DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email on May 5, 2021

Administrator
Harry Meyering Ctr Inc
109 Homestead Road
Mankato, MN 56001

RE: Event ID: 8XRI11

Dear Administrator:

On April 13, 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 Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid program. At the time of the survey, the survey team noted one or more deficiencies.

Federal certification deficiencies are delineated on the electonically delivered form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC must:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

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Emailed on May 5, 2021

Administrator
Harry Meyering Ctr Inc
109 Homestead Road
Mankato, MN 56001

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number Event ID: 8XRI11

Dear Administrator:

The above facility was surveyed on April 13, 2021 through April 13, 2021 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. 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 of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Supervised Living Facilities.

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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.

When all orders are corrected, the first page of the order form should be signed and returned to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 Elizabeth Silkey. A written plan for correction of licensing orders is not required.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kim Tyson

Kim Tyson, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-3831
Email: kim.tyson@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01008	A. BUILDING: _____ B. WING _____	C 04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRY MEYERING CTR INC	109 HOMESTEAD ROAD MANKATO, MN 56001

(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
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. On 4/13/21, a complaint investigation was conducted to investigate complaint #HG010025C and #HG010026C. Harry Meyering Center is not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF). The following complaints were found to be substantiated: HG010025C (MN71735, MN71664, MN71660), with a licensing order issued at MN Statute	5 000		

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5 000	Continued From page 1 626.557 and MN Rule 4665.3300 HG010026C (MN71792), however NO licensing order were issued.	5 000		
5 380	MN Rule 4665.3300 PURPOSE OF HEALTH SERVICES. Health services shall be utilized to maintain an optimal general level of health and to maximize function, prevent disability, and promote optimal development of each resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide supervision and client safety for 1 of 1 (C1) client, who was left unsupervised in the facility transportation van. This practice resulted in the client leaving the van, falling and obtaining a hip fracture. Findings include: Review of a serious injury report dated 4/6/21, at 6:00 p.m. indicated C1 was taken to a dental appointment by registered nurse (RN)-A on 4/6/21, per facility van. The report indicated C1 was in a hurry to get to the van after his appointment. C1 would not wait for RN-A to receive his dental paperwork. RN-A then walked with C1 to the van. RN-A put the seat belt on C1 and stood outside the van door, to wait for the dental staff to bring out the clients paperwork. After waiting 5 minutes, the RN-A decided to go in to the clinic and get the paperwork. RN-A told C1 to remain in the van seated. After 5 minutes, RN-A returned to the van and observed C1 on the ground next to the rear tire. C1 was examined by	5 380		

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5 380	Continued From page 2	5 380		

the dental provider. C1 attempted to stand with assistance, but could only bear minimal weight on the right leg. The ambulance was called and C 1 was taken to the hospital, and diagnosed with a fractured right hip. The incident report indicated the incident occurred on 4/6/21, and the SA was not notified until 4/7/21, at 12:34 p.m.

Review of C1's face sheet found in the medical record, identified C1 as having diagnosis of moderate intellectual disability, impulsive behaviors, presbyopia (gradual loss of ability to focus eyes on nearby objects), cataracts, polyosteoarthritis (arthritis or joint pain that affects five or more joints simultaneously), unsteady gait, venous insufficiently (flow of blood through the veins is blocked, causing blood to pool in the legs) and unspecified affective mood disorder.

Review of C1's intensive support self-management assessment (ISMA) dated 4/2020 to July 2021, identified C1 as requiring support with personal safety with community survival skills. The assessment indicated C1 should be within arms length of staff and never left alone. The assessment further identified C1 as having an unsteady gait and is at risk for falls. C1 utilizes a walker and staff is to provide support, when needed in the community.

Review of C1's individual abuse prevention plan (IAPP) dated 11/20/20, identified C1 as having a lack of community orientation skills. Staff are to assist C1 with making decisions when in the community and provide assistance when crossing streets and walking the sidewalk. C1 mobilizes with a walker and staff is to be within arms reach of C1 when in the community. The IAPP identified C1 as not being able to demonstrate cognitive ability skills. C1 requires direction and assistance

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5 380	Continued From page 3 to prevent safety hazards in the community. The IAPP identified C1 as having a lack of self-preservation skills. Staff are to assist C1 with all activities in the community, that may pose a threat to his personal safety. Review of a physician discharge progress note dated 4/12/21, indicated C1 was admitted to the hospital on 4/6/21, after sustaining a fall in the community and having severe pain in the right hip. X-rays were completed of the right hip and identified a displaced femoral neck fracture. The progress note indicated C1 required a right total hip replacement due to the injury. C1 had a right hemiarthroplasty on 4/8/21. Interview on 4/13/21, at 11:00 a.m. direct support professions (DSP)-A indicated she had not transported clients in the facility van for several months. DSP-A stated the facility RN transports clients to their medical appointments. DSP-A indicated upon hire she recalled being trained on the safety of the facility van, but could not recall if the training included leaving clients alone in the van. DSP-A further included she would not leave a client alone and unsupervised in a vehicle, when out in the community. Interview on 4/13/21, at 11:30 a.m. DSP- B indicated she had not transported clients in the facility van for several months. DSP-B stated the facility RN transports clients to their medical appointments. DSP-B indicated upon hire staff are trained on the safety of the facility van, but did not think the training include supervision of clients left alone in the van. DSP-A further included she would not leave a client alone and unsupervised in a vehicle, when out in the community.	5 380		

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5 380	Continued From page 4 Interview on 4/13/21, at 11:45 a.m. DSP-C indicated since clients have not been going out in the community in the past several months, she has not transported clients in the facility van. DSP-C indicated upon hire she recalled being trained on the safety of the van, but could not recall the specifics of the training. DSP-C further included she would not leave a client alone and unsupervised in a vehicle when out in the community. Interview on 4/13/21, at 12:00 p.m. DSP-D indicated she had not transported clients in the facility van for several months, but when she has transported a client in the past she has never left them alone unsupervised. DSP-D indicated upon hire she recalled being trained on the safety of the van, but could not recall the specifics. Interview on 4/13/21, at 12:30 p.m.,. registered nurse (RN)-A confirmed C1 was left unsupervised in the facility van while he went into the clinic to retrieve the clients paperwork. RN-A stated he thought it was ok to leave C1 unsupervised in the van, because he would be gone for a short time. RN-A further stated C 1 had a seatbelt on and has always followed directions in the past. RN-A indicated C 1 was unsupervised for about 5 minutes. RN-A stated when he returned to the facility van, C 1 was laying on the ground near the rear tire of the van. RN-A further indicated C 1 was assessed for injuries and was identified with a possible hip injury. 911 was then called.. RN-A confirmed clients were not assessed for safety related to client supervision, while in a vehicle alone Interview on 4/13/21, at 1:30 a.m. the facility administrator indicated it was not facility practice to leave a client in a transportation vehicle alone.	5 380		

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5 380	Continued From page 5 The administrator further indicated the facility did not have a policy that included safety practices to include supervision of clients, when left alone in a vehicle. Interview with the program director (PD), at this time, indicated it all depended on each client if they were capable of being left unsupervised in a vehicle. The PD confirmed clients had not been assessed for the safety of this practice. The PD stated it was unusual for C1 not to follow RN-A's instructions, but did confirm C1's ISMA included staff support with personal safety skills. Support was needed due to C1's unsteady gait, risk of falls and diagnosis of impulsive behaviors. Review of the policy Transportation Services dated 10/16, did not include specific client safety practices related to supervision when alone in a vehicle unsupervised	5 380		
5 815	MN Statute 626.557 Subd. 3. VA Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe	5 815		

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5 815	Continued From page 6 that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of neglect of care to designated State Agency (SA) for 1 of 1 client (C1) reviewed for allegations of neglect of care. Findings include:	5 815		

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5 815	Continued From page 7 Review of a serious injury report dated 4/6/21, at 6:00 p.m. indicated C1 was taken to a dental appointment by registered nurse (RN)-A on 4/6/21, per facility van. The report indicated C1 was in a hurry to get to the van after his appointment. C1 would not wait for RN-A to receive his dental paperwork. RN-A then walked with C1 to the van. RN-A put the seat belt on C1 and stood outside the van door, to wait for the dental staff to bring out the clients paperwork. After waiting 5 minutes, the RN-A decided to go in to the clinic and get the paperwork. RN-A told C1 to remain in the van seated. After 5 minutes, RN-A returned to the van and observed C1 on the ground next to the rear tire. C1 was examined by the dental provider. C1 attempted to stand with assistance, but could only bear minimal weight on the right leg. The ambulance was called and C 1 was taken to the hospital, and diagnosed with a fractured right hip. The incident report indicated the incident occurred on 4/6/21, and the SA was not notified until 4/7/21, at 12:34 p.m. Interview on 4/13/21, at 2:00 p.m. the program director (PD) confirmed the above incident had not been reported to the SA in a timely manner per facility policy. The facility's policy "Protection of Vulnerable Adults Procedure" revised 2/2019 was reviewed. The reporting procedures included; a mandated reporter should report immediately to the Program Manager (PM) and/or Program Director (PD), or in their absence, respective program on-call personnel. This designated staff then is required to immediately report the incident to the Minnesota Adult Abuse Reporting Center (MAARC) when there is reasonable cause to believe that a vulnerable adult is being, or has	5 815		

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5 815	Continued From page 8 been, abused, neglected or financially exploited.	5 815		

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	24G010	A. BUILDING _____ B. WING _____	C 04/13/2021

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W 000	INITIAL COMMENTS On 4/13/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID). The following complaints were found to be substantiated: HG010025C (MN71735, MN71664, MN71660) with deficiencies cited at W149 and W331. HG010026C (MN71792) no deficiencies issued, due to actions implemented by the facility prior to survey.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of neglect of care to designated State Agency (SA) for 1 of 1 client (C1) reviewed for allegations of neglect of care. Findings include: Review of a serious injury report dated 4/6/21, at 6:00 p.m. indicated C1 was taken to a dental appointment by registered nurse (RN)-A on	W 153		

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

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W 153	Continued From page 1 4/6/21, per facility van. The report indicated C1 was in a hurry to get to the van after his appointment. C1 would not wait for RN-A to receive his dental paperwork. RN-A then walked with C1 to the van. RN-A put the seat belt on C1 and stood outside the van door, to wait for the dental staff to bring out the clients paperwork. After waiting 5 minutes, the RN-A decided to go in to the clinic and get the paperwork. RN-A told C1 to remain in the van seated. After 5 minutes, RN-A returned to the van and observed C1 on the ground next to the rear tire. C1 was examined by the dental provider. C1 attempted to stand with assistance, but could only bear minimal weight on the right leg. The ambulance was called and C 1 was taken to the hospital, and diagnosed with a fractured right hip. The incident report indicated the incident occurred on 4/6/21, and the SA was not notified until 4/7/21, at 12:34 p.m. Interview on 4/13/21, at 2:00 p.m. the program director (PD) confirmed the above incident had not been reported to the SA in a timely manner per facility policy. The facility's policy "Protection of Vulnerable Adults Procedure" revised 2/2019 was reviewed. The reporting procedures included; a mandated reporter should report immediately to the Program Manager (PM) and/or Program Director (PD), or in their absence, respective program on-call personnel. This designated staff then is required to immediately report the incident to the Minnesota Adult Abuse Reporting Center (MAARC) when there is reasonable cause to believe that a vulnerable adult is being, or has been, abused, neglected or financially exploited.	W 153		
W 331	NURSING SERVICES	W 331		

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W 331	Continued From page 2 CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to provide supervision and client safety for 1 of 1 (C1) client, who was left unsupervised in the facility transportation van. This practice resulted in the client leaving the van, falling and obtaining a hip fracture. Findings include: Review of a serious injury report dated 4/6/21, at 6:00 p.m. indicated C1 was taken to a dental appointment by registered nurse (RN)-A on 4/6/21, per facility van. The report indicated C1 was in a hurry to get to the van after his appointment. C1 would not wait for RN-A to receive his dental paperwork. RN-A then walked with C1 to the van. RN-A put the seat belt on C1 and stood outside the van door, to wait for the dental staff to bring out the clients paperwork. After waiting 5 minutes, the RN-A decided to go in to the clinic and get the paperwork. RN-A told C1 to remain in the van seated. After 5 minutes, RN-A returned to the van and observed C1 on the ground next to the rear tire. C1 was examined by the dental provider. C1 attempted to stand with assistance, but could only bear minimal weight on the right leg. The ambulance was called and C 1 was taken to the hospital, and diagnosed with a fractured right hip. The incident report indicated the incident occurred on 4/6/21, and the SA was not notified until 4/7/21, at 12:34 p.m.	W 331		

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W 331	Continued From page 3 Review of C1's face sheet found in the medical record, identified C1 as having diagnosis of moderate intellectual disability, impulsive behaviors, presbyopia (gradual loss of ability to focus eyes on nearby objects), cataracts, polyosteoarthritis (arthritis or joint pain that affects five or more joints simultaneously), unsteady gait, venous insufficiently (flow of blood through the veins is blocked, causing blood to pool in the legs) and unspecified affective mood disorder. Review of C1's intensive support self-management assessment (ISMA) dated 4/2020 to July 2021, identified C1 as requiring support with personal safety with community survival skills. The assessment indicated C1 should be within arms length of staff and never left alone. The assessment further identified C1 as having an unsteady gait and is at risk for falls. C1 utilizes a walker and staff is to provide support, when needed in the community. Review of C1's individual abuse prevention plan (IAPP) dated 11/20/20, identified C1 as having a lack of community orientation skills. Staff are to assist C1 with making decisions when in the community and provide assistance when crossing streets and walking the sidewalk. C1 mobilizes with a walker and staff is to be within arms reach of C1 when in the community. The IAPP identified C1 as not being able to demonstrate cognitive ability skills. C1 requires direction and assistance to prevent safety hazards in the community. The IAPP identified C1 as having a lack of self-preservation skills. Staff are to assist C1 with all activities in the community, that may pose a threat to his personal safety. Review of a physician discharge progress note	W 331		

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W 331	Continued From page 4	W 331		

dated 4/12/21, indicated C1 was admitted to the hospital on 4/6/21, after sustaining a fall in the community and having severe pain in the right hip. X-rays were completed of the right hip and identified a displaced femoral neck fracture. The progress note indicated C1 required a right total hip replacement due to the injury. C1 had a right hemiarthroplasty on 4/8/21.

Interview on 4/13/21, at 11:00 a.m. direct support professions (DSP)-A indicated she had not transported clients in the facility van for several months. DSP-A stated the facility RN transports clients to their medical appointments. DSP-A indicated upon hire she recalled being trained on the safety of the facility van, but could not recall if the training included leaving clients alone in the van. DSP-A further included she would not leave a client alone and unsupervised in a vehicle, when out in the community.

Interview on 4/13/21, at 11:30 a.m. DSP- B indicated she had not transported clients in the facility van for several months. DSP-B stated the facility RN transports clients to their medical appointments. DSP-B indicated upon hire staff are trained on the safety of the facility van, but did not think the training include supervision of clients left alone in the van. DSP-A further included she would not leave a client alone and unsupervised in a vehicle, when out in the community.

Interview on 4/13/21, at 11:45 a.m. DSP-C indicated since clients have not been going out in the community in the past several months, she has not transported clients in the facility van. DSP-C indicated upon hire she recalled being trained on the safety of the van, but could not

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recall the specifics of the training. DSP-C further included she would not leave a client alone and unsupervised in a vehicle when out in the community.

Interview on 4/13/21, at 12:00 p.m. DSP-D indicated she had not transported clients in the facility van for several months, but when she has transported a client in the past she has never left them alone unsupervised. DSP-D indicated upon hire she recalled being trained on the safety of the van, but could not recall the specifics.

Interview on 4/13/21, at 12:30 p.m.,. registered nurse (RN)-A confirmed C1 was left unsupervised in the facility van while he went into the clinic to retrieve the clients paperwork. RN-A stated he thought it was ok to leave C1 unsupervised in the van, because he would be gone for a short time. RN-A further stated C 1 had a seatbelt on and has always followed directions in the past. RN-A indicated C 1 was unsupervised for about 5 minutes. RN-A stated when he returned to the facility van, C 1 was laying on the ground near the rear tire of the van. RN-A further indicated C 1 was assessed for injuries and was identified with a possible hip injury. 911 was then called.. RN-A confirmed clients were not assessed for safety related to client supervision, while in a vehicle alone

Interview on 4/13/21, at 1:30 a.m. the facility administrator indicated it was not facility practice to leave a client in a transportation vehicle alone. The administrator further indicated the facility did not have a policy that included safety practices to include supervision of clients, when left alone in a vehicle. Interview with the program director (PD), at this time, indicated it all depended on each

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W 331	Continued From page 6 client if they were capable of being left unsupervised in a vehicle. The PD confirmed clients had not been assessed for the safety of this practice. The PD stated it was unusual for C1 not to follow RN-A's instructions, but did confirm C1's ISMA included staff support with personal safety skills. Support was needed due to C1's unsteady gait, risk of falls and diagnosis of impulsive behaviors. Review of the policy Transportation Services dated 10/16, did not include specific client safety practices related to supervision when alone in a vehicle unsupervised	W 331		

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W 000	INITIAL COMMENTS On 4/13/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID). The following complaints were found to be substantiated: HG010025C (MN71735, MN71664, MN71660) with deficiencies cited at W149 and W331. HG010026C (MN71792) no deficiencies issued, due to actions implemented by the facility prior to survey.	W 000	POC received 5/14/21 Resubmitted 6/14/21 and 6/25/21 POC approved 7/10/21 Liz Silkey Liz Silkey	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of neglect of care to designated State Agency (SA) for 1 of 1 client (C1) reviewed for allegations of neglect of care. Findings include: Review of a serious injury report dated 4/6/21, at 6:00 p.m. indicated C1 was taken to a dental appointment by registered nurse (RN)-A on	W 153	W153 All staff will be retrained on the Vulnerable Adult policy, including reporting allegations immediately. Date of Completion: May 28, 2021 Person responsible: Jodi Sapp, Program Director. On-Call staff will notify a Program Manager or Program Director who will be responsible for timely reporting of allegations to MAARC. The Executive Director, who supervises the Program Director, will review all reports to insure timely reporting for a period of 3 months and randomly after that. Person Responsible: Program Managers; Program Director, Executive Director	

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

Jodi Sapp PD — Program Director — 6/24/21

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

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W 153	Continued From page 1 4/6/21, per facility van. The report indicated C1 was in a hurry to get to the van after his appointment. C1 would not wait for RN-A to receive his dental paperwork. RN-A then walked with C1 to the van. RN-A put the seat belt on C1 and stood outside the van door, to wait for the dental staff to bring out the clients paperwork. After waiting 5 minutes, the RN-A decided to go in to the clinic and get the paperwork. RN-A told C1 to remain in the van seated. After 5 minutes, RN-A returned to the van and observed C1 on the ground next to the rear tire. C1 was examined by the dental provider. C1 attempted to stand with assistance, but could only bear minimal weight on the right leg. The ambulance was called and C 1 was taken to the hospital, and diagnosed with a fractured right hip. The incident report indicated the incident occurred on 4/6/21, and the SA was not notified until 4/7/21, at 12:34 p.m. Interview on 4/13/21, at 2:00 p.m. the program director (PD) confirmed the above incident had not been reported to the SA in a timely manner per facility policy. The facility's policy "Protection of Vulnerable Adults Procedure" revised 2/2019 was reviewed. The reporting procedures included; a mandated reporter should report immediately to the Program Manager (PM) and/or Program Director (PD), or in their absence, respective program on-call personnel. This designated staff then is required to immediately report the incident to the Minnesota Adult Abuse Reporting Center (MAARC) when there is reasonable cause to believe that a vulnerable adult is being, or has been, abused, neglected or financially exploited.	W 153		
W 331	NURSING SERVICES	W 331		

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W 331	Continued From page 2 CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to provide supervision and client safety for 1 of 1 (C1) client, who was left unsupervised in the facility transportation van. This practice resulted in the client leaving the van, falling and obtaining a hip fracture. Findings include: Review of a serious injury report dated 4/6/21, at 6:00 p.m. indicated C1 was taken to a dental appointment by registered nurse (RN)-A on 4/6/21, per facility van. The report indicated C1 was in a hurry to get to the van after his appointment. C1 would not wait for RN-A to receive his dental paperwork. RN-A then walked with C1 to the van. RN-A put the seat belt on C1 and stood outside the van door, to wait for the dental staff to bring out the clients paperwork. After waiting 5 minutes, the RN-A decided to go in to the clinic and get the paperwork. RN-A told C1 to remain in the van seated. After 5 minutes, RN-A returned to the van and observed C1 on the ground next to the rear tire. C1 was examined by the dental provider. C1 attempted to stand with assistance, but could only bear minimal weight on the right leg. The ambulance was called and C 1 was taken to the hospital, and diagnosed with a fractured right hip. The incident report indicated the incident occurred on 4/6/21, and the SA was not notified until 4/7/21, at 12:34 p.m.	W 331	W 331 All DSPs, Location Coordinators, and other ICF staff will be trained that individuals should never be left unattended in a vehicle. The facility Transportation Policy will be revised to indicate that no individuals will be left unattended in the vehicles. All staff will read and sign off on the new policy as proof of training. All DSPs will train on the Transportation policy annually to ensure that all staff acknowledge the responsibility of not leaving individuals unsupervised in the vehicles. Program Managers and the Program Coordinator will do random checks as people are being loaded for activities to insure staff are not leaving people unattended in the vans. Completion Date: 5/28/2021 Person(s) Responsible: Jodi Sapp, Program Director Karen Nelson, Program Manager	

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W 331	Continued From page 3	W 331		

Review of C1's face sheet found in the medical record, identified C1 as having diagnosis of moderate intellectual disability, impulsive behaviors, presbyopia (gradual loss of ability to focus eyes on nearby objects), cataracts, polyosteoarthritis (arthritis or joint pain that affects five or more joints simultaneously), unsteady gait, venous insufficiently (flow of blood through the veins is blocked, causing blood to pool in the legs) and unspecified affective mood disorder.

Review of C1's intensive support self-management assessment (ISMA) dated 4/2020 to July 2021, identified C1 as requiring support with personal safety with community survival skills. The assessment indicated C1 should be within arms length of staff and never left alone. The assessment further identified C1 as having an unsteady gait and is at risk for falls. C1 utilizes a walker and staff is to provide support, when needed in the community.

Review of C1's individual abuse prevention plan (IAPP) dated 11/20/20, identified C1 as having a lack of community orientation skills. Staff are to assist C1 with making decisions when in the community and provide assistance when crossing streets and walking the sidewalk. C1 mobilizes with a walker and staff is to be within arms reach of C1 when in the community. The IAPP identified C1 as not being able to demonstrate cognitive ability skills. C1 requires direction and assistance to prevent safety hazards in the community. The IAPP identified C1 as having a lack of self-preservation skills. Staff are to assist C1 with all activities in the community, that may pose a threat to his personal safety.

Review of a physician discharge progress note

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W 331	Continued From page 4	W 331		

dated 4/12/21, indicated C1 was admitted to the hospital on 4/6/21, after sustaining a fall in the community and having severe pain in the right hip. X-rays were completed of the right hip and identified a displaced femoral neck fracture. The progress note indicated C1 required a right total hip replacement due to the injury. C1 had a right hemiarthroplasty on 4/8/21.

Interview on 4/13/21, at 11:00 a.m. direct support professions (DSP)-A indicated she had not transported clients in the facility van for several months. DSP-A stated the facility RN transports clients to their medical appointments. DSP-A indicated upon hire she recalled being trained on the safety of the facility van, but could not recall if the training included leaving clients alone in the van. DSP-A further included she would not leave a client alone and unsupervised in a vehicle, when out in the community.

Interview on 4/13/21, at 11:30 a.m. DSP- B indicated she had not transported clients in the facility van for several months. DSP-B stated the facility RN transports clients to their medical appointments. DSP-B indicated upon hire staff are trained on the safety of the facility van, but did not think the training include supervision of clients left alone in the van. DSP-A further included she would not leave a client alone and unsupervised in a vehicle, when out in the community.

Interview on 4/13/21, at 11:45 a.m. DSP-C indicated since clients have not been going out in the community in the past several months, she has not transported clients in the facility van. DSP-C indicated upon hire she recalled being trained on the safety of the van, but could not

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recall the specifics of the training. DSP-C further included she would not leave a client alone and unsupervised in a vehicle when out in the community.

Interview on 4/13/21, at 12:00 p.m. DSP-D indicated she had not transported clients in the facility van for several months, but when she has transported a client in the past she has never left them alone unsupervised. DSP-D indicated upon hire she recalled being trained on the safety of the van, but could not recall the specifics.

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Interview on 4/13/21, at 1:30 a.m. the facility administrator indicated it was not facility practice to leave a client in a transportation vehicle alone. The administrator further indicated the facility did not have a policy that included safety practices to include supervision of clients, when left alone in a vehicle. Interview with the program director (PD), at this time, indicated it all depended on each

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