

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.

Harry Meyering Ctr Inc

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 Typon

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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.

Harry Meyering Ctr Inc

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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, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Kim Tyson

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING.			,
		01008	B. WING		_	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HARRY	MEYERING CTR INC		ESTEAD RO. D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 000 Initial Comments		5 000				
	144.56 and/or Minr 144.653, this correspursuant to a surver found that the deficiency of the many of the Minnesota Dep Determination of wearened requirements of the number and MN Ruindicated below. We several items, failuitems will be considered of multi-part ruassessment of a fir violated during the corrected.	hether a violation has been compliance with all e rule provided at the tagule number or MN Statute when a rule or statute contains re to comply with any of the lered lack of compliance.				
	orders provided that the Department with notice of assessment on 4/13/21, a compliance or and #HG010026C in compliance with	n non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance. Colaint investigation was tigate complaint #HG010025C. Harry Meyering Center is not requirements of Minnesota 55 requirements for Supervised (F).				
	substantiated: HG010025C (MN7	olaints were found to be 1735, MN71664, MN71660), er issued at MN Statute				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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5 000	Continued From pa	ge 1	5 000			
	626.557 and MN Ru HG010026C (MN71 order were issued.	ule 4665.3300 1792), however NO licensing				
5 380	MN Rule 4665.3300 SERVICES.) PURPOSE OF HEALTH	5 380			
	optimal general leve	all be utilized to maintain an el of health and to maximize sability, and promote optimal ch resident.				
	by: Based on interview facility failed to prov safety for 1 of 1 (C1 unsupervised in the This practice resulte	and document review, the vide supervision and client c) client, who was left facility transportation van. ed in the client leaving the aining a hip fracture.				
	Findings include:					
	6:00 p.m. indicated appointment by reg 4/6/21, per facility v was in a hurry to ge appointment. C1 we receive his dental p with C1 to the van. and stood outside the dental staff to bring After waiting 5 minuin to the clinic and cC1 to remain in the RN-A returned to the	injury report dated 4/6/21, at C1 was taken to a dental istered nurse (RN)-A on an. The report indicated C1 of to the van after his ould not wait for RN-A to aperwork. RN-A then walked RN-A put the seat belt on C1 he van door, to wait for the out the clients paperwork. Ites, the RN-A decided to go get the paperwork. RN-A told van seated. After 5 minutes, e van and observed C1 on the rear tire. C1 was examined by				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
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5 380	the dental provider. assistance, but couthe right leg. The arwas taken to the hofractured right hip. The incident occurrent not notified until 4/7 Review of C1's face record, identified Comoderate intellectubehaviors, presbyor focus eyes on near polyosteoarthritis (a five or more joints as venous insufficiently veins is blocked, callegs) and unspecified Review of C1's intereself-management at 4/2020 to July 2021 support with person survival skills. The assistance as having an unstead at 1/20 and the support, when need Review of C1's indicultated and the support of C1's indicultated and the support, when need Review of C1's indicultated and the support of C1's indicult	C1 attempted to stand with ald only bear minimal weight on abulance was called and C1 aspital, and diagnosed with a The incident report indicated and c4 and c5 and t6 and c6 and c7 and the SA was c721, at 12:34 p.m. The sheet found in the medical as having diagnosis of all disability, impulsive pia (gradual loss of ability to by objects), cataracts, arthritis or joint pain that affects simultaneously), unsteady gait, y (flow of blood through the ausing blood to pool in the end affective mood disorder.	5 380			

Minnesota Department of Health

STATE FORM 8XRI11 If continuation sheet 3 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLET				
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5 380	to prevent safety had IAPP identified C1 as self-preservation skall activities in the conthreat to his person. Review of a physic dated 4/12/21, indicated 4/12/21, indicated a displace progress note indicated a displace progress note indicated in preplacement dusto hemiarthroplasty or interview on 4/13/2 professions (DSP)-transported clients months. DSP-A state clients to their medicated upon hire the safety of the fact the training included van. DSP-A further a client alone and unwhen out in the confictive on 4/13/2 indicated she had infacility van for sever facility RN transport appointments. DSP are trained on the state on the state of the training included she would included she would	azards in the community. The as having a lack of tills. Staff are to assist C1 with ommunity, that may pose a all safety. ian discharge progress note sated C1 was admitted to the after sustaining a fall in the ring severe pain in the right impleted of the right hip and ad femoral neck fracture. The ated C1 required a right total in the injury. C1 had a right in 4/8/21. 1, at 11:00 a.m. direct support A indicated she had not in the facility van for several ted the facility RN transports cal appointments. DSP-A she recalled being trained on sility van, but could not recall if d leaving clients alone in the included she would not leave insupervised in a vehicle,	5 380			

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5 380	Continued From pa	ge 4	5 380			
	Interview on 4/13/2 indicated since clie the community in thas not transported DSP-C indicated uptrained on the safet recall the specifics included she would unsupervised in a vicommunity.	1, at 11:45 a.m. DSP-C Ints have not been going out in the past several months, she is clients in the facility van. From hire she recalled being by of the van, but could not of the training. DSP-C further not leave a client alone and rehicle when out in the				
	indicated she had r facility van for seve transported a client them alone unsupe hire she recalled be	not transported clients in the ral months, but when she has in the past she has never left rvised. DSP-D indicated upon leing trained on the safety of not recall the specifics.				
	nurse (RN)-A confir in the facility van wiretrieve the clients thought it was ok to van, because he work RN-A further stated has always followed indicated C 1 was uninutes. RN-A state facility van, C 1 was rear tire of the van. was assessed for in a possible hip injury confirmed clients worelated to client supalone	1, at 12:30 p.m., registered med C1 was left unsupervised hile he went into the clinic to paperwork. RN-A stated he leave C1 unsupervised in the buld be gone for a short time. I C 1 had a seatbelt on and directions in the past. RN-A unsupervised for about 5 ed when he returned to the salaying on the ground near the RN-A further indicated C 1 injuries and was identified with y. 911 was then called RN-A were not assessed for safety pervision, while in a vehicle				
	administrator indica	1, at 1:30 a.m. the facility ated it was not facility practice a transportation vehicle alone.				

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STATE FORM 8XRI11 If continuation sheet 5 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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5 380	not have a policy the include supervision vehicle. Interview wat this time, indicated client if they were consupervised in a volients had not been this practice. The Protection to follow RN-A's C1's ISMA included safety skills. Support unsteady gait, risk of impulsive behaviors. Review of the policy dated 10/16, did not remark to the policy dated 10/16, did not remark.	urther indicated the facility did at included safety practices to of clients, when left alone in a with the program director (PD), and it all depended on each apable of being left rehicle. The PD confirmed in assessed for the safety of in Stated it was unusual for C1 is instructions, but did confirm a staff support with personal in the safety of falls and diagnosis of stated its and diagnosi	5 380			
5 815	(a) A mandated rep believe that a vulne been maltreated, or vulnerable adult has which is not reason immediately report common entry poin vulnerable adult sol admitted to a facility required to report s individual that occu unless: (1) the individual wa another facility and reason to believe the maltreated in the present sulling that the present sulling that the sulling that t	ne vulnerable adult was	5 815			

Minnesota Department of Health

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OVA) ID SUM	IMADV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(VE)
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that the incidefined in sclause (4). (b) A person provisions report as discovered as d	n not recoff this sees of the sees of	s a vulnerable adult as 26.5572, subdivision 21, quired to report under the ection may voluntarily	5 815			

Minnesota Department of Health

STATE FORM 8XRI11 If continuation sheet 7 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION		SURVEY PLETED	
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	6:00 p.m. indicated appointment by reg 4/6/21, per facility was in a hurry to ge appointment. C1 we receive his dental p with C1 to the van. and stood outside t dental staff to bring After waiting 5 minuin to the clinic and C1 to remain in the RN-A returned to the ground next to the integral to the dental provider assistance, but couthe right leg. The air was taken to the horizontal provider.	injury report dated 4/6/21, at C1 was taken to a dental istered nurse (RN)-A on ran. The report indicated C1 at to the van after his ould not wait for RN-A to raperwork. RN-A then walked RN-A put the seat belt on C1 he van door, to wait for the out the clients paperwork. Ites, the RN-A decided to go get the paperwork. RN-A told van seated. After 5 minutes, we van and observed C1 on the rear tire. C1 was examined by C1 attempted to stand with all only bear minimal weight on mbulance was called and C1 ospital, and diagnosed with a The incident report indicated and on 4/6/21, and the SA was 7/21, at 12:34 p.m.				
	director (PD) confir	21, at 2:00 p.m. the program med the above incident had o the SA in a timely manner				
	Adults Procedure" I The reporting proce reporter should rep Program Manager (PD), or in their abs on-call personnel. I required to immedia Minnesota Adult Ab (MAARC) when the	"Protection of Vulnerable revised 2/2019 was reviewed. edures included; a mandated ort immediately to the (PM) and/or Program Director sence, respective program This designated staff then is ately report the incident to the use Reporting Center ere is reasonable cause to trable adult is being, or has				

Minnesota Department of Health

STATE FORM 8XRI11 If continuation sheet 8 of 9

AND DUAN OF CODDECTION DENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	COMPLETED	
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Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION			E SURVEY PLETED
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HARRY I	MEYERING CTR INC			109 HOMESTEAD ROAD MANKATO, MN 56001			
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W 000	INITIAL COMMEN	ΓS	w o	000			
W 153	conducted at your for to be NOT in compute to be NOT in compute NOT in compute NOT in compute NOT in the following compute Substantiated: HG010025C (MN7 with deficiencies cith HG010026C (MN7 due to actions implies NOT in the facility must ensurely. STAFF TREATMENT CFR(s): 483.420(d) The facility must ensure of the officials in accordance in the officials in accordance stablished proced. This STANDARD in Based on interview facility failed to immine neglect of care to do for 1 of 1 client (C1 neglect of care. Findings include:	plaints were found to be 1735, MN71664, MN71660) ted at W149 and W331. 1792) no deficiencies issued, emented by the facility prior to NT OF CLIENTS (2) Issure that all allegations of ect or abuse, as well as a source, are reported administrator or to other nce with State law through	W 1	153			
	appointment by reg	istered nurse (RN)-A on					
LABORATOR'	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE			(X6) DATE

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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W 153	4/6/21, per facility was in a hurry to ge appointment. C1 we receive his dental pwith C1 to the van. and stood outside the dental staff to bring After waiting 5 minured in to the clinic and ge C1 to remain in the RN-A returned to the ground next to the end the dental provider assistance, but count the right leg. The alwas taken to the heart fractured right hip. The incident occurred not notified until 4/7 Interview on 4/13/2 director (PD) confirm not been reported the per facility policy. The facility's policy Adults Procedure in The reporting procedure in the reporter should reperform Manager (PD), or in their abson-call personnel. The required to immedia Minnesota Adult Ab (MAARC) when the believe that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the staff of the receiver that a vulne in the receiver the receiver that a vulne in the receiver that a vulne in the receiver that a vulne in the receiver that a vulne in the receiver the receiver the receiver that a vulne in the receiver that the receiver that the receiver that the receiver the receiver that the receiver the receiver the receiver the receiver that the r	ran. The report indicated C1 bet to the van after his could not wait for RN-A to caperwork. RN-A then walked RN-A put the seat belt on C1 he van door, to wait for the cout the clients paperwork. Lites, the RN-A decided to go get the paperwork. RN-A told van seated. After 5 minutes, lie van and observed C1 on the rear tire. C1 was examined by C1 attempted to stand with lid only bear minimal weight on mbulance was called and C 1 cospital, and diagnosed with a The incident report indicated and on 4/6/21, and the SA was 1/21, at 12:34 p.m. 21, at 2:00 p.m. the program med the above incident had to the SA in a timely manner "Protection of Vulnerable revised 2/2019 was reviewed. The decided or timmediately to the (PM) and/or Program Director sence, respective program This designated staff then is lately report the incident to the luse Reporting Center let is reasonable cause to let adult is being, or has let the course of the cour	W 15			

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION UILDING	(X3) DATE SURVEY COMPLETED	
24G010 B. W	/ING	C 04/13/2021	
NAME OF PROVIDER OR SUPPLIER HARRY MEYERING CTR INC	STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMESTEAD ROAD MANKATO, MN 56001	0 11 10/2021	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PF	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION	
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 C1 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	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		TE SURVEY MPLETED		
		24G010	B. WING _		04	C / 13/2021	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMESTEAD ROAD MANKATO, MN 56001			04/13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 331	record, identified C moderate intellectubehaviors, presbyo focus eyes on near polyosteoarthritis (a five or more joints a venous insufficiently veins is blocked, calegs) and unspecification of C1's interest and unspecification of C1's interest alone. The asset as having an unstered utilizes a walker support, when need Review of C1's indication of C1's i	as sheet found in the medical 1 as having diagnosis of al disability, impulsive pia (gradual loss of ability to by objects), cataracts, arthritis or joint pain that affects simultaneously), unsteady gait, y (flow of blood through the ausing blood to pool in the ed affective mood disorder. Insive support assessment (ISMA) dated 1, identified C1 as requiring hal safety with community assessment indicated C1 ms length of staff and never ressment further identified C1 ady gait and is at risk for falls. In and staff is to provide ded in the community. Vidual abuse prevention plan y20, identified C1 as having a orientation skills. Staff are to ing decisions when in the ovide assistance when crossing y the sidewalk. C1 mobilizes thaff is to be within arms reach community. The IAPP identified le to demonstrate cognitive quires direction and assistance as having a lack of kills. Staff are to assist C1 with community, that may pose a	W 33				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	CON	TE SURVEY MPLETED	
		24G010	B. WING _			C / 13/2021
NAME OF PROVIDER OR SUPPLIER HARRY MEYERING CTR INC				STREET ADDRESS, CITY, STATE, ZIP C 109 HOMESTEAD ROAD MANKATO, MN 56001		10/2021
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 331	dated 4/12/21, indichospital on 4/6/21, community and have hip. X-rays were consideratified a displace progress note indichip replacement dust hemiarthroplasty of the miarthroplasty of the miarthroplasty of the months. DSP-A standicated upon hire the safety of the fact the training include van. DSP-A further a client alone and under when out in the considerated with the training include van. DSP-A further a client alone and under when out in the consideration of the did not think the tracilients left alone in included she would unsupervised in a variable to the community. Interview on 4/13/2 indicated since client the community in the not transported DSP-C indicated unsupervised in a variable to the community in the not transported DSP-C indicated unsupervised unsupervised in a variable to the community in the not transported DSP-C indicated unsupervised unsuperv	cated C1 was admitted to the after sustaining a fall in the wing severe pain in the right ompleted of the right hip and ed femoral neck fracture. The stated C1 required a right total se to the injury. C1 had a right in 4/8/21. 11, at 11:00 a.m. direct support A indicated she had not in the facility van for several sted the facility RN transports ical appointments. DSP-A is she recalled being trained on cility van, but could not recall if d leaving clients alone in the included she would not leave unsupervised in a vehicle,	W 33			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION	(X3) DATE COMP	LETED		
		24G010	B. WING			3/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMESTEAD ROAD MANKATO, MN 56001	7 0 11 10 12 02 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 331	included she would unsupervised in a vicommunity. Interview on 4/13/2 indicated she had refacility van for seventransported a client them alone unsuper hire she recalled be the van, but could refacility van woretrieve the clients thought it was ok to van, because he word RN-A further stated has always follower indicated C 1 was a minutes. RN-A state facility van, C 1 was rear tire of the van. was assessed for in a possible hip injury confirmed clients wore related to client supalone. Interview on 4/13/2 administrator indicated to leave a client in a The administrator for the van policy the include supervision vehicle. Interview word interview word include supervision vehicle.	of the training. DSP-C further not leave a client alone and rehicle when out in the send to transported clients in the ral months, but when she has in the past she has never left rvised. DSP-D indicated upon eing trained on the safety of not recall the specifics. 1, at 12:30 p.m., registered med C1 was left unsupervised hile he went into the clinic to paperwork. RN-A stated he believe C1 unsupervised in the buld be gone for a short time. 1 C 1 had a seatbelt on and didirections in the past. RN-A unsupervised for about 5 and when he returned to the selaying on the ground near the RN-A further indicated C 1 injuries and was identified with year of the season while in a vehicle at transportation vehicle alone. The program director (PD), and it all depended on each	W 331				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION ING	COM	TE SURVEY MPLETED	
		24G010	B. WING			C / 13/2021
NAME OF PROVIDER OR SUPPLIER HARRY MEYERING CTR INC				STREET ADDRESS, CITY, STATE, ZIP 109 HOMESTEAD ROAD MANKATO, MN 56001		713/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 331	unsupervised in a vicients had not been this practice. The Proof to follow RN-A's C1's ISMA included safety skills. Suppounsteady gait, risk of impulsive behaviors Review of the policy dated 10/16, did no	apable of being left rehicle. The PD confirmed in assessed for the safety of D stated it was unusual for C1 is instructions, but did confirm staff support with personal rt was needed due to C1's of falls and diagnosis of states. Y Transportation Services t include specific client safety supervision when alone in a	W 3	31		

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		212212				С
		24G010	B. WING		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		TEMENT OF DEFICIENCIES	lD	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION
PREFIX TAG	I	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
170		,	17.0	DEFICIENCY)	110011	
W 000	INITIAL COMMENT	·s	W 00	POC received 5/14/21		
			., .,	Resubmitted 6/14/21 an	d 6/25/2	1
	On 4/13/21 a ston	dard abbreviated survey was		POC approved 7/10/21	x 0/20/2	•
		acility. Your facility was found		Liz Silkey		
		iance with the requirements of				
		ubpart I, requirements for		Liz Silkey		
		acilities for Individuals with				
	Intellectual Disabilit	ies (ICF/ID).				
		, ,		W153		
		laints were found to be				
	substantiated:			All staff will be retrained on the		
		735, MN71664, MN71660)		Vulnerable Adult policy, includir	α	
		ed at W149 and W331.		reporting allegations immediate	~	
		792) no deficiencies issued, emented by the facility prior to		reperung anegations immodiate	y .	
	survey.	smented by the facility prior to		Date of Completion: May 28, 2	121	
W 153	STAFF TREATMEN	IT OF CLIENTS	W 15		· - ·	
** 100	CFR(s): 483.420(d)		** 10	Person responsible:		
		`		Jodi Sapp, Program Director.		
	The facility must en	sure that all allegations of		oca capp, cogram 200000		
		ct or abuse, as well as		On-Call staff will notify a Progra	m	
		source, are reported		Manager or Program Director w		
		administrator or to other		be responsible for timely reporti		
		ce with State law through		allegations to MAARC. The Exc		
	established procedu	ires.		Director, who supervises the Pr		
				Director, will review all reports to		
	This STANDARD is	not met as evidenced by:		timely reporting for a period of 3		
		and document review, the		and randomly after that.	1110111110	
		ediately report allegations of		and tarracting after that		
		esignated State Agency (SA)		Person Responsible: Program		
		reviewed for allegations of		Managers; Program Director, Ex	ecutive	
	neglect of care.			Director	.codiro	
	Eindings insteads:					
	Findings include:					
	Review of a serious	injury report dated 4/6/21, at				
		C1 was taken to a dental				
		stered nurse (RN)-A on				
		` '				
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		X6) DATE

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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	BUILDING	(X3) DATE SURVEY COMPLETED
24G010 B.	WING	C 04/13/2021
NAME OF PROVIDER OR SUPPLIER HARRY MEYERING CTR INC	STREET ADDRESS, CITY, STATE, ZIP 109 HOMESTEAD ROAD MANKATO, MN 56001	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIC TAG CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION IE APPROPRIATE DATE
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 331 NURSING SERVICES	W 153	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		040040	D 14/11/0			С	
		24G010	B. WING		04/	13/2021	
	PROVIDER OR SUPPLIER MEYERING CTR INC			STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMESTEAD ROAD MANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W 331		_	W 3	W 331			
	Based on interview facility failed to provide safety for 1 of 1 (Counsupervised in the This practice results van, falling and obtained the Findings include: Review of a serious 6:00 p.m. indicated appointment by registry was in a hurry to ge appointment. C1 wo receive his dental pwith C1 to the van. and stood outside the dental staff to bring After waiting 5 minuting to the clinic and ground next to the results of the dental provider. assistance, but could result to form the dental provider.	and document review, the vide supervision and client it client, who was left if facility transportation van. It is injury report dated 4/6/21, at C1 was taken to a dental istered nurse (RN)-A on an. The report indicated C1 is to the van after his uld not wait for RN-A to aperwork. RN-A then walked RN-A put the seat belt on C1 in evan door, to wait for the out the clients paperwork. RN-A told van seated. After 5 minutes, it is van and observed C1 on the ear tire. C1 was examined by C1 attempted to stand with d only bear minimal weight on inbulance was called and C1		All DSPs, Location Coordinate other ICF staff will be trained the individuals should never be left unattended in a vehicle. The facility Transportation Pobe revised to indicate that no inwill be left unattended in the very All staff will read and sign off onew policy as proof of training. All DSPs will train on the Transpolicy annually to ensure that a acknowledge the responsibility leaving individuals unsupervised vehicles. Program Managers and the Procoordinator will do random che people are being loaded for accinsure staff are not leaving people unattended in the vans. Completion Date: 5/28/2021 Person(s) Responsible:	licy will adividuals hicles. In the portation af not of not of in the pogram ecks as ivities to		
	fractured right hip.	spital, and diagnosed with a The incident report indicated on 4/6/21, and the SA was 1/21, at 12:34 p.m.		Jodi Sapp, Program Director Karen Nelson, Program Manag	er		

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		24G010	B. WING			C 04/13/2021	
HARRY MEYERING CTR INC				STREET ADDRESS, CITY, STATE, ZIP CO 109 HOMESTEAD ROAD MANKATO, MN 56001	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
W 331	record, identified C moderate intellectu behaviors, presbyo focus eyes on near polyosteoarthritis (a five or more joints seemous insufficiently veins is blocked, calegs) and unspecified Review of C1's interestly support with person survival skills. The asshould be within arrileft alone. The asseas having an unsteact utilizes a walker support, when need Review of C1's individed in the community and provided in the community and provided in the community and provided in the community skills. C1 required to prevent safety has laPP identified C1 a self-preservation skill activities in the contract to his personal	e sheet found in the medical 1 as having diagnosis of al disability, impulsive pia (gradual loss of ability to by objects), cataracts, arthritis or joint pain that affects simultaneously), unsteady gait, y (flow of blood through the rusing blood to pool in the ed affective mood disorder. Insive support ssessment (ISMA) dated , identified C1 as requiring ral safety with community ressessment further identified C1 rus length of staff and never ressment further identified C1 rus length of staff and never ressment further identified C1 rus length of staff and never ressment further identified C1 rus length of staff and never ressment further identified C1 rus length of staff and never ressment further identified C1 rus length of staff and never rus	W 3	31			

	OF DEFICIENCIES OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24G010	B. WING	B. WING			C 13/2021
	PROVIDER OR SUPPLIER MEYERING CTR INC			STREET ADDRESS, CITY, STATE, ZIP C 109 HOMESTEAD ROAD MANKATO, MN 56001	ODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
W 331	hospital on 4/6/21, community and have hip. X-rays were consideratified a displace progress note indicated progress note indicated upon the safety of the fact the training include van. DSP-A further a client alone and upon the safety of the fact the training include van. DSP-A further a client alone and upon the safety of the fact the training include van. DSP-A further a client alone and upon the safety of the fact the training include van. DSP-A further a client alone and upon the safety of the fact the training include van. DSP-A further a client alone and upon the safety of the fact the training include van. DSP-are trained on the safety van for seve facility van for se	cated C1 was admitted to the after sustaining a fall in the ving severe pain in the right ampleted of the right hip and ed femoral neck fracture. The sated C1 required a right total e to the injury. C1 had a right of 4/8/21. 1, at 11:00 a.m. direct support in the facility van for several ed the facility van for several ed the facility RN transports ical appointments. DSP-A she recalled being trained on cility van, but could not recall if d leaving clients alone in the included she would not leave unsupervised in a vehicle,	W3	31			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24G010	B. WING			l.	C 13/3034
NAME OF	PROVIDER OR SUPPLIER	240010		OTDEE	T ADDDESS OFFI STATE ZID CODE	04/	13/2021
HARRY MEYERING CTR INC				109 H	ET ADDRESS, CITY, STATE, ZIP CODE OMESTEAD ROAD KATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	included she would	ge 5 of the training. DSP-C further not leave a client alone and rehicle when out in the	W 3	31			
	indicated she had r facility van for seventransported a client them alone unsupe hire she recalled be	1, at 12:00 p.m. DSP-D not transported clients in the ral months, but when she has in the past she has never left rvised. DSP-D indicated upon leing trained on the safety of not recall the specifics.					
	nurse (RN)-A confirming the facility van will retrieve the clients puthought it was ok to van, because he work RN-A further stated thas always followed indicated C 1 was uninutes. RN-A state facility van, C 1 was rear tire of the van. was assessed for in a possible hip injury confirmed clients were	1, at 12:30 p.m.,. registered med C1 was left unsupervised hile he went into the clinic to paperwork. RN-A stated he leave C1 unsupervised in the buld be gone for a short time. C1 had a seatbelt on and directions in the past. RN-A unsupervised for about 5 d when he returned to the laying on the ground near the RN-A further indicated C1 niguries and was identified with v. 911 was then called RN-A ere not assessed for safety ervision, while in a vehicle					
	administrator indica to leave a client in a The administrator fu not have a policy tha include supervision vehicle. Interview w	1, at 1:30 a.m. the facility ted it was not facility practice a transportation vehicle alone. In their indicated the facility did at included safety practices to of clients, when left alone in a ith the program director (PD), and it all depended on each					

Facility ID: 01008

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED
		24G010	B. WING			C / 13/2021
NAME OF PROVIDER OR SUPPLIER HARRY MEYERING CTR INC				STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMESTEAD ROAD MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 331	unsupervised in a vicients had not been this practice. The Prot to follow RN-A's C1's ISMA included safety skills. Suppounsteady gait, risk of impulsive behaviors. Review of the policy dated 10/16, did not seem to be a seem t	apable of being left rehicle. The PD confirmed n assessed for the safety of D stated it was unusual for C1 s instructions, but did confirm staff support with personal rt was needed due to C1's of falls and diagnosis of s. y Transportation Services t include specific client safety supervision when alone in a	W 3	31		