DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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:

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 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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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 only a suggestion 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00930	A. BUILDING: _____ B. WING _____	C 04/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 4/26/21, to 4/27/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5313053C, H5313054C (MN00060188, MN00058351), with a licensing order issued at 0830. The following complaint was found to be UNSUBSTANTIATED: H5313052C (MN00072022). 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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. .	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record	2 830	"corrected"	6/11/21

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2 830	Continued From page 3 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 required extensive assistance with bed mobility, transfers and toilet use, and R5 did not walk. 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 fallen prior to admission and had no falls since admission to the facility. 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 call light was within reach, staff were to encourage him to use it, and floor mat next to bed. R5's care plan instructed staff to ensure the floor mat was in place and the bed was in low position while R5 was in bed. On 4/26/21, at 1:40 p.m. R5 was lying in his bed, with the bed in low position and his call light attached to his grab bar on the bed. There was no floor mat next to R5's bed. At 3:41 p.m. R5 was observed lying in his bed, facing the wall	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 4 lying on his right side with a pillow behind his back and blankets covering him. There was no floor mat next to the bed or observed anywhere in his room. At 4:01 p.m. licensed practical nurse (LPN)-A entered R5's room to check his wander-guard (bracelet alarm to prevent elopement from facility). R5 was lying in bed, awake and lying on his right side. No floor mat was next to R5's bed. On 4/27/21, at 9:02 a.m. R5 was seated in his wheelchair in his doorway and his call light was on. Nursing assistant (NA)-A answered R5's call light and R5 stated he wanted to lay down. NA-A and NA-B returned to R5's room with the mechanical lift and proceeded to transfer R5 with the mechanical lift to his bed. NA-A and NA-B assisted R5 with incontinence care while in bed, then covered R5 with his bedding. NA-A then lowered R5's bed and attached his call light to his bedding and informed R5 where his call light was. NA-A and NA-B exited R5's room and no floor mat had been placed next to R5's bed prior to their exit. On 4/26/21, at 1:28 p.m. NA-C indicated R5 was at risk for falls. NA-C stated they used pillows to prevent R5 from rolling out of bed and checked on R5 about every hour. NA-C did not indicate a fall mat was to be used in R5's interventions to prevent falls. NA-C stated he was not aware R5 had any recent falls. On 4/27/21, at 4:10 p.m. NA-D indicated R5 was at risk for falls. NA-D stated if R5 was restless they would transfer him out of bed and when he was in bed they would place the bed to the lowest position. NA-D stated she was not aware that R5 should have a floor mat by his bed when he was lying in it and stated she had never seen a floor	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 5 mat placed by his bed. The facility untitled nursing assistant care sheet updated 4/12/21, lacked an intervention to indicate staff were to ensure the floor mat was in place and the bed was in low position while R5 was in bed. R5's incident report dated 2/26/21, identified R5 was found on the floor next to his bed at 3:30 a.m. R5 had taken off his brief and appeared to be trying to get up to possibly use the bathroom. No injuries were observed at the time of the incident. On 3/1/21, IDT (interdisciplinary team) reviewed R5's fall and they determined the fall was possibly related to R5 needing to use the restroom. R5's care plan was updated with a new intervention to offer R5 the toilet at 2 a.m. rounds. R5's incident report dated 4/4/21, identified R5 was found lying on the floor beside his bed at 5:08 p.m. and no injuries were observed at the time of the incident. On 4/26/21, a note identified new interventions of a hi/low bed and floor mat in place as well as reminder/cues to use call light. R5's note included reorientation as needed and a review of R5's medications was to be completed with PCP (primary care provider). R5's incident report dated 4/15/21, identified R5 was found lying on the floor next to his wheel chair at 3:56 a.m. The report identified R5 stated he thought there was a fire and was attempting to get out of the building. R5 received a three centimeter (cm.) by 2 cm. abrasion to his right elbow. R5's report note dated 4/26/21, identified new interventions of a hi/low bed and a floor mat in place. R5's report note instructed staff to get R5 up during periods of wakefulness and check/change/reposition periodically as needed	2 830		

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MEADOW LANE RESTORATIVE CARE CENTEF	2209 UTAH AVENUE BENSON, MN 56215

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2 830	Continued From page 6 with incontinence episodes. R5's note further instructed staff to orientate R5 to the situation and assure R5 he was in a safe place. On 4/27/21, at 4:20 p.m. interim director of nursing (IDON) stated R5's care plan identified R5 was high risk for falls and his interventions included a floor mat next to his bed and to have his bed placed in low position. IDON confirmed the floor mat was not in place. IDON indicated the MDS coordinator (MDSC) had initiated the intervention for the floor mat. IDON called the MDSC on the phone and confirmed R5 was supposed to have a floor mat next to his bed while he was in bed. MDSC indicated they would put one in place immediately. IDON stated she would expect the floor mat to be in place when R5 was in bed to prevent falls. A facility policy related to fall prevention was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 04/27/2021

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F 000	INITIAL COMMENTS On 4/26/21, to 4/27/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5313053C (MN00060188), with a deficiency cited at F689. H5313054C (MN00058351), with a deficiency cited at F689. The following complaint was found to be UNSUBSTANTIATED: H5313052C (MN00072022) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		6/4/21

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

Electronically Signed | 05/24/2021

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F 689	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 required extensive assistance with bed mobility, transfers and toilet use, and R5 did not walk. 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 fallen prior to admission and had no falls since admission to the facility. 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 call light was within reach, staff were to encourage him to use it, and floor mat next to bed. R5's care plan instructed staff to	F 689	This plan of correction constitutes my written allegation of the compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists, or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. It is the expectation of Meadow Lane Restorative Care Center that the facility implements appropriate interventions for fall safety to help reduce and prevent falls for all residents. Upon identification of the deficient practice, R5□s care plan, assessments and interventions were reviewed and updated to include immediate placement of floor mat by bedside. The facility policies and procedures for falls, accidents and resident supervision were reviewed to assure at like residents□ have appropriate assessments and interventions in place; including that provider is promptly notified with any change in condition. No other individuals were adversely affected. Education is scheduled on 5/27/2021 to all licensed staff by DON/Designee. Education included is review of the facility	

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F 689	Continued From page 2 ensure the floor mat was in place and the bed was in low position while R5 was in bed. On 4/26/21, at 1:40 p.m. R5 was lying in his bed, with the bed in low position and his call light attached to his grab bar on the bed. There was no floor mat next to R5's bed. At 3:41 p.m. R5 was observed lying in his bed, facing the wall lying on his right side with a pillow behind his back and blankets covering him. There was no floor mat next to the bed or observed anywhere in his room. At 4:01 p.m. licensed practical nurse (LPN)-A entered R5's room to check his wander-guard (bracelet alarm to prevent elopement from facility). R5 was lying in bed, awake and lying on his right side. No floor mat was next to R5's bed. On 4/27/21, at 9:02 a.m. R5 was seated in his wheelchair in his doorway and his call light was on. Nursing assistant (NA)-A answered R5's call light and R5 stated he wanted to lay down. NA-A and NA-B returned to R5's room with the mechanical lift and proceeded to transfer R5 with the mechanical lift to his bed. NA-A and NA-B assisted R5 with incontinence care while in bed, then covered R5 with his bedding. NA-A then lowered R5's bed and attached his call light to his bedding and informed R5 where his call light was. NA-A and NA-B exited R5's room and no floor mat had been placed next to R5's bed prior to their exit. On 4/26/21, at 1:28 p.m. NA-C indicated R5 was at risk for falls. NA-C stated they used pillows to prevent R5 from rolling out of bed and checked on R5 about every hour. NA-C did not indicate a fall mat was to be used in R5's interventions to prevent falls. NA-C stated he was not aware R5	F 689	policies, procedures and ensuring appropriate assessment and interventions are in place to help reduce and prevent falls. The DON or designee will complete weekly audits for 6 weeks, then monthly audits for 3 months regarding proper assessment and interventions with falls; including notification of the change of condition to MD. Any deficient practices will be immediately addressed and education provided. Audits will be reviewed and brought to QAPI for further recommendations and ongoing monitoring. Date of compliance: June 4, 2021	

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F 689	Continued From page 3	F 689		

had any recent falls.

On 4/27/21, at 4:10 p.m. NA-D indicated R5 was at risk for falls. NA-D stated if R5 was restless they would transfer him out of bed and when he was in bed they would place the bed to the lowest position. NA-D stated she was not aware that R5 should have a floor mat by his bed when he was lying in it and stated she had never seen a floor mat placed by his bed.

The facility untitled nursing assistant care sheet updated 4/12/21, lacked an intervention to indicate staff were to ensure the floor mat was in place and the bed was in low position while R5 was in bed.

R5's incident report dated 2/26/21, identified R5 was found on the floor next to his bed at 3:30 a.m. R5 had taken off his brief and appeared to be trying to get up to possibly use the bathroom. No injuries were observed at the time of the incident. On 3/1/21, IDT (interdisciplinary team) reviewed R5's fall and they determined the fall was possibly related to R5 needing to use the restroom. R5's care plan was updated with a new intervention to offer R5 the toilet at 2 a.m. rounds.

R5's incident report dated 4/4/21, identified R5 was found lying on the floor beside his bed at 5:08 p.m. and no injuries were observed at the time of the incident. On 4/26/21, a note identified new interventions of a hi/low bed and floor mat in place as well as reminder/cues to use call light. R5's note included reorientation as needed and a review of R5's medications was to be completed with PCP (primary care provider).

R5's incident report dated 4/15/21, identified R5

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F 689	Continued From page 4	F 689		

was found lying on the floor next to his wheel chair at 3:56 a.m. The report identified R5 stated he thought there was a fire and was attempting to get out of the building. R5 received a three centimeter (cm.) by 2 cm. abrasion to his right elbow. R5's report note dated 4/26/21, identified new interventions of a hi/low bed and a floor mat in place. R5's report note instructed staff to get R5 up during periods of wakefulness and check/change/reposition periodically as needed with incontinence episodes. R5's note further instructed staff to orientate R5 to the situation and assure R5 he was in a safe place.

On 4/27/21, at 4:20 p.m. interim director of nursing (IDON) stated R5's care plan identified R5 was high risk for falls and his interventions included a floor mat next to his bed and to have his bed placed in low position. IDON confirmed the floor mat was not in place. IDON indicated the MDS coordinator (MDSC) had initiated the intervention for the floor mat. IDON called the MDSC on the phone and confirmed R5 was supposed to have a floor mat next to his bed while he was in bed. MDSC indicated they would put one in place immediately. IDON stated she would expect the floor mat to be in place when R5 was in bed to prevent falls.

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