

Electronically delivered July 23, 2021

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

RE: CCN: 245313

Cycle Start Date: April 20, 2021

Dear Administrator:

On May 5, 2021, we notified you a remedy was imposed. On July 8, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 25, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective May 20, 2021 be discontinued as of June 25, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of May 5, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 20, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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



Electronically delivered

July 23, 2021

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

Re: Reinspection Results

Event ID: W1RV12, ODT311 and 6B8711

Dear Administrator:

On July 8, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 8, 2021. At this time these correction orders were found corrected.

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



Electronically delivered

May 12, 2021

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

RE: CCN: 245313

Cycle Start Date: April 20, 2021

Dear Administrator:

On May 5, 2021, we informed you of imposed enforcement remedies.

On April 27, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 20, 2021, will remain in effect.

This Department recommends that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 20, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 20, 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.

As we notified you in our letter of May 5, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 20, 2021.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" 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 October 20, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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:

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 Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Meadow Lane Restorative Care Center May 12, 2021 Page 5 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



Electronically delivered May 12, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: 6B8711

Dear Administrator:

The above facility was surveyed on April 26, 2021 through April 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. 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

(X6) DATE

Minnesota Department of Health

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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/24/21

TITLE

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Minnesota Department of Health

STATE FORM 6899 6B8711 If continuation sheet 2 of 7

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Minnesota Department of Health

STATE FORM 6899 6B8711 If continuation sheet 3 of 7

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2 830	review, the facility fainterventions to pre (R5) investigated for Findings include: R5's admission Min 2/25/21, identified Fimpairment and dia Alzheimer's disease MDS identified R5 with bed mobility, tr did not walk. R5's Na was not steady duri seated to standing, to surface and R5 with staff assistance. R5	ailed to implement vent falls for 1 of 5 resor fall safety. Immum Data Set (MDS R5 had severe cogniting gnoses which include e, dementia, and arthrogenized extensive assensfers and toilet used MDS identified R5's being transition of moving on and off toilet, and was only able to stabil 5's MDS further identification of moving and safety and had no	S) dated ve ed: ritis. R5's sistance and R5 alance arg from surface ize with fied R5	2 830				
	an ADL (activities of deficit related to de R5's care plan iden of two staff with Hotransfers. R5's care high risk for falls regait/balance proble problems. R5's care to ensure R5's call were to encourage next to bed. R5's care ensure the floor may was in low position On 4/26/21, at 1:40 with the bed in low attached to his grat no floor mat next to	sed 4/7/21, identified If daily living) performs mentia and impaired stified R5 required assiver (mechanical lift) for plan further identified lated to confusion, ms and vision/hearing plan interventions in light was within reach him to use it, and flood are plan instructed stat was in place and the while R5 was in bed. 1 p.m. R5 was lying in position and his call light plan on the bed. Their plan in his bed. At 3:41 p. in his bed. facing the	ance sight. istance or d R5 was cluded , staff or mat off to e bed his bed, ght re was m. R5					

Minnesota Department of Health

STATE FORM 6899 6B8711 If continuation sheet 4 of 7

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	at risk for falls. NA- prevent R5 from ro on R5 about every fall mat was to be u	p.m. NA-C indicated R5 was C stated they used pillows to lling out of bed and checked hour. NA-C did not indicate a used in R5's interventions to C stated he was not aware R5 s.				
	at risk for falls. NA- they would transfer was in bed they wo position. NA-D state should have a floor	p.m. NA-D indicated R5 was D stated if R5 was restless him out of bed and when he uld place the bed to the lowesed she was not aware that R5 mat by his bed when he was d she had never seen a floor	st .			

Minnesota Department of Health

STATE FORM 6899 6B8711 If continuation sheet 5 of 7

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		, ,	E CONSTRUCTION		SURVEY PLETED
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	was found lying on 5:08 p.m. and no ir time of the incident new interventions of place as well as ref R5's note included	t dated 4/4/21, identified the floor beside his bed ajuries were observed at an one of a hi/low bed and floor minder/cues to use call I reorientation as needed lications was to be compare provider).	at the ntified mat in light.				
	was found lying on chair at 3:56 a.m. The thought there was get out of the building centimeter (cm.) by elbow. R5's report new interventions of in place. R5's report R5 up during period	t dated 4/15/21, identified the floor next to his when the report identified R5 sas a fire and was attemping. R5 received a three of 2 cm. abrasion to his rimote dated 4/26/21, identified a hi/low bed and a floor the note instructed staff to do of wakefulness and esition periodically as need.	eel stated oting to e ight or mat o get				

Minnesota Department of Health

STATE FORM 6899 6B8711 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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MEADOW LANE RESTORATIVE	CARE CENTER	H AVENUE MN 56215			
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
instructed staff to orie assure R5 he was in a Sure R5 he was in a On 4/27/21, at 4:20 p. nursing (IDON) stated R5 was high risk for faincluded a floor mat mhis bed placed in low the floor mat was not MDS coordinator (MD intervention for the flo MDSC on the phone a supposed to have a flowhile he was in bed. In put one in place immed would expect the floor R5 was in bed to prevent A facility policy related requested, but not proceed a supposed to have a flowhile he was in bed to prevent A facility policy related requested, but not proceed a facility policies falls, accidents and reproper assessment are implemented and the of a change in condition staff on the policies are for evaluating and mo implementation of the developed, with the rebrought to the facility's Committee for review.	sodes. R5's note further entate R5 to the situation and a safe place. .m. interim director of d R5's care plan identified alls and his interventions next to his bed and to have position. IDON confirmed in place. IDON indicated the DSC) had initiated the por mat. IDON called the and confirmed R5 was loor mat next to his bed MDSC indicated they would ediately. IDON stated she r mat to be in place when went falls. d to fall prevention was ovided. OD OF CORRECTION: and procedures related to esident supervision to assure and interventions are being provider is promptly notified ion. They could re-educate and procedures. A system onitoring consistent ase policies could be esults of these audits being s Quality Assurance	2 830			

Minnesota Department of Health STATE FORM

PRINTED: 05/26/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245313	B. WING				C 27/2021
	PROVIDER OR SUPPLIER V LANE RESTORATI			STREET ADDRESS, CITY, STATE, ZIF 2209 UTAH AVENUE BENSON, MN 56215	CODE		
(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 CX (EACH CORRECTIVE ACTIVE ACTIV	ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 000	survey was conductive was found to be Not requirements of 42 Requirements for II. The following computes SUBSTANTIATED H5313053C (MN00 cited at F689. The following compunity at F689.	7/21, a standard abbreviated cted at your facility. Your facility OT in compliance with the CFR 483, Subpart B, Long Term Care Facilities. Colaints were found to be 10060188), with a deficiency colaint was found to be ED: 10072022) of correction (POC) will serve of compliance upon the	FO	000			
SS=D	enrolled in ePOC, at the bottom of the form. Your electron be used as verifical Upon receipt of an onsite revisit of you validate that substategulations has be Free of Accident H CFR(s): 483.25(d) (§483.25(d) Accident The facility must en §483.25(d)(1) The as free of accident	azards/Supervision/Devices (1)(2) nts.	F 6	589			6/4/21 (X6) DATE

Electronically Signed 05/24/2021

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.

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE S	LETED
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			2209 UTAH AVENUE	1 04,21	72021
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
Continued From p	age 1	F 689			
supervision and as accidents. This REQUIREME by: Based on observareview, the facility interventions to pr (R5) investigated for findings include: R5's admission Mic 2/25/21, identified impairment and di Alzheimer's disease MDS identified R5 with bed mobility, did not walk. R5's was not steady duseated to standing to surface and R5 staff assistance. Find fallen prior to since admission to the fall	esistance devices to prevent entries and record failed to implement event falls for 1 of 5 residents for fall safety. Inimum Data Set (MDS) dated R5 had severe cognitive agnoses which included: se, dementia, and arthritis. R5's required extensive assistance transfers and toilet use, and R5 MDS identified R5's balance ring transition of moving from and off toilet, and surface was only able to stabilize with establishment of the facility. Issed 4/7/21, identified R5 had of daily living) performance ementia and impaired sight. Intified R5 required assistance over (mechanical lift) for the plan further identified R5 was elated to confusion, ems and vision/hearing re plan interventions included		written allegation of the compliance deficiencies cited. However, submo of this plan of correction is not an admission that a deficiency exists, one was cited correctly. This plan correction is submitted to meet requirements established by state federal law. It is the expectation of Meadow La Restorative Care Center that the fimplements appropriate interventic fall safety to help reduce and prev for all residents. Upon identification deficient practice, R5 s care plan assessments and interventions we reviewed and updated to include immediate placement of floor mat bedside. The facility policies and procedure falls, accidents and resident super were reviewed to assure at like residents have appropriate asse and interventions in place; includir provider is promptly notified with a change in condition. No other indivere adversely affected.	and ane acility ons for ent falls on of the by es for rvision ssments ng that ny ividuals	
were to encourage	e him to use it, and floor mat		licensed staff by DON/Designee.		
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From p §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observa review, the facility interventions to pre (R5) investigated f Findings include: R5's admission Mi 2/25/21, identified impairment and di Alzheimer's diseas MDS identified R5 with bed mobility, did not walk. R5's was not steady du seated to standing to surface and R5 staff assistance. R had fallen prior to since admission to R5's care plan rev an ADL (activities of deficit related to de R5's care plan ide of two staff with Ho transfers. R5's car high risk for falls re gait/balance proble problems. R5's cal were to encourage	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 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions to prevent falls for 1 of 5 residents (R5) investigated for fall safety.	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 1 \$483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions to prevent falls for 1 of 5 residents (R5) investigated for fall safety. Findings include: R5's admission Minimum Data Set (MDS) dated 2/25/21, identified R5 had severe cognitive impairment and diagnoses which included: Alzheimer's disease, dementia, and arthritis. R5's MDS identified R5's balance was not steady during transition of moving from seated to standing, on and off toilet, and surface to surface and R5 was only able to stabilize with staff assistance. R5's MDS further identified R5 had an ADL (activities of daily living) performance deficit related to dementia and impaired sight. R5's care plan revised 4/7/21, identified R5 had an ADL (activities of daily living) performance deficit related to dementia and impaired sight. R5's care plan identified R5 required assistance of two staff with Hoyer (mechanical lift) for transfers. R5's care plan further identified R5 was high risk for falls related to confusion, gait/balance problems and vision/hearing problems. R5's care plan interventions included to ensure R5's care light was within reach, staff were to encourage him to use it, and floor mat	TOURIER OR SUPPLIER VIANE RESTORATIVE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WISE BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 \$483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions to prevent falls for 1 of 5 residents (R5) investigated for fall safety. Findings include: R5's admission Minimum Data Set (MDS) dated 2/25/21, identified R5 had severe cognitive impairment and diagnoses which included: Alzheimer's disease, dementia, and arthritis. R5's MDS identified R5's balance was not steady during transition of moving from seated to standing, on and off toilet, and surface to surface and R5 was only able to stabilize with staff assistance. R5's MDS further identified R5 had an ADL (activities of daily living) performance deficit related to dementia and impaired sight. R5's care plan revised 4/7/21, identified R5 had an ADL (activities of daily living) performance of two staff with Hoyer (mechanical lift) for transfers. R5's care plan interventions included to ensure R5's care plan and vision/hearing problems. R5's care plan interventions included to ensure R5's call light was within reach, staff were to encourage him to use it, and floor mat	PROVIDER OR SUPPLIER 245313 B. WING STREET ADDRESS. CITY, STATE, ZIP CODE 229 UTAH AVENUE BENSON, MN 56215 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Continued From page 1 Continued From page 1 F 689 F 689 F 689 F 689 F 689 F 689 This PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) This Plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is submitted to meat admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meat requirements established by state and federal law. This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is submitted to meat admission that a deficiency exists, or that one was cited correctly. 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		245313	B. WING			C 27/2021
	PROVIDER OR SUPPLIER	VE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	ensure the floor may was in low position On 4/26/21, at 1:40 with the bed in low attached to his gral no floor mat next to was observed lying lying on his right side back and blankets floor mat next to the his room. At 4:01 p (LPN)-A entered R wander-guard (bracelopement from fact awake and lying on was next to R5's bed on. Nursing assistalight and R5 stated and NA-B returned mechanical lift and the mechanical lift and the mechanical lift and the mechanical lift assisted R5 with in then covered R5 w lowered R5's bed abedding and inform NA-A and NA-B eximat had been place their exit. On 4/26/21, at 1:28 at risk for falls. NA-prevent R5 from roon R5 about every fall mat was to be used to see the second seco	at was in place and the bed while R5 was in bed. I p.m. R5 was lying in his bed, position and his call light be bar on the bed. There was R5's bed. At 3:41 p.m. R5 in his bed, facing the wall de with a pillow behind his covering him. There was no e bed or observed anywhere in .m. licensed practical nurse R5's room to check his celet alarm to prevent cility). R5 was lying in bed, in his right side. No floor mat	F 689	policies, procedures and ensuappropriate assessment and are in place to help reduce an falls. The DON or designee will corweekly audits for 6 weeks, the audits for 3 months regarding assessment and interventions including notification of the chondition to MD. Any deficien will be immediately addressed education provided. Audits wreviewed and brought to QAP recommendations and ongoin monitoring. Date of compliance: June 4, 2	interventions and prevent implete the monthly in proper is with falls; the ange of the practices in the proper in the practices in the proper in the practices	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	COM	E SURVEY IPLETED
		245313	B. WING				C 27/2021
	PROVIDER OR SUPPLIER			ST 22	REET ADDRESS, CITY, STATE, ZIP CODE 09 UTAH AVENUE ENSON, MN 56215	1 04/	2112021
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 689	had any recent falls On 4/27/21, at 4:10 at risk for falls. NA- they would transfer was in bed they wo position. NA-D stat should have a floor lying in it and state mat placed by his b The facility untitled updated 4/12/21, la indicate staff were place and the bed was in bed. R5's incident repor was found on the fl a.m. R5 had taken be trying to get up fl No injuries were ob incident. On 3/1/21 reviewed R5's fall a was possibly relate restroom. R5's care intervention to offer R5's incident repor was found lying on 5:08 p.m. and no in time of the incident new interventions of place as well as rei R5's note included review of R5's med with PCP (primary	op.m. NA-D indicated R5 was D stated if R5 was restless him out of bed and when he ould place the bed to the lowest ed she was not aware that R5 mat by his bed when he was dishe had never seen a floor oed. Increased an intervention to to ensure the floor mat was in was in low position while R5 foor next to his bed at 3:30 off his brief and appeared to to possibly use the bathroom. Observed at the time of the plan was updated with a new of R5 the toilet at 2 a.m. rounds. It dated 4/4/21, identified R5 the floor beside his bed at an injuries were observed at the increased and alications was to be completed	F6	689			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		245313	B. WING			C
	PROVIDER OR SUPPLIER N LANE RESTORATIV		D. WING	STREET ADDRESS, CITY, STATE 2209 UTAH AVENUE BENSON, MN 56215		/27/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 689	was found lying on chair at 3:56 a.m. The thought there was get out of the buildicentimeter (cm.) by elbow. R5's report new interventions on place. R5's report to place. R5 up during period check/change/repowith incontinence e instructed staff to older assure R5 he was in cluded a floor manus bed placed in lothe floor mat was not manus bed placed in lothe floor mat was not manus posed to have a while he was in bed put one in place impould expect the flor R5 was in bed to provide the place.	the floor next to his wheel the report identified R5 stated as a fire and was attempting to an	F 6	89		