spoke with th three feet from her	2 a.m. (HK)-A walked down the ds the end of the hall, erneath his nose. HK-A walked 115, which the resident was hair at a table by the wall. he resident, approximately , his mask remained se. HK-A wiped the floor, then					

Facility ID: 00930

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>´</i>		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE		
MEADOV	W LANE RESTORATIV	E CARE CENTER			SENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	left the room. -at 7:12 a.m. HK-A hallway, his mask u mouth exposed. -at 7:49 a.m. HK-A hallway, walked tow face mask was below -at 8:06 a.m. HK-A hallway and walked hallway. HK-A's fac and upper lip. HK-A practical nurse (LPI	was observed in the west underneath his chin, nose and was observed in the west vards the nurses station, his ow his nose and mouth. was observed in the west towards the end of the se mask was below his nose A walked past licensed N)-A and trained medication either staff member directed	F 8	80			
	R14 had severe coo diagnoses which in poly-arthritis and lyr identified R14 requi bed mobility, transfe	S dated 7/13/21, indicated gnitive impairment and had cluded: depression, mphedema. The MDS ired two staff assistance with ers, dressing, toileting, one ygiene and supervision with					

Facility ID: 00930

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	co	MPLETED		
		245313	B. WING		C 08/27/2021			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•			
MEADO	V LANE RESTORATI	VE CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 880	During observation was in bed on her (NA)-B entered her was noted to be or proceeded to make straightened up the and soiled linen. N garbage and soiled hallway on the othe while her eye prote head. NA-B entered linen and garbage her hands. - at 8:26 a.m. NA-E and down the hallw remained on top of tissue at the nurse with her hand and walked down the h	age 130 is on 8/25/21, at 8:17 a.m. R14 back when nursing assistant r room and her eye protection the top of her head. NA-B e R14's room mates bed, e room, collected the garbage A-B exited R14's room with the d linen and walked down the er end of the nursing home ection remained on top of her ed the utility room, placed the in the proper bins and washed B walked out of the utility room vay while her eye protection F her head. NA-B grabbed a s desks, pulled down her mask blew her nose while she allway to R14's room. NA-B n, threw the tissue in the	F 8	80				
	her nose and mouth NA-B approached bed and said good covers while her ey of her head and the and landing on R14 supplies. NA-B unit touched the soiled and indicated R14 wash cloth, washed tucked R14's brief wash R14's peri an asked R14 to roll to her buttocks area, with her bare hand NA-B placed a clear	her mask, pulled it back over th area and washed her hands. R14 while she was laying in morning. NA-B removed R14's /e protection remained on top ere were flies buzzing around 4 while NA-B collected her nooked R14's incontinent brief, surface with her bare hands was wet. NA-B obtained a wet d R14's hands and face, on the left side and began to ea with her bare hands. NA-B o the right while she washed removed the wet soiled brief s and threw it in the garbage. an incontinent brief under R14, t and hooked the incontinent						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 10/07/2021 APPROVED). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION		TE SURVEY MPLETED C
		245313	B. WING			08	/27/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MEADO	V LANE RESTORATIN	E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	chose what she wa R14's pants, donner wraps to her lower R14's feet, removed under her armpits a head. NA-B rolled F straightening her cl under her. NA-B co protection on the to provided cares. - at 8:52 a.m. NA-B ask for assistance a protection on top of into the room, posit R14 and hooked th medication aid (TM and TMA-A transfer from her bed to her from the sling and immediately left R1 peddles to R14's wi the peddles, combe glasses on her face linen, washed her ha grabbed a blanket a - at 9:03 a.m. NA-B area, down the hall with her eye protect Several residents w area. On 8/25/21, at 9:14 above findings and assistance with all o	-	Fξ	380			

Facility ID: 00930

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DA	TE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED	
	245313	B. WING _		08	C 3/27/2021	
PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD			
V LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETIO DATE	
residents. NA-B inc eye protection at al stated she should h her hands while pro- the spread of infect R6 R6's quarterly MDS was cognitively inta- included: diabetes schizophrenia. The extensive assistance mobility, toileting, p assistance with dre transfers. During observation was seated in her w herself towards the was sweeping R6's surgical mask. HK- on the top of his ch exposed while R6 I At 7:27 a.m. registe R6's room to assist - at 7:41 a.m. R6 ha it to be cleaned by room to inform HK- - at 7:59 a.m. HK-A was sleeping in bec mask. HK-A's surgi of his chin with his - at 8:06 a.m. R26 s clean R6's room. H	dicated staff were to wear their I times and during cares. NA-B have worn gloves and washed oviding peri cares to prevent tion. a dated 5/27/21, indicated R6 het and had diagnoses which mellitus, anxiety and MDS identified R6 required ce of one staff with bed ersonal hygiene, limited essing and supervision with s on 8/25/21, at 7:25 a.m., R6 wheel chair and wheeling door. Housekeeper (HK)-A a room and was wearing a A's surgical mask was down in with his mouth and nose ooked in her closet for clothes. ered nurse (RN)-A entered ther and HK-A left the room. ad soiled her bed and needed housekeeping. RN-A left R6's A. Cleaned R6's bed while R26 d. HK-A was wearing a surgical ical mask was down on the top mouth and nose exposed. slept while HK-A continued to IK-A mask continued the same	F 88	30			
	PROVIDER OR SUPPLIER V LANE RESTORATIV SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From paresidents. NA-B ince eye protection at all stated she should h her hands while protection at all stated she should h her hands at all stated she should h his chin with his - at 8:06 a.m. R26 si clean R6's room. H exposing his nose at all states at all she should h her hands at all she should	DF CORRECTION IDENTIFICATION NUMBER: 245313 245313 PROVIDER OR SUPPLIER X LANE RESTORATIVE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 132 residents. NA-B indicated staff were to wear their eye protection at all times and during cares. NA-B stated she should have worn gloves and washed her hands while providing peri cares to prevent the spread of infection. R6 R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS identified R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with	OF DEFICIENCIES FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 245313 B. WING 245313 B. WING PROVIDER OR SUPPLIER 245313 V LANE RESTORATIVE CARE CENTER ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 132 residents. NA-B indicated staff were to wear their eye protection at all times and during cares. NA-B stated she should have worn gloves and washed her hands while providing peri cares to prevent the spread of infection. F 88 R6 R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS identified R6 required extensive assistance of one staff with bed mobility, toileting, personal hygiene, limited assistance with dressing and supervision with transfers. During observations on 8/25/21, at 7:25 a.m., R6 was seated in her wheel chair and wheeling herself towards the door. Housekkeeper (HK)-A was sweeping R6's room and was wearing a surgical mask. HK-A's surgical mask was down on the top of his chin with his mouth and nose exposed while R6 looked in her closet for clothes. At 7:27 a.m. registered nurse (RN)-A entered R6's room to assist her and HK-A left the room. - at 7:41 a.m. R6 had soiled her bed and needed it to be cleaned by housekeeping. RN-A left R6's room to inform HK-A. - at 7:59 a.m. HK-A cleaned R6's bed while R26 was sleeping in bed. HK-A was wearing a surgical mask. HK-A's surgical mask was down on the top of his chin with his mouth and nose exposed. - at 8:06 a.m. R26 slept while HK-A continued to clean R6's room. HK-A mask con	OP DEFICIENCIES (X1) PROVIDERSUPPLENCLA (X2) MULTIPLE CONSTRUCTION A BUILDING 245313 B. WING PROVIDER OR SUPPLIER 245313 STREET ADDRESS, CITY, STATE, ZIP COD V LANE RESTORATIVE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP COD VEXAME RESTORATIVE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP COD VEXAME RESTORATIVE CARE CENTER Z209 UTAH AVENUE BENING PERCINC (EACH DEFICIENCY MUST BE PRECEDED BE PY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRE residents, NA-B indicated staff were to wear their reye protection at all times and during cares. NA-B stated she should have worn gloves and washed her hands while providing peri cares to prevent the spread of infection. F 880 R6 R6's quarterly MDS dated 5/27/21, indicated R6 was cognitively intact and had diagnoses which included: diabetes mellitus, anxiety and schizophrenia. The MDS identified R6 required extensive assistance of one staff with bed mobility, tolieting, personal hygiene, limited assistance with dressing and supervision with transfers. F During observations on 8/25/21, at 7:25 a.m., R6 was seated in her wheel chair and wheeling herself towards the door. Housekeeper (HK)-A was sweeping R6's room and was wearing a surgical mask, HK-A's surgical mask was down on the top of his chin with his mouth and nose exposed while R6 looked in her closel for clothes. At 7:27 a.m. registered nurse (RN)-A entered R6's room to assist her and HK-A left the room. - at 7:41 a.m. R2	OP DEFICIENCIES (x1) PROVIDER/SUPPLEXCUA (X2) MULTIFLE CONSTRUCTION (X3) DA PE CORRECTION 245313 B. WING	

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIF	PLE	CONSTRUCTION		E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	· /					PLETED
		245313	B. WING					C
NAME OF F	PROVIDER OR SUPPLIER			-	STI	REET ADDRESS, CITY, STATE, ZIP CODE	00/	27/2021
						09 UTAH AVENUE		
	V LANE RESTORATIV	E CARE CENTER			BE	NSON, MN 56215		
(X4) ID			ID			PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	х		(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
						DEFICIENCY)		
F 880	Continued From no	100	– – –					
F 000		ge 133 es and hand hygiene to be	F 8	880	,0			
		glove changes and when						
	appropriate. DON s	tated it was important to						
		of infection, prevent cross						
	contamination and	for basic hygienic purposes.						
		p.m. during a joint interview						
		consultant (MDSC)-A DON						
		e expected to wear masks at asks were to cover the nose						
		. DON stated these practices						
	were important to p	revent the spread of infection,						
		nd COVID-19. DON confirmed les to be worn correctly at all						
		reasons previously stated.						
		p.m. during a phone interview						
		ist (IP)-A confirmed staff were neir masks and goggles at all						
		was important to keep the						
		safe and prevent them from						
	respiratory illness.	OVID 19 or any other						
	respiratory miless.							
	, , ,	led Perineal Care, dated						
		he purpose was to provide nfort to the resident, and to						
		nd skin irritation, and to						
	observe the resider	nt's skin condition. The policy						
		included: to wash and dry						
		hly and put on gloves, and remove gloves and to wash						
	and dry hands thore							
		led I leady see his sult is suit						
		led Handwashing/Hand 7/21, identified the facility						
		giene the primary means to						
	prevent the spread	of infection. The policy						
	identified all person	nel would be trained and						

Facility ID: 00930

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		AND HUMAN SERVICES			FORM): 10/07/2021 / APPROVED). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION		TE SURVEY MPLETED C
		245313	B. WING		08	6/27/2021
-	PROVIDER OR SUPPLIER	/E CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 2209 UTAH AVENUE BENSON, MN 56215	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 880 F 883 SS=D	hygiene to prevent care-associated inf followed the handw procedures to help infections to other p visitors. The policy rub or alternatively the following situati and after direct com moving from a cont body site during res gloves. The facility policy tit Equipment-Using G identified the use of prevent the spread instructed staff to w gloves. The policy i be worn when touc blood, body fluids, n non-intact skin. Influenza and Pneu CFR(s): 483.80(d)(1) §483.80(d)(1) Influenz immunizations §483.80(d)(1) Influenz immunization state cites education potential side effect (ii) Each resident or the receives education potential side effect (ii) Each resident is immunization Octol annually, unless the	d on the importance of hand the transmission of health ections and all personnel vashing/hand hygiene prevent the spread of personnel, residents and instructed alcohol-based hand soap and water to be used in ons which included: before tact with residents, before tact with residents	F 8			10/11/21

Facility ID: 00930

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STATEMENT	OF DEFICIENCIES OF CORRECTION	KANNERS KANNERS	l` í	IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245313	B. WING _		C 08/27/2	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIN	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 883	immunized during t (iii) The resident or has the opportunity (iv)The resident's m documentation that following: (A) That the resident was provided educa and potential side e immunization; and (B) That the resident immunization or dic immunization or dic immunization due to refusal. §483.80(d)(2) Pneu must develop policit that- (i) Before offering th immunization, each representative rece benefits and potent immunization; (ii) Each resident is immunization, unlest medically contraind already been immu (iii) The resident or has the opportunity (iv)The resident's m documentation that following: (A) That the resident was provided educa and potential side e immunization; and (B) That the resident	his time period; the resident's representative to refuse immunization; and nedical record includes indicates, at a minimum, the nt or resident's representative ation regarding the benefits effects of influenza in either received the influenza d not receive the influenza o medical contraindications or imococcal disease. The facility ies and procedures to ensure the pneumococcal in resident or the resident's sives education regarding the ial side effects of the offered a pneumococcal ss the immunization is licated or the resident has	F 88	33		

		AND HUMAN SERVICES				FORM	10/07/202 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE SURV COMPLETEI C	
		245313	B. WING				_ 27/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	/E CARE CENTER			209 UTAH AVENUE SENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 883	the pneumococcal contraindication or This REQUIREMEI by: Based on interview facility failed to ens R10) were offered and/or influenza vat the Center for Dise recommendations. Findings include: R23's quarterly Min 9/8/21, indicated R2 had diagnoses while stroke and hemiple indicated R23 was of daily living and w 2/1/21. Review of R23's Im Refusal form signe R23 last received th 10/18/19. The form consented or refus after he was admitted On 8/27/21, at 1:03 confirmed the abow was no record of R vaccine in Minneso Connection (MICC)	immunization due to medical refusal. NT is not met as evidenced v and document review, the ure 2 of 5 residents (R23, or received pneumococcal ccinations in accordance with ase Control (CDC) imum Data Set (MDS) dated 23 was cognitively intact and ch included: diabetes mellitus, rgia or hemiparesis. The MDS independent with all activities vas admitted to the facility on munization Consent or d on 3/1/21, by R23 indicated he influenza vaccine on lacked any evidence R23 ed to have a influenza vaccine ied to the facility. p.m. MDS consultant (MDSC) re finding and indicated there 23 receiving his influenza ita Immunization Information as well. MDSC indicated staff	F8	883	 It is the expectation of the facilit ensure residents are offered or rec pneumococcal and/or influenza vaccinations in accordance with the Center for Disease Control (CDC) recommendations. R23 R10 have a been offered the vaccinations. All residents have the potential affected by not being offered and receiving vaccinations in accordance the Center for Disease Control recommendations. The facility poli and procedures were reviewed, an recent admissions reviewed to ens other individuals were affected by the deficient practice. In addition, vacc status will be reviewed ongoing at a conferences and administered per consent. A nursing in-service training is p for 10/4/2021 which includes educate from the infection preventionist to r the facility policies and procedures ensure residents are offered or reconsenting to the pneumococcal and influenza vaccinations according to CDC recommendations. 	eived e since to be ce with icies d ure no he ination care blanned ation review to peived if nd/or	
		red this with R23 on admission t if he had consented to			4. Effective 10/1/2021, a quality assurance program was initiated ut the direction of the director of nursi audit residents on a regular basis t ensure compliance with influenza a	ing to o	

Event ID:RSG411

Facility ID: 00930

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			CON	E SURVEY IPLETED C
		245313	B. WING				27/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	V LANE RESTORATIV	VE CARE CENTER			209 UTAH AVENUE ENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883	Continued From pa	age 137	F 8	83	pneumococcal immunizations. An completed weekly for 6 weeks and monthly for 3 months to ensure compliance		
	R10						
	 R10's quarterly Minimum Data Set (MDS) dated 6/11/21, identified R10 had diagnoses which included cerebral vascular disease, depression, chronic pain, arthritis and depression. The MDS identified R10 had severe cognitive impairment and required extensive assistance with activities of daily living (ADL's.) Review of R10's Immunization Consent or Refusal form signed 11/3/20, by a facility nurse, lacked any documentation or evidence of R10 consent or refusal to have any of the two pneumococcal vaccines after he was admitted to 						
	the facility. On 8/27/21, at 1:11 reviewed Minnesot Connection (MIIC,) record. She confirm been offered either vaccines. The MDS	p.m. MDS consultant (MDSC) a Immunization Information system and R10's medical ned R10 had not received or of the pneumococcal SC stated R10 should have accine upon admission.					
	updated 2/1/18, ide offered pneumocod	d, Pneumococcal Vaccine entified all residents would be ccal vaccines to aid in ococcal infections (e.g.,					
	Control of Seasona	d, Influenza, Prevention and al updated 2/1/18, identified the current guidelines and					

		AND HUMAN SERVICES				FORM	: 10/07/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·			CON	E SURVEY IPLETED C
		245313	B. WING				27/2021
	PROVIDER OR SUPPLIER	/E CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE SENSON, MN 56215	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883 F 886	of seasonal influen: facility Infection Pre administer seasona	for the prevention and control za. The policy revealed the eventionist would promote and al influenza vaccine and hts would be offered the	F 8 F 8				10/11/21
	CFR(s): 483.80 (h) §483.80 (h) COVID must test residents individuals providin and volunteers, for for all residents and individuals providin and volunteers, the §483.80 (h)((1) Cor parameters set fort but not limited to: (i) Testing frequence (ii) The identification this paragraph diag COVID-19 in the fa (iii) The identification this paragraph with consistent with CO suspected exposur (iv) The criteria for asymptomatic indiv paragraph, such as COVID-19 in a cou (v) The response times the constant of the support (v) The response times the support times the support of the support (v) The response times the support of the suppor	 (1)-(6) -19 Testing. The LTC facility and facility staff, including g services under arrangement COVID-19. At a minimum, d facility staff, including g services under arrangement LTC facility must: nduct testing based on h by the Secretary, including y; n of any individual specified in nosed with cility; on of any individual specified in symptoms VID-19 or with known or e to COVID-19; conducting testing of iduals specified in this is the positivity rate of nty; me for test results; and becified by the Secretary that event the 					

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		(X3) DA). 0938-039 TE SURVEY MPLETED	
				NG		C	
		245313	B. WING		08/27/2021		
	PROVIDER OR SUPPLIER	/E CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 2209 UTAH AVENUE BENSON, MN 56215	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 886	Continued From pa	ige 139	F 8	86			
		nduct testing in a manner that urrent standards of practice for -19 tests;					
	 §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. 						
	individual specified symptoms consistent with CO	on the identification of an in this paragraph with VID-19, or who tests positive actions to prevent the VVID-19.					
	residents and staff, services under arra	ve procedures for addressing including individuals providing ingement and volunteers, who e unable to be tested.					
	emergencies due te contact state and local health de efforts, such as obt processing test res This REQUIREME	en necessary, such as in o testing supply shortages, partments to assist in testing aining testing supplies or ults. NT is not met as evidenced					
	facility failed to mai resident COVID-19 positivity rates. This	v and document review, the ntain documentation of testing results and county s practice had the potential to nts and staff who resided at the		1. It is the expectation of the maintain documentation of re COVID-19 testing results an positivity rates. It was identifi turnover of IP the facility cou POC testing logs for month of one positivity percentage rec	esident d county ed that with ld not locate of June; or		

Facility ID: 00930

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) OXER SUPPLIER INME OF PROVIDER OR SUPPLIER 245313 INVING (X3) OXER SUPPLIER (X3) OXER SUPPLIER INME OF PROVIDER OR SUPPLIER 245313 INVING (X3) OXER SUPPLIER (X3) OXER SUPPLIER INAME OF PROVIDER OR SUPPLIER 245313 INVING (X3) OXER SUPPLIER (X3) OXER SUPPLIER INAME OF PROVIDER OR SUPPLIER 245313 INVING (X3) OXER SUPPLIER (X3) OXER SUPPLIER IMAME OF PROVIDER OR SUPPLIER 245313 INVING (X3) OXER SUPPLIER (X3) OXER SUPPLIER IMAME OF PROVIDER OR SUPPLIER 245313 INVING (X3) OXER SUPPLIER (X3) OXER SUPPLIER IMAME OF PROVIDER OR SUPPLIER 245313 INVING (X3) OXER SUPPLIER <		-	AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391
245313 B. WING 08/27/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2009 UTAH AVENUE STREET ADDRESS, CITY, STATE, ZIP CODE 2009 UTAH AVENUE BENSON, MN 56215 (%) (x4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (%) F 886 Continued From page 140 Findings include: F 886 Perceive and the state of the appropriate and residents, vaccinated and, unvaccinated, that previously tested negative until no new cases for vaccination status, were to be tested immediately, and all staff and residents that tested negative were to be retested every 3 days to 7 days until testing identified no new cases of COVID-19 infection, among staff or residents for a period of at least 14 days since the most recent positive result. An all staff in-service training is planned for 10/1/2021 which includes education from the infection preventionist to review the facility policies and procedures to ensure compliance with testing and tracking of covid 19 in residents and staff. An all staff in-service training is planned for 10/1/2021 which includes education from the infection preventionist to review the facility policies and procedures to ensure compliance with testing and tracking of covid 19 in residents and staff. The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older aduits and more than 80 percrent of COVID-19 deaths had occu				` '			COM	PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MEADOW LANE RESTORATIVE CARE CENTER Z39 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 REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) COMPLETION (EACH DEFICIENCY) F 886 Continued From page 140 Findings include: F F F BEROSON, MN 56215 COMPLETION (EACH DEFICIENCY) F 886 Continued From page 140 Findings include: F F F BEROSON, MN 56215 COMPLETION (EACH DEFICIENCY) F 886 Continued From page 140 Findings include: F F BEROSON, MN 56215 COMPLETION (CROSS-REFERENCE) TO IT MENTOR FORMATION) Met and is failed and utbreak as any new case that arrose in the facility. The memo advised to test all staff and residents, all staff and residents frage staff or residents, all staff and residents that tested langravite were to be resteted every 3 days to 7 days until testing identified no new cases of COVID-19 infection, among staff or residents for a period of at least 14 days since the most recent positive result. 3. An all staff in-service training is planned for 10/4/2021 which includes education from the infection of review tha facility policies and procedures to ensure compliance with testing and tracking logs to ensure continued compliance with mand mo			245313	B. WING				
MEADOW LANE RESTORATIVE CARE CENTER BENSON, MN 56215 (x)) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION BE PROUDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH CORRECTIVE ACTION OF CORRECTION (COMPLETION DEFICIENCY) COMPLETION (EACH CORRECTIVE ACTION OF CORRECTION (COMPLETION DEFICIENCY) COMPLETION (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPR	NAME OF I	PROVIDER OR SUPPLIER						
PRÉFIX TAG(EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PRÉFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLETION DATEF 886Continued From page 140 Findings include:F 886FFFF886FF <td< td=""><td>MEADO</td><td>W LANE RESTORATIN</td><td>/E CARE CENTER</td><td></td><td></td><td></td><td></td><td></td></td<>	MEADO	W LANE RESTORATIN	/E CARE CENTER					
 Findings include: Findings include: Ref: QSO-20-38-NH revised on 04/27/2021, identified an outbreak as any new case that arose in the facility. The memo advised to test all staff and residents, vaccinated, that previously tested negative until no new cases had been identified. Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents, regardless of vaccination status, were to be tested immediately, and all staff and residents that tested negative were to be retested every 3 days to 7 days until testing identified no new cases of COVID-19 infection, among staff or residents for a period of at least 14 days since the most recent positive result. The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older adults were more likely to get seriously ill from COVID-19. More than 80 percent of COVID-19 deaths had occurred in people older than 45. Further, among adults, the risk for severe illness from COVID-19 increased with age, with older adults at 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	ЗE	COMPLETION
 with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die. Nursing assistant (NA)-I laboratory report dated 4/23/21, indicated NA-I was positive for COVID-19. Review of MDH (Minnesota Department of Health) COVID-19 Report dated 5/4/21, under "Percent of Tests Positive by County of 	F 886	Findings include: Ref: QSO-20-38-NI identified an outbre in the facility. The m and residents, vacco previously tested no been identified. Up new case of COVIE residents, all staff at vaccination status, and all staff and res were to be retested testing identified no infection, among st at least 14 days sim result. The CDC guidance Conditions dated 5/ were more likely to COVID-19. More the deaths had occurre and more than 95 p had occurred in per among adults, the m COVID-19 increase highest risk. Severe with COVID-19 mag intensive care, or a breathe, or they mag Nursing assistant (I 4/23/21, indicated N COVID-19. Review of MDH (M Health) COVID-19	H revised on 04/27/2021, eak as any new case that arose nemo advised to test all staff cinated and, unvaccinated, that egative until no new cases had on identification of a single 0-19 infection in any staff or and residents, regardless of were to be tested immediately, sidents that tested negative 1 every 3 days to 7 days until o new cases of COVID-19 aff or residents for a period of once the most recent positive People with Certain Medical /13/21, identified older adults get seriously ill from nan 80 percent of COVID-19 ed in people over the age of 65, oercent of COVID-19 deaths ople older than 45. Further, risk for severe illness from ed with age, with older adults at e illness meant that the person y require hospitalization, ventilator to help them ay even die. NA)-I laboratory report dated NA-I was positive for	F8	86	testing logs are being tracked and documentation reviewed daily in IDT meetings to ensure compliance with testing requirements. 2. All resident's and staff have the potential to be affected by the deficie practice; re-education and review of facility policies and procedures were conducted to ensure that ongoing tra and documentation reviewed was in compliance with the testing requirem 3. An all staff in-service training is planned for 10/4/2021 which include education from the infection prevent to review the facility policies and procedures to ensure compliance wit testing and tracking of covid 19 in residents and staff. 4. Effective 10/1/2021, a quality assurance program was initiated und the direction of the director of nursin audit testing and tracking logs to en- continued compliance with maintain documentation of Covid-19 results. Audits completed weekly for 6 week monthly for 3 months to ensure compliance with recommendations. deficiencies will be corrected immed and findings brought to and monitore through the quality assurance comm	ent ent acking nents. es tionist ith der og to sure ing s and Any diately, ed nittee	

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		AND HUMAN SERVICES				FOR	D: 10/07/2021 M APPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		ATE SURVEY DMPLETED
		245313	B. WING			0	B/27/2021
	ROVIDER OR SUPPLIER	/E CARE CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CC 2209 UTAH AVENUE BENSON, MN 56215	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 886	Positive" of 5.1%. Review of MDH CC under "Percent of T Residence" reveale Positive" of 7.7%. Review of MDH CC under "Percent of T Residence" reveale Positive" of 5.2%. Review of the COV by facility on 8/27/2 -No testing log prov -Testing completed results were docum -No testing log prov -No testing log prov -No testing log prov -No testing log prov 1, 2021, to August 9 During a telephone p.m. assistant direct the facility checked rates every two wee was going on like the identified the facility to weekly which state 2021. ADON stated county positivity rat indicated the facility testing for staff and the infection contro organized yet and compared the facility of the facility	A Swift County had a "% DVID-19 Report dated 8/3/21, Tests Positive by County of ad Swift County had a "% DVID-19 Report dated 8/24/21, Tests Positive by County of ad Swift County had a "% ID testing logs record provided 1 identified: vided on residents April 2021. on residents May 2021, no nented on testing log. vided on residents June 2021. vided on residents June 2021. vided on residents June 2021. vided on residents June 2021. vided on residents July 2021. vided on residents from August	Fε	386			

Facility ID: 00930

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	10/07/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
	245313	B. WING	i			C 27/2021
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW LANE RESTORATIV	E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 was in the green coverse outbreaks and no second pulse outbreaks and no second pulse outbreaks and no second pulse of the second pulse of the guidance indicates was in the green the test residents and coverse of the second for June and August 2021, the far and unvaccinated received for June and August 2021, the far and unvaccinated received for June and August 2021, the far and unvaccinated received for June and August 2021, the far and unvaccinated received for June and August 2021, the far and unvaccinated received for June and August 2021, the far and unvaccinated received for June and August 2021, the far and unvaccinated received for June and August 2021, the far and unvaccinated received for the variant and a During an interview administrator stated R23 were fully vaccinesting June or July no symptoms. During an interview director of nursing (verified residents have fully vaccine field residents have a far Al/21/21, nursing asset tested positive on 8 and NA-K lived toge on a routine testing DON stated neither 8/21/21. DON indicates asked to leave the fibeen off work for at On 8/27/21, facility rates tracker log an and public tracker log and public track	ge 142 July. ADON stated the facility bunty level and was now in the stated the facility had no taff tested positive in June or on 8/27/21, at 3:08 p.m. coordinator (MDSC)-G stated ted that if the positivity rate e facility were not required to only unvaccinated staff were July. MDSC-G stated up until acility tested both vaccinated esidents due to the prevalence Il residents were negative. on 8/27/21, at 3:10 p.m. the d 3 residents R4, R14, and sinated and had not received 2021, due to no outbreak and on 08/27/21, at 3:15 p.m. DON) and MDSC-G both ad not been tested since back o county positivity rates. DON red positive for COVID-19 on sistant (NA)-J and NA-K both /10/21. DON indicated NA-J ether and both tested positive on Tuesday, 8/24/21. The staff had worked since ated NA-J and NA-K were facility immediately and had cleast for fourteen days. COVID-19 county positivity d staff and resident testing s for April 2021, through	F	386			

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		AND HUMAN SERVICES				FORM	10/07/2021 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	CON	E SURVEY IPLETED C	
		245313	B. WING	;			27/2021	
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
MEADO	V LANE RESTORATIN	/E CARE CENTER			209 UTAH AVENUE ENSON, MN 56215			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 886	Continued From pa	ge 143	F	886				
		requested and not received. Pest Control Program ·)	F	925			10/11/21	
	program so that the rodents. This REQUIREMEN by: Based on observat review, the facility fis safe, functional, safe environment for 2 co expressed concern for 4 of 4 residents observed to have fil during cares and w facility failed to ensi- related to flies land service. This deficite to affect all 25 resid Findings include: R4 R4's quarterly Minin 5/31/21, identified F included multiple so neurological conditi systems,) parapleg The MDS identified required extensive daily living (ADL's) of toileting. The MDS	ain an effective pest control e facility is free of pests and NT is not met as evidenced tion, interview and document ailed to provide and maintain a nitary, and comfortable of 2 residents (R4 and R9) who about the pest control of flies, (R16, R11, R14 and R6) ies on them while eating, hile sleeping. In addition, the ure a pest free environment ing on food during meal ent practice had the potential lents in the facility.			. It is the expectation of the facil provide and maintain a safe, fun sanitary, and comfortable enviror residents; ensuring a pest free environment. R4 and R9 had ex- concerns, R16, R11, R14 and R been observed to have flies on t eating, during cares and while st and there was observation of a f in the dining room. The facility is contracted with Guardian Pest C who was present for routine mor inspections during survey on Au 2021, which included addressing Guardian was again contacted b Maintenance Supervisor for ano onsite visit that occurred on Aug to address observations of flies present. 2. All residents have the potenti adversely affected; maintenance supervisor used temporary repe measures to keep flies away, sta re-educated to be mindful of opening/closing exit doors and a fly traps were placed on the exter facility. Guardian was again con- the Maintenance Director for ano onsite visit that occurred on Aug	ctional, nment for opressed 6 had hem while leeping, (ly on food s Control nthly gust 24, g fly traps. by the ther ust 31st still al to be enditional erior of the stacted by other		

Facility ID: 00930

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1		0		APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			Сом	E SURVEY PLETED
		245313	B. WING				C 27/2021
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIN	/E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 925	On 8/25/21, at 1:16 meeting, R4 stated flies in the facility by them herself. R4 st side of a barn," whe provided with a fly st the staff should hav as they were all ove had not specifically bothered her. R9 R9's quarterly MDS had diagnoses whic failure, diabetes, ar MDS identified R9 had lin bilateral lower extree On 8/24/21, at 8:38 R9, several dozen f room, flying around arms, on his table, time, R9 stated he was too weak at that flies. R9 stated the felt there was a hig average at that time the nursing assistant flies when he asked remain in his rooms care for other resid facility staff should flies in the building	p.m. during a resident council she was bothered by all of the ut was not able to swat at ated, "I couldn't hit the broad en asked if she had been swatter. R4 indicated she felt ve been aware of all of the flies er the facility. R4 stated she reported to staff the flies had asked 6/9/21, identified R9 ch included, chronic heart thritis and depression. The was cognitively intact and assistance with ADL's of bed and toileting. The MDS mited range of motion of	F 9	25	to address observations of flies stil present. 3. An all staff in-service training is planned for 10/4/2021 which include education from the Maintenance D in review the facility policies and procedures to ensure proper identi notification and action to address concerns involving pest control. 4. Effective 10/1/2021, a quality assurance program was initiated u the direction of the Maintenance D to audit environmental rounds to en- adequate pest control. Audits corn weekly for 6 weeks and monthly for months to ensure compliance with recommendations. Any deficiencia be corrected immediately, and find brought to and monitored through for quality assurance committee for fur review and ongoing monitoring.	les irector fication, nder irector nsure npleted r 3 es will ings the	

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE			E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	ING _			PLETED
		245313	B. WING_				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	W LANE RESTORATIV	/E CARE CENTER			09 UTAH AVENUE ENSON, MN 56215		
(X4) ID			ID	-	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 925	Continued From pa	ge 145	F 92	25			
	R16						
	Minimum Data Set identified R16 had of dementia, polymyal disorder causing m around the shoulde The MDS identified impairment and req with activities of dai mobility, transfers a indicated R16 had of inattention, altered delirium. The MDS maintain her baland physical assistance last MDS assessme On 8/23/21, from 2 observed lying on h were closed and her	ange of status (SCSA) (MDS) dated 7/15/21, diagnoses which included: gia rheumatica (inflammatory uscle pain and stiffness rs and hips) and psychosis. R1 had severe cognitive guired extensive assistance ly living (ADL's) of bed and toileting. The MDS disorganized thinking, levels of consciousness and didentified R16 was unable to be during transition without and had one fall since the ent. 2:35 p.m. to 2:54 p.m. R16 was her back in a low bed, eyes ar mouth was opened. R16 had room, of which a few would					
	repeatedly land on and fly away. -at 5:55 p.m. R16 w her back, moved he bed towards the flow with her left hand al was unable to sit up her eyes. At that tim picked up the yellow indicated R16 was told the nurse about left the room and R Several flies remain	her face towards her mouth vas observed lying in bed, on er legs and bare feet out of or, took hold of the grab bar nd attempted to sit up. R16 o, let go of the bar and shut ne, NA-G entered R16's room, w gripper socks from the floor, restless and stated she had t R16's restlessness. NA-G 16's legs remained out of bed. ned flying around R16's room A-G made no attempt to					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _			PLETED
		245313	B. WING _				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	V LANE RESTORATIV	/E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 925	Continued From pa	age 146	F 92	25			
	remove the flies.	0					
		vas observed lying in a low bed were closed, her body was					
	covered with a shee	et, a pink blanket covered her					
		I flies were observed flying in 16's body, periodically landing					
	and flying away.	· • • • • • • • • • • • • • • • • • • •					
		a.m. R16 was observed lying					
		r back, pillows were positioned ne had a blanket covering her					
	legs and body up to	her mid chest. Several flies					
	were observed in R on her face and boo	16's room, periodically landing dy.					
		a.m. R16 was observed lying					
		, covered with a sheet, eyes ad pillows placed on both her					
	right and left sides a	and underneath her legs. R16 move her legs out of bed or					
	to try to sit up.	Those her legs out of bed of					
	0	s on 8/23/21, at 6:01 p.m. A was serving the supper meal					
	from the steam tabl	le in the main dining room					
		r hands gloved, she grabbed a op of turkey, a scoop of gravy					
	on the turkey and a	scoop of baked beans on the					
		d a handful of raw carrots with aced them on the plate and					
		steam table to be delivered. Iltiple flies were flying around					
	the steam table land	ding on the steam table and					
	on food at times.						
	R11						

Facility ID: 00930

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG .			PLETED C
		245313	B. WING				_ 27/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEADOV	V LANE RESTORATIV	/E CARE CENTER			209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
	1		p		DEFICIENCY)		
F 925	Continued From pa	ge 147	F 92	25			
	had severe cognitiv diagnoses which in depression and mu identified R11 was i	dated 6/11/21, indicated R11 re impairment and had cluded: seizure disorder, scle weakness. The MDS independent with bed mobility, toileting, eating and personal					
	walked independen her room. R11 was denim jeans and the to her knees and he light brown colored chair in her room in	s on 8/23/21, at 5:08 p.m. R11 htty in the hallway and back to wearing a light blue pair of e inside of her legs, half way er entire buttocks area had stain. R11 sat down in her hdependently and she had ng around and landing on her					
	R14						
	R14 had severe con diagnoses which in poly-arthritis and lyn identified R14 requi bed mobility, transfe	S dated 7/13/21, indicated gnitive impairment and had cluded: depression, mphedema. The MDS ired two staff assistance with ers, dressing, toileting, one ygiene and supervision with					
	NA-B approached F bed, removed R14's multiple flies buzzin while NA-B collecte provided cares to R around and NA-B m at them. NA-B walk	s on 8/25/21, at 8:26 a.m. R14 while she was laying in s covers and there were ag around and landing on R14 ed her supplies. While NA-B R14, the flies continued to fly made several attempts to swat ked to the closet, picked out d multiple flies continued to fly					

Facility ID: 00930

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		AND HUMAN SERVICES				FORM): 10/07/2021 /I APPROVED). 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED C	
		245313	B. WING			08	/27/2021	
	PROVIDER OR SUPPLIER	VE CARE CENTER		220	REET ADDRESS, CITY, STATE, ZIP COI 19 UTAH AVENUE NSON, MN 56215	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 925	and R14 chose wh grabbed R14's part applied ace wraps tried to swat away attempted to land of R6: R6's quarterly MDS was cognitively inta- included: diabetes schizophrenia. The extensive assistant mobility, toileting, p assistance with dre- transfers. The MDS incontinent of bowe bladder, and was m toileting program. During observation was seated in her w area and her shirt of several soiled white buzzing around her her shirt. During observation was seated in her w had several flies bu on her pants and s them away with he attempting to get ri During observation was seated in her w	nd on her. 8 brought over some clothes at she wanted to wear. NA-B its, donned the pants and to her lower legs while she several flies that landed or on R14. 8 dated 5/27/21, indicated R6 act and had diagnoses which mellitus, anxiety and e MDS identified R6 required ce of one staff with bed personal hygiene, limited assing and supervision with 5 identified R6 was always el and frequently incontinent of iot on a bowel or bladder as on 8/23/21, at 5:20 p.m. R6 wheelchair in the dining room continued to be wet with e spots. R6 had several flies r and landing on the chest of as on 8/24/21, at 1:49 p.m. R6 wheelchair in her room and uzzing around her and landing hirt. R6 was trying to swat r hands and had no success	F 93	25				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:	· ·	G		MPLETED
		245313	B. WING			C
NAME OF	PROVIDER OR SUPPLIER	2-0010		STREET ADDRESS, CITY, STATE, ZIP COI	•	/27/2021
	W LANE RESTORATIV	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 925	fig bar there were s and landing on her - at 12:21 p.m. R6 her wheelchair at th flies were buzzing a while she tried to sl On 8/24/21, at 2:45 exterminator techn facility. The technic a routine visit to sp the facility had seve both wings, resider area of the facility. the facility would ha outside by the entra he felt the flies wer bothersome this ye technician indicated fly trap by the kitch felt it would be ben hallway to control th through those door he was not aware of the company regar On 8/27/21, at 12:4 environmental tour manager he confirr the facility, though f flies were not abno an "infestation." Th stated he did not fe problem and reside He stated the facility	several flies buzzing around while she ate. was laying in bed resting, with he side of the bed and several around her and landing on her leep. b p.m. the facility's contracted ician was observed at the sian indicated he was there for ray for spiders. He confirmed eral dozen flies throughout ht rooms and in the common The technician stated he felt ave benefited from spraying ances for fly control. He stated e more prominent and ar versus previous years. The d the facility had a black light en entrance and indicated he eficial to place one in each he flies that could enter ways. The technician stated of the facility reaching out to ding pest control for flies.	F 92	5		

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		AND HUMAN SERVICES				FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPL			0938-0391 SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:				СОМ	PLETED
		245313	B. WING				C 27/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	007	
MEADOV	V LANE RESTORATIV	/E CARE CENTER					
				E	BENSON, MN 56215		0.47
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 005			1				
F 925		ge 150 ad voiced any concerns to him	F 9	25			
	regarding the flies.						
	A policy was reques not provided.	sted on pest control and was					

Facility ID: 00930

		AND HUMAN SERVICES	F53′	13	030	FORM	: 10/25/2021 APPROVED : 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245313	B. WING			08/	24/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MEADOW	V LANE RESTORATIV	/E CARE CENTER					
				E	BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 0	00			
	FIRE SAFETY						
	conducted by the M Public Safety, State time of this survey, Care Center was for with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe Existing Health Car NFPA 99, Health Car						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY					
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION D.					
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE
Electron	ically Signed						10/01/2021

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/25/2021 APPROVED
STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		245313	B. WING			0.9/	24/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00/	24/2021
MEADO	W LANE RESTORATIV	E CARE CENTER			2209 UTAH AVENUE BENSON, MN 56215		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
К 000	 Healthcare Fire Insistate Fire Marshall 445 Minnesota St., St. Paul, MN 55101 By email to: FM.HC.Inspections THE PLAN OF COPDEFICIENCY MUSFOLLOWING INFO 1. A detailed descentation of planned to 2. Address the metaplace to ensure the 3. Indicate how the future performance sustained. 4. Identify who is mactions and monitor 5. The actual or performance for the remedy. Meadow Lane Restore one-story building was construction was built that was defined to connect the building, which was 	pections Division Suite 145 -5145, OR @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION: ription of the corrective action correct the deficiency. easures that will be put in deficiency does not reoccur. e facility plans to monitor to ensure solutions are	K	000			

If continuation sheet Page 2 of 4

PRINTED: 10/25/2021

		AND HUMAN SERVICES			INTED: 10/25/2021 FORM APPROVED IB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		X3) DATE SURVEY COMPLETED
		245313	B. WING		08/24/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MEADO	W LANE RESTORATIN	/E CARE CENTER		2209 UTAH AVENUE BENSON, MN 56215	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
K 000	and the two addition	ns meet the construction types buildings, the facility was	K 000		
	facility has a fire ala detection in the cor	sprinkled throughout, and the arm system with smoke ridors and spaces open to the onitored for automatic fire tion.			
	census of 25 at the	-			
	NOT MET as evide	: 42 CFR, Subpart 483.70(a) is inced by: - Testing and Maintenance	K 34	5	10/11/21
	A fire alarm system accordance with an with the requirement Electric Code, and and Signaling Code acceptance, mainter available. 9.6.1.3, 9.6.1.5, NF This REQUIREMENT	- Testing and Maintenance is tested and maintained in approved program complying hts of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily PA 70, NFPA 72 NT is not met as evidenced			
	facility failed to insp required by the NFI Safety Code, section edition), The Nation Code, section 14.3.	eview and staff interview, the bect the fire alarm system as PA 101 (2012 edition), Life on 9.6.1.5 and NFPA 72 (2010 hal Fire Alarm and Signaling .1. This deficient condition pread impact on the residents		 It is the expectation of the facility conduct semi-annual fire alarm inspections as required by the regula requirements. The Maintenance Dir has since scheduled an inspection a has been completed. A quality assurance program was initiated by the Maintenance Director ongoing auditing of monitoring for 	atory rector and it

Facility ID: 00930

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES				FORM	10/25/202 APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED	
		245313	B. WING			08/2	24/2021	
	PROVIDER OR SUPPLIER		1	2	TREET ADDRESS, CITY, STATE, ZIP CODE 209 UTAH AVENUE BENSON, MN 56215	RESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
K 345	was revealed that t evidence of complet inspection.	tween 9:30 AM to 1:30 PM, it the facility could not provide eting a semi-annual fire alarm ition was verified by the	K	345	compliance with conducting semi-a fire alarm inspections. 3. The findings will be brought to th monthly quality assurance committe monitor and provide further recommendations. 4. Maintenance Director is respons the monitoring of compliance. 5. The completion date is October 1 2021.	e ee to ible for		

Facility ID: 00930

If continuation sheet Page 4 of 4

Form Approved OMB Exempt

	PORT - 2012 LIFE SAFETY COD LTHCARE	E 1. (A) F	PROVIDER NUMBE	ER 1. (B) N	MEDICAID I.D. NO.		
OPTIONAL — CI		Facilities Code, No commendation for Crucial Data Extra	ew and Existing Waiver act]	CMS-2786T		
Identifying information as shown in applic	cable records. Enter changes, if any, alo	ngside each item,	giving date of c	change.			
2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS) A. BUILDING B. WING C. FLOOR	2. (B) ADDRESS OF	FACILITY (STREE	ET, CITY, STATE,	ZIP CODE) A. Fully Sprinklered (All required areas are sprinklered) B. Partially Sprinklered (Not all required areas are sprinklered) C. None (No sprinkler system) K0180		
3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APP	PROVAL S	URVEY UNDER	1.00.000		
MEDICARE	к4	К6	5. ĸī		012 EXISTING 6. 2012 NEW		
5. SURVEY FOR CERTIFICATION OF	1	1					
1. HOSPITAL 2. SKILLED/NU	JRSING FACILITY 4. ICF/IID UN	DER HEALTH CARE	5.	HOSPICE			
IF "2" OR "5" ABOVE IS MARKED, CHECK APPRO	OPRIATE ITEM(S) BELOW ART OF (SPECIFY)		3. IF DISTIN		PITAL, IS HOSPITAL ACCREDITED?		
	HOSPITAL BEDS OR MEDICARE C. NUMBER OF SKILLEE CERTIFIED FOR MED		IUMBER OF SKILL ERTIFIED FOR M		e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID		
7. A. THE FACILITY MEETS THE STANDARI	D, BASED UPON (CHECK ALL APPROPRIATE E	BOXES)					
1. COMPLIANCE WITH ALL PROVIS B. THE FACILITY DOES NOT MEET THE	SIONS 2. ACCEPTANCE OF A PLAN OF CO	RRECTION 3. RE	ECOMMENDED WA	IVERS 4. S	SES 5. PERFORMANCE BASED DESIGN		
SURVEYOR (S Kimberly Swens	TITLE	OFFICE			DATE		
SURVEYOR ID							
FIRE AUTHORITY OFFIC William Abderhalden	37009 TITLE	OFFICE			DATE		
CMS FORMS SHALL BE COMPLETED AND RET	AINED AS PART OF THE SURVEY RECORD.						

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I – NFPA 101 LSC REQUIREMENTS (Items in italics relate to the FSES)				
	SECTION 1 – GENERAL REQUIREMENTS				
K100	General Requirements – Other				
	List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				
K111	Building Rehabilitation				
	Repair, Renovation, Modification, or Reconstruction				
	Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following:				
	Requirements of Chapter 18 and 19.				
	• Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6.				
	18.1.1.4.3, 19.1.1.4.3, 43.1.2.1				
	Change of Use or Change of Occupancy				
	Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2.				
	18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7)				
	Additions				
	Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2 hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K112	Sprinkler Requirements for Major Rehabilitation If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft ² of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3				
К131	 Multiple Occupancies – Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 				
K132	Multiple Occupancies – Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1				

ID PREFIX				MET	NOT MET	N/A	REMARKS
K133	Multip	ole Occupancies – Constructi	on Type				
	18/19. buildir	.1.3.4, the most stringent const ng, unless a two hour separatio	accordance with 18/19.1.3.2 or ruction type is provided throughout the n is provided in accordance with n type is determined as follows:				
	oc ac	ccupancy is based on the story coordance with 18/19.1.6 and T					
	00	ccupancies shall be based on the	s of the building enclosing the other a applicable occupancy chapters.				
K161		3.5, 19.1.3.5, 8.2.1.3					
K161		ing Construction Type and He EXISTING	aight				
	Buildir	ng construction type and stories vise permitted by 19.1.6.2 throu					
		6.4, 19.1.6.5	gii 19.1.0.7				
		Construction Type					
	1	I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered				
	2	II (111)	One story non-sprinklered Maximum 3 stories sprinklered				
	3	II (000)					
	4	III (211)	Not allowed non-sprinklered				
	5	IV (2HH)	Maximum 2 stories sprinklered				
	6	V (111)	-				
	7	III (200)	Not allowed non-sprinklered				
	8	V (000)	Maximum 1 story sprinklered				
	Super Give a includi fire ba	brief description, in REMARKS, c ing basements, floors on which p	ed throughout by an approved, rdance with section 9.7. (See 19.3.5) of the construction, the number of stories, atients are located, location of smoke or complete sketch or attach small floor				

ID PREFIX				MET	NOT MET	N/A	REMARKS
K161	otherwi	g construction type and stories ise permitted by 18.1.6.2 throu 4, 18.1.6.5	meets Table 18.1.6.1, unless gh 18.1.6.7				
		Construction Type					
	1	I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered				
	2	II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered				
	3	II (000)					
	4	III (211)	Not allowed non-sprinklered				
	5	IV (2HH)	Maximum 1 story sprinklered				
	6	V (111)					
	7 8	III (200) V (000)	- Not allowed non-sprinklered				
	Supervi Give a l includin fire bari	ised automatic system in acco brief description, in REMARKS, c ng basements, floors on which p	ed throughout by an approved, rdance with section 9.7. (See 18.3.5) f the construction, the number of stories, atients are located, location of smoke or omplete sketch or attach small floor				
K162		g Systems Involving Comb u XISTING	stibles				
	Building having roofing	gs of Type I (442), Type I (332 roof systems employing comb meet the following:), Type II (222), or Type II (111) ustible roofing supports, decking or				
		f covering meets Class C requ					
	nor	f is separated from occupied b noombustible floor assembly us gypsum fill.	sing not less than 2½ inches concrete				
		c or other space is either unoc proved automatic sprinkler sys	cupied or protected throughout by an tem.				
	19.1.6	.2*, ASTM E108, ANSI/UL 790)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	2012 NEW				
	Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following:				
	1. roof covering meets Class A requirements.				
	 roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2¹/₂ inches concrete or gypsum fill. 				
	 the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2. ASTM E108. ANSI/UL 790 				
K163	Interior Nonbearing Wall Construction				
	Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials.				
	Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures.				
	18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5				
-	SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	Means of Egress Requirements – Other				
	List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				
	18.2, 19.2				
K211	Means of Egress – General				
	Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.				
	18.2.1, 19.2.1, 7.1.10.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K221	Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key- locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4				
K222	Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:				
	 □ CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 				
	 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic fire detection system and an approved, supervised automatic fire detection system. 				
K223	 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: Required manual fire alarm system; and Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and Automatic sprinkler system, if installed; and Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	Horizontal-Sliding Doors				
	Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound.				
	Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met:				
	Area served by the door has no high hazard contents.				
	• Door is operable from either side without special knowledge or effort.				
	• Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width.				
	 Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. 				
	• Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound.				
	18.2.2.2.10, 19.2.2.2.10				
K225	Stairways and Smokeproof Enclosures				
	Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.				
	18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2				
K226	Horizontal Exits				
	Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4.				
	18.2.2.5, 19.2.2.5				
K227	Ramps and Other Exits				
	Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10				
K231	Means of Egress Capacity				
	The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K232	Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5				
	2012 NEW The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5				
K233	Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7				
	2012 NEW Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7				
K241	Number of Exits – Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K251	Dead-End Corridors and Common Path of Travel				
	2012 EXISTING				
	Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them.				
	19.2.5.2				
K251	2012 NEW				
	Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet.				
	18.2.5.2, 18.2.5.3				
K252	Number of Exits – Corridors				
	Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies.				
	18.2.5.4, 19.2.5.4				
K253	Number of Exits – Patient Sleeping and Non-Sleeping Rooms				
	Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other.				
	18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2				
K254	Corridor Access				
	All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system.				
	18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4				
K255	Suite Separation, Hazardous Content, and Subdivision				
	All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	Sleeping Suites				
	Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system.				
	Suites more than 1,000 ft ² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements.				
	Suites shall not exceed the following size limitations:				
	 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. 				
	 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. 				
	 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. 				
	Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered).				
	18.2.5.7.2, 19.2.5.7.2				
K257	Non-Sleeping Suites				
	Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where \geq 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior.				
	Suites more than 2,500 ft ² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements.				
	Suites shall not exceed 10,000 ft ² .				
	Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered).				
	18.2.5.7.3, 19.2.5.7.3				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	Travel Distance to Exits				
	Travel distance (excluding suites) to exits are measured in accordance with 7.6.				
	 From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). 				
	 Point in a room to room door less than or equal to 50 feet. 				
	18.2.6, 19.2.6				
K271	Discharge from Exits				
	Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7				
K281	Illumination of Means of Egress				
	Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.				
1/00/	18.2.8, 19.2.8				
K291	Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.				
	18.2.9.1, 19.2.9.1				
K292	Life Support Means of Egress				
	2012 NEW (INDICATE N/A FOR EXISTING)				
	Buildings equipped with or requiring the use of life support systems (electro- mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99.				
	(Indicate N/A if life support equipment is for emergency purposes only.)				
	18.2.9.2, 18.2.10.5				

	MET	NOT MET	N/A	REMARKS
Exit Signage				
2012 EXISTING				
Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.				
where the line of exit travel is obvious.)				
2012 NEW				
Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1				
SECTION 3 – PROTECTION			1	
Protection – Other				
List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				
Vertical Openings – Enclosure				
2012 EXISTING				
Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6.				
19.3.1.1 through 19.3.1.6				
If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.				
2012 NEW				
Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1-hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7.				
	2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 SECTION 3 – PROTECTION Protection – Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Vertical Openings – Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box. □ 2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1-hour	Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 SECTION 3 – PROTECTION Protection – Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Vertical Openings – Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least 2 hour fire resistance rating, also check this box. 2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire	MEI MET Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 SECTION 3 – PROTECTION Protection – Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Vertical Openings – Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least 2 hour fire resistance rating, also check this box. 2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1-hour for single story building and bui	MET MET N/A Exit Signage 2012 EXISTING Image: Control of the state of the s

ID PREFIX					MET	NOT MET	N/A	REMARKS
K321	Hazardous Areas – Enclosure 2012 EXISTING Hazardous areas are protected by resistance rating (with ¾ hour fire r extinguishing system in accordance approved automatic fire extinguish shall be separated from other space doors in accordance with 8.4. Door closing and permitted to have none that do not exceed 48 inches from Describe the floor and zone location in REMARKS. 19.3.2.1, 19.3.5.9	rated doors) or an a e with 8.7.1 or 19.3 ing system option i es by smoke resist rs shall be self-clos rated or field-applie the bottom of the d	automatic fir 3.5.9. When s used, the ing partition ing or autor d protective loor.	e the areas is and natic- plates				
	Area	Automatic Sprinkler	Separation	N/A				
	a. Boiler and Fuel-Fired Heater Rooms							
	b. Laundries (larger than 100 sq. ft.)							
	c. Repair, Maintenance, and Paint Shops							
	d. Soiled Linen Rooms (exceeding 64 gal.) e. Trash Collection Rooms (exceeding 64 gal.) f. Combustible Storage Rooms/Spaces (over 50 sq. ft.) g. Laboratories (if classified as Severe Hazard - see K322)							

ID PREFIX						MET	NOT MET	N/A	REMARKS
K321	2012 NEW								
	Hazardous areas are protected in shall be enclosed with a 1-hour fire door without windows (in accordan closing or automatic-closing in acc are protected by a sprinkler system 8.4. Describe the floor and zone location in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7	e-rated barrier, with ice with 8.7.1.1). Do ordance with 7.2.1 n in accordance with	a ¾ hour fi oors shall b .8. Hazardo h 9.7, 18.3.	re-rated e self- us area 2.1, an	as d				
	Area	Automatic Sprinkler	Separation	N/A					
	a. Boiler and Fuel-Fired Heater Rooms								
	b. Laundries (larger than 100 sq. ft.)								
	c. Repair, Maintenance, and Paint Shops								
	d. Soiled Linen Rooms (exceeding 64 gal.)								
	e. Trash Collection Rooms (exceeding 64 gal.)								
	f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)								
	g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)								
	h. Laboratories (if classified as Severe Hazard - see K322)								

ID PREFIX		MET	NOT MET	N/A	REMARKS
K322	Laboratories				
	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99.				
	Laboratories not considered a severe hazard are protected as hazardous areas (see K321).				
	Laboratories using chemicals are in accordance with NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.				
	Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99).				
	18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC)				
	9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K323	Anesthetizing Locations				
	Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99.				
	Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others.				
	Area alarm panels are provided to monitor all medical gas, medical- surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies.				
	The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system.				
	Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58.				
	18.3.2.3, 19.3.2.3 (LSC) 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	Cooking Facilities				
	Cooking equipment is protected in accordance with NFPA 96, <i>Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations</i> , unless:				
	• residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2.				
	 cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or 				
	• cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.				
	Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.				
	18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2				
K325	Alcohol Based Hand Rub Dispenser (ABHR)				
	ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:				
	Corridor is at least 6 feet wide.				
	• Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols.				
	Dispensers shall have a minimum of four foot horizontal spacing.				
	• Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room.				
	• Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30.				
	• Dispensers are not installed within 1 inch of an ignition source.				
	 Dispensers over carpeted floors are in sprinklered smoke compartments. 				
	ABHR does not exceed 95 percent alcohol.				
	• Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11).				
	ABHR is protected against inappropriate access.				
	18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K331	Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s).				
	2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2 Indicate flame spread rating(s).				
K332	Interior Floor Finish 2012 NEW (Indicate N/A for 2012 EXISTING) Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3, 10.2, 10.2.7.1, 10.2.7.2				
K341	Fire Alarm System – Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, <i>National Electric Code</i> , and NFPA 72, <i>National Fire Alarm Code</i> to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K342	Fire Alarm System – Initiation				
	Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded.				
	18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5				
K343	 Fire Alarm – Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) 2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by 				
	 audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4 				
K344	Fire Alarm – Control Functions				
	The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	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, <i>National</i> <i>Electric Code,</i> and NFPA 72, <i>National Fire Alarm and Signaling Code.</i> Records of system acceptance, maintenance and testing are readily				
	available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72				
K346	Fire Alarm – Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6				
K347	Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2				
	 2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: smoke detection, or automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3 				

Sprinkler System – Installation		MET		REMARKS
2012 EXISTING				
Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation of Sprinkler Systems.</i>				
In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.				
In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for Installation of Sprinkler Systems.</i>				
19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)				
2012 NEW				
Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation of Sprinkler Systems.</i>				
In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers.				
Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms.				
In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for Installation of Sprinkler Systems.</i>				
18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10				
Sprinkler System – Supervisory Signals				
Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, <i>National Fire Alarm</i> <i>and Signaling Code</i> , and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired.				
	rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for</i> <i>Installation of Sprinkler Systems</i> . 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation</i> <i>of Sprinkler Systems</i> . In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for</i> <i>Installation of Sprinkler Systems</i> . 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 Sprinkler System – Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, <i>National Fire Alarm</i> <i>and Signaling Code</i> , and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler	rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for</i> <i>Installation of Sprinkler Systems.</i> 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation</i> <i>of Sprinkler Systems.</i> In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for</i> <i>Installation of Sprinkler Systems.</i> 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 Sprinkler System – Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, <i>National Fire Alarm</i> <i>and Signaling Code,</i> and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired.	rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for</i> <i>Installation of Sprinkler Systems</i> . 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation</i> <i>of Sprinkler Systems</i> . In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for</i> <i>Installation of Sprinkler Systems</i> . 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 Sprinkler System – Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, <i>National Fire Alarm</i> <i>and Signaling Code</i> , and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired.	rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for</i> <i>Installation of Sprinkler Systems</i> . 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation</i> <i>of Sprinkler Systems</i> . In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft ² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for</i> <i>Installation of Sprinkler Systems</i> . 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 Sprinkler System – Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, <i>National Fire Alarm</i> <i>and Signaling Code</i> , and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired.

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	Sprinkler System – Maintenance and Testing				
	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, <i>Standard for the Inspection,</i> <i>Testing, and Maintaining of Water-based Fire Protection Systems.</i> Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. b) Who provided system test. c) Water system supply source.				
	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.				
	9.7.5, 9.7.7, 9.7.8, and NFPA 25				
K354	Sprinkler System – Out of Service				
	Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)				
K355	Portable Fire Extinguishers				
	Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, <i>Standard for Portable Fire Extinguishers.</i> 18.3.5.12, 19.3.5.12, NFPA 10				
K361	Corridors – Areas Open to Corridor				
	Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K362	Corridors – Construction of Walls				
	2012 EXISTING				
	Corridors are separated from use areas by walls constructed with at least ¹ / ₂ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code.				
	Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames.				
	If the walls have a fire resistance rating, give the rating if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7				
	2012 NEW				
	Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	 Corridor – Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¼ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Duch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. 				
	 2012 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. 				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K364	Corridor – Openings				
	Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut.				
	In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in ² and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in ² .				
	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3				
K371	Subdivision of Building Spaces – Smoke Compartments				
	2012 EXISTING				
	Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier.				
	19.3.7.1, 19.3.7.2				
	Detail in REMARKS zone dimensions including length of zones and dead- end corridors.				
	2012 NEW				
	Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use.				
	Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier.				
	Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2.				
	18.3.7.1, 18.3.7.2				
	Detail in REMARKS zone dimensions including length of zones and dead- end corridors.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K372	Subdivision of Building Spaces – Smoke Barrier Construction				
	2012 EXISTING				
	Smoke barriers shall be constructed to a $\frac{1}{2}$ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.				
	19.3.7.3, 8.6.7.1(1)				
	Describe any mechanical smoke control system in REMARKS.				
	2012 NEW				
	Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3				
1/070	Describe any mechanical smoke control system in REMARKS.				
K373	Subdivision of Building Spaces – Accumulation Space Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2				
К374	Subdivision of Building Spaces – Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9				

ID		MET	NOT	N/A	REMARKS
PREFIX			MET	IN/A	REIVIARRO
K374	2012 NEW				
	Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1 ³ / ₄ -inch thick solid bonded core wood.				
	Required clear widths are provided per 18.3.7.6(4) and (5).				
	Nonrated protective plates of unlimited height are permitted. Horizontal- sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction.				
	Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required.				
	18.3.7.6, 18.3.7.7, 18.3.7.8				
K379	Smoke Barrier Door Glazing				
	2012 EXISTING				
	Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames.				
	19.3.7.6, 19.3.7.6.2, 8.5				
	2012 NEW				
	Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames.				
	18.3.7.9				
K381	Sleeping Room Outside Windows and Doors				
	Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor.				
	42 CFR 403, 418, 460, 482, 483, and 485				
	SECTION 4 – SPECIAL PROVISIONS				
K400	Special Provisions – Other				
	List in the REMARKS section any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	High-Rise Buildings				
	2012 EXISTING				
	High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2				
	2012 NEW				
	High-rise buildings comply with section 11.8. 18.4.2				
	SECTION 5 – BUILDING SERVICES				
K500	Building Services – Other				
	List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				
K511	Utilities – Gas and Electric				
	Equipment using gas or related gas piping complies with NFPA 54, <i>National Fuel Gas Code</i> , electrical wiring and equipment complies with NFPA 70, <i>National Electric Code</i> . Existing installations can continue in service provided no hazard to life.				
	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2				
K521	HVAC				
	Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.				
	18.5.2.1, 19.5.2.1, 9.2				
K522	HVAC – Any Heating Device				
	Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also:				
	is chimney or vent connected.				
	takes air for combustion from outside.				
	• provides for a combustion system separate from occupied area atmosphere.				
	18.5.2.2, 19.5.2.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
PREFIX K523 K524	 HVAC - Suspended Unit Heaters Suspended unit heaters are permitted provided the following are met: Not located in means of egress or in patient rooms. Located high enough to be out of reach of people in the area. Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1) HVAC - Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 		MET		REMARKS
K525	 18.5.2.3(2), 19.5.2.3(2), NFPA 54 HVAC - Solid Fuel-Burning Fireplaces Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: Areas are separated by 1-hour fire resistance construction. Fireplace complies with 9.2.2. Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass. Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3) 				
K531	Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i> . Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i> . All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K531	2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and</i> <i>Escalators</i> . Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, <i>Safety Code for Elevators</i> <i>and Escalators</i> , including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3				
K532	 Escalators, Dumbwaiters, and Moving Walks 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2 				
	2012 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	Rubbish Chutes, Incinerators, and Laundry Chutes				
	2012 EXISTING				
	(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.				
	(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.				
	(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)				
	(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
	19.5.4, 9.5, 8.4, NFPA 82				
	2012 NEW				
	Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2.				
	• The fire resistance rating of chute charging room shall not be required to exceed 1-hour.				
	• Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7.				
	 Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 				
	18.5.4.2, 8.7, 9.5, 9.7, NFPA 82				
	SECTION 6 – RESERVED				
	SECTION 7 – OPERATING FEATURES				
K700	Operating Features – Other				
	List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their				
	 evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.3 				
K712	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of				
	emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.				
	18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 				
K751	Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	Upholstered Furniture and Mattresses				
	Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered.				
	Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered.				
	Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered.				
	Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date.				
	18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4				
K753	Combustible Decorations				
	Combustible decorations shall be prohibited unless one of the following is met:				
	 Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. 				
	Decorations meet NFPA 701.				
	 Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. 				
	• Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).				
	 The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 18.7.5.6, 19.7.5.6 				
K761	Maintenance, Inspection & Testing - Doors				
	Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 Standard for Fire Doors and Other Opening Protectives.				
	Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.				
	Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review.				
	18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	Soiled Linen and Trash Containers				
	Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended.				
	Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7				
K771	Engineer Smoke Control Systems 2012 EXISTING				
	When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises.				
	19.7.7				
	2012 NEW				
	 When installed, engineered smoke control systems are tested in accordance with NFPA 92, <i>Standard for Smoke Control Systems</i>. Test documentation is maintained on the premises. 18.7.7 				
K781	Portable Space Heaters				
	Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius).				
	18.7.8, 19.7.8				
K791	Construction, Repair, and Improvement Operations				
	Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241.				
	18.7.9, 19.7.9, 4.6.10, 7.1.10.1				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS		1112 1	1	
K900	Health Care Facilities Code - Other List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567.				
K901	Fundamentals – Building System Categories				
	Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)				
K902	Gas and Vacuum Piped Systems – Other				
	List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99)				
K903	Gas and Vacuum Piped Systems – Categories				
	Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated:				
	□ Category 2. Systems in which failure is likely to cause minor injury.				
	□ Category 3. Systems in which failure is not likely to cause injury, but can cause discomfort.				
	Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system.				
	5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)				
K904	Gas and Vacuum Piped Systems – Warning Systems				
	All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)				
		1			

ID PREFIX		MET	NOT MET	N/A	REMARKS
K905	Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling				
	Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)				
K906	Gas and Vacuum Piped Systems – Central Supply System Operations				
	Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)				
K907	Gas and Vacuum Piped Systems – Maintenance Program				
	Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	Gas and Vacuum Piped Systems – Inspection and Testing Operations				
	The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)				
K909	Gas and Vacuum Piped Systems – Information and Warning Signs				
	Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)				
K910	Gas and Vacuum Piped Systems – Modifications				
	Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)				
K911	Electrical Systems – Other				
	List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)				
K912	Electrical Systems – Receptacles				
	Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover.				
	If used in patient care room, ground-fault circuit interrupters (GFCI) are listed.				
	6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	Electrical Systems – Wet Procedure Locations Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2				
K914	Electrical Systems – Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of \leq 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals \leq 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)				
K915	 Electrical Systems – Essential Electric System Categories Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	Electrical Systems – Essential Electric System Alarm Annunciator				
	A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.				
	6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)				
K917	Electrical Systems – Essential Electric System Receptacles				
	Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking.				
	6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)				
K918	Electrical Systems – Essential Electric System Maintenance and Testing				
	The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.				
	Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	Electrical Equipment – Other List in the REMARKS section any NFPA 99 Chapter 10, <i>Electrical</i> <i>Equipment</i> , requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)				
K920	Electrical Equipment – Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	Electrical Equipment – Testing and Maintenance Requirements				
	The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training.				
K922	Gas Equipment – Other				
	List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 11 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	Gas Equipment – Cylinder and Container Storage				
	≥ 3,000 cubic feet				
	Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.				
	> 300 but <3,000 cubic feet				
	Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.				
	≤ 300 cubic feet				
	In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of \leq 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.				
	A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING".				
	Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.				
	11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)				
K924	Gas Equipment – Testing and Maintenance Requirements				
	Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	Gas Equipment – Respiratory Therapy Sources of Ignition				
	Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)				
K926	Gas Equipment – Qualifications and Training of Personnel				
	Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)				
K927	Gas Equipment – Transfilling Cylinders				
	Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, <i>Transfilling of High Pressure Gaseous Oxygen Used for</i> <i>Respiration.</i> Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	Gas Equipment – Labeling Equipment and Cylinders				
	Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting.				
К929	11.5.3.1 (NFPA 99) Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds				
	Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)				
K930	Gas Equipment – Liquid Oxygen Equipment				
	The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)				
K931	Hyperbaric Facilities				
	All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)				
K932	Features of Fire Protection – Other				
	List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 15 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	Features of Fire Protection – Fire Loss Prevention in Operating Rooms				
	Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers:				
	packaging is non-flammable.				
	applicators are in unit doses.				
	 Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: 				
	 application site is dry prior to draping and use of surgical equipment. 				
	 pooling of solution has not occurred or has been corrected. 				
	 solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. 				
	 policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. 				
	Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99)				

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)

JUSTIFICATION

K400

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	Title	Office	Date

PART IV - FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS 2786 FORMS)

Prov	ider N	umber	Facility Name			Survey Date		
Provider Number Facility Name								
K1						*K4		
1/0								
^{K6} DATE OF PLAN APPROVAL		K3 MULTIPLE CONSTRUCTION			A. BUILDING			
		TOTAL NUMBER OF BUILDINGS _						
						C. FLOOR		
NUMBER OF THIS BUILDI			THIS BUILDING		D. APARTMEN			
LSC FORM INDICATOR				COMPLETE IF I EXISTING	ICF/IID IS SURVEYE	D UNDER CHAPTER 33,		
		HEALTH	CARE FORM					
	12	2786R	2012 EXISTING	3	SMALL (10	6 BEDS OR LESS)		
	13	2786R	2012 NEW			1. PROMP	Т	
					К8	2. SLOW 3. IMPRAC	TICAL	
		AHC	D FORM		LARGE			
	14	2786U	2012 EXISTING	3				
	15	2786U	2012 NEW			4. PROMP	Т	
					К8	5. SLOW 6. IMPRAC	TICAL	
		ICF/II	D FORM		APARTMENT HOUSE			
	16 2786V, W, X 2012 EXISTING		G	APARIMENT				
	17	2786V, W, X	2012 NEW		К8	7. PROMP 8. SLOW		
		I				9. IMPRAC	CTICAL	
*K7				SED FROM ABOVE				
1								
			appliachta	COMPLETE IF I EXISTING	ICF/IID IS SURVEYE	D UNDER CHAPTER 33,		
(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)			арріїсаріе	ENTER E – SC				
		K321:	K351:		K5:	e.g. 2.5		
*K9	FA	CILITY MEETS	LSC BASED OF	N (Check all that Appl	y)			
	A1	I.	A2.	A3		A4.	A5.	
		MP. WITH ALL	(ACCEP	TABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)	
FACILITY DOES NOT MEET LSC K0180				K0180				
			7	A.	В.		C.	
B.				FULLY SPRINKLER (All required areas are sprinklered)		LY SPRINKLERED Il required areas are sprinklered)	NONE (No sprinkler system)	

*MANDATORY

FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME		SURVEY DATE			
K1 245313	MEADOW LANE RESTORATIVE	CARE CENTER	*K4 08/24/2021			
K6 DATE OF PLAN APPROVAL	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS NUMBER OF THIS BUILDING	<u> </u>	A BUILDING B WING C FLOOR D APARTMENT UNIT			
12 2786 R 13 2786 R	Ith Care Form 2012 EXISTING 2012 NEW	COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21 SMALL (16 BEDS OR LESS) 1 PROMPT 2 SLOW 3 IMPRACTICAL				
14 2786 U 15 2786 U IG 16 2786 V, W, T	ASC Form 2012 EXISTING 2012 NEW CF/MR Form X 2012 EXISTING	LARGE 4 PROMPT 5 SLOW 6 IMPRACT	ICAL			
	X 2012 NEW DF FORM USED FROM ABOVE re marked as not applicable in the	APARTMENT HOUSE K8: 7 PROMPT 8 SLOW 9 IMPRACTICAL				
2786 M, R, T, U, V, W, X,	11	ENTER E-SCORE HERE K5: e.g 2.5				
*K9 : FACILITY MEETS LSC BASED ON: (Check all that apply) A1 A2 X A3 A4 A5 (COMP. WITH ALL PROVISIONS) (ACCEPTABLE POC) (WAIVERS) (FSES) (PERFORMANCE BASED DESIGN)						
FACILITY DOES NOT MEET	LSC: K180: A. X FULLY SPRINKLE (All required areas are spin)		C. NONE (No sprinkler system)			

*MANDATORY