

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 Typon

Saint Paul, Minnesota 55164-0970

Phone: 651-201-3831

Email: kim.tyson@state.mn.us

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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5 000	Initial Comments		5 000				
	144.56 and/or Minn 144.653, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Rundicated below. We several items, failuritems will be considered to multi-part runds assessment of a firm	nether a violation has been compliance with all rule provided at the tagule number or MN Statute then a rule or statute contains to to comply with any of the lered lack of compliance.					
	that may result fron orders provided that the Department with notice of assessme On 4/13/21, a compaconducted to invest and #HG010026C, in compliance with Rules, Chapter 466 Living Facilities (SL	hearing on any assessments in non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. Delaint investigation was beiggate complaint #HG010025C. Harry Meyering Center is not requirements of Minnesota 15 requirements for Supervised 15.					
		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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION 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 l) 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	s injury report dated 4/6/21, at C1 was taken to a dental istered nurse (RN)-A on an. The report indicated C1 at 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 fear tire. C1 was examined by				

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	the dental provider. assistance, but couthe right leg. The arwas taken to the hofractured right hip. The incident occurrent notified until 4/7 Review of C1's face record, identified Comoderate intellectual behaviors, presbyof focus eyes on near polyosteoarthritis (a five or more joints seenous insufficiently veins is blocked, care	C1 attempted to stand with Id only bear minimal weight on abulance was called and C 1 espital, and diagnosed with a The incident report indicated ed on 4/6/21, and the SA was					
	Review of C1's inte self-management a 4/2020 to July 2021 support with persor survival skills. The ashould be within an left alone. The asse as having an unsteact utilizes a walker support, when need Review of C1's indir (IAPP) dated 11/20, lack of community of assist C1 with maki community and prostreets and walking with a walker and sof C1 when in the cC1 as not being abl						

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:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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IAPP identified C1 a self-preservation ski all activities in the conthreat to his personal Review of a physicial dated 4/12/21, indicated 4/12/21, indicated a displace progress note indicated in replacement due to the miarthroplasty on Interview on 4/13/21 professions (DSP)-A transported clients in months. DSP-A state clients to their medic indicated upon hire state the training included van. DSP-A further in a client alone and unwhen out in the communicated she had not facility van for sever facility RN transports appointments. DSP-are trained on the state clients left alone in the included she would include s	zards in the community. The is having a lack of ills. Staff are to assist C1 with ommunity, that may pose a all safety.  an discharge progress note ated C1 was admitted to the after sustaining a fall in the ing severe pain in the right impleted of the right hip and different fracture. The ated C1 required a right total at to the injury. C1 had a right 4/8/21.  I, at 11:00 a.m. direct support a lindicated she had not in the facility van for several and the facility RN transports cal appointments. DSP-A she recalled being trained on illity van, but could not recall if I leaving clients alone in the included she would not leave insupervised in a vehicle,	5 380			

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Minnesota Department of Health STATE FORM

TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  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 seatblet to 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 turther 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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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FREER TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 since of 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 safety	HAKKI I	WETERING CIR INC	MANKATO	O, MN 56001			
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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	Interview on 4/13/2 indicated since client the community in thas not transported DSP-C indicated up trained on the safet recall the specifics included she would unsupervised in a vocmmunity.  Interview on 4/13/2 indicated she had not facility van for seventransported a client them alone unsupe hire she recalled be the van, but could not linterview on 4/13/2 nurse (RN)-A confirming the facility van whole the van the facility van whole the van that the salways followed indicated C 1 was undicated C 1 was undicate	1, at 11:45 a.m. DSP-C ints have not been going out in the past several months, she clients in the facility van. Soon hire she recalled being y of the van, but could not of the training. DSP-C further not leave a client alone and rehicle when out in the serious of the past she has never left rail months, but when she has in the past she has never left rivised. DSP-D indicated uponeing trained on the safety of not recall the specifics.  1, at 12:30 p.m., registered med C1 was left unsupervised med C1 was left unsupervised in the could be gone for a short time. C 1 had a seatbelt on and didirections in the past. RN-A ansupervised for about 5 and when he returned to the salaying on the ground near the RN-A further indicated C 1 highly in	5 380			

Minnesota Department of Health

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 SURVEY COMPLETED		
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HARRY MEYERING CTR INC			ESTEAD ROAD, MN 56001			
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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. Suppose unsteady gait, risk of impulsive behaviors.  Review of the policity dated 10/16, did not remark to follow RN-A's C1's ISMA included safety skills. Suppose unsteady gait, risk of impulsive behaviors.	urther indicated the facility did nat 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 PD stated it was unusual for C1 is instructions, but did confirm a staff support with personal out was needed due to C1's of falls and diagnosis of its.  Transportation Services it include specific client safety supervision when alone in a	5 380			
5 815	(a) A mandated rep believe that a vulne been maltreated, or vulnerable adult ha which is not reason immediately report common entry poin vulnerable adult so 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 pilosen will be seen to be	ne vulnerable adult was	5 815			

Minnesota Department of Health

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5 815	that the individual is defined in section 6 clause (4).  (b) A person not recognovisions of this sereport as described (c) Nothing in this sknown or suspected reporter knows or hereport has been made (d) Nothing in this sereporter from also reagency.  (e) A mandated represson to believe the 626.5572, subdivision. If the rebelieves that an invivial determine or shereported error was criteria under section paragraph (c), claus may provide to the to the lead agency event meets the crisubdivision 17, paralead agency shall comaking an initial dissubdivision 9c.  This MN Requirements of care to dispersion of the communication of the comm	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:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	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 gC1 to remain in the RN-A returned to the ground next to the right leg. The arwas taken to the hor fractured right hip. The incident occurrent not notified until 4/7	·				
	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.					
	Adults Procedure" r The reporting proce reporter should reporter should reporter should reporter should reporter for the reporter should report for the reporter should be required to immediate the required to immediate the required to immediate the required to immediate the reporter should be reported by the reporter should be reported by the reporter should be reported by the re	"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 are is reasonable cause to trable adult is being, or has				

Minnesota Department of Health

STATE FORM 8XRI11 If continuation sheet 8 of 9

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY 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:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				` '	E SURVEY PLETED	
		24G010	B. WING					C <b>13/2021</b>
	NAME OF PROVIDER OR SUPPLIER  HARRY MEYERING CTR INC			109 HON	ADDRESS, CITY, STATE, AMBIESTEAD ROAD STORM 56001	ZIP CODE	1 04/	13/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC ROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
W 000		dard abbreviated survey was	W 0	00				
	to be NOT in compl 42 CFR Part 483, s	acility. Your facility was found liance with the requirements of ubpart I, requirements for Facilities for Individuals with ies (ICF/ID).						
	substantiated: HG010025C (MN7' with deficiencies cit HG010026C (MN7' due to actions implesurvey.	laints were found to be 1735, MN71664, MN71660) ed at W149 and W331. 1792) no deficiencies issued, emented by the facility prior to						
W 153	CFR(s): 483.420(d) The facility must en mistreatment, negle injuries of unknown immediately to the a	sure that all allegations of ect or abuse, as well as source, are reported administrator or to other noce with State law through	W 1	53				
	Based on interview facility failed to immediate to fare to d	s not met as evidenced by: y and document review, the hediately report allegations of esignated State Agency (SA) reviewed for allegations of						
	Findings include:							
	6:00 p.m. indicated	s injury report dated 4/6/21, at C1 was taken to a dental istered nurse (RN)-A on						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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 AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	COM	(X3) DATE SURVEY COMPLETED		
	24G010		B. WING _			C / <b>13/2021</b>	
NAME OF PROVIDER OR SUPPLIER  HARRY MEYERING CTR INC				STREET ADDRESS, CITY, STATE, ZIP C 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
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 the receiver the value and the receiver that a vulne in the receiver that a vulne in the receiver the value and the receiver that a vulne in the receiver that a vulne in the receiver the value and the receiver that a vulne in the receiver the value and the receiver that a vulne in the receiver the value and the receiver that a vulne in the receiver that	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 did only or Program Director sence, respective program This designated staff then is lately report the incident to the luse Reporting Center lies is reasonable cause to lies adult is being, or has lies at the lies and lies being, or has lies and lies and lies being, or has lies and lies being, or has lies to the lies and lies being, or has lies and lies being, or has lies to the lies and lies being, or has lies and lies being, or has lies to the lies and lies being, or has lies to the lies and lies being, or has lies to the lies and lies being, or has lies to the lies and lies being, or has lies to the lies and l	W 15				

AND BLAN OF CORRECTION   IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION UILDING	(X3) DATE SURVEY COMPLETED		
<b>24G010</b> B. W	/ING	C <b>04/13/2021</b>		
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:		` ′	PLE CONSTRUCTION  G	CON	TE SURVEY MPLETED  C			
		24G010	B. WING _		I	/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		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
W 331	record, identified C moderate intellectu behaviors, presbyo focus eyes on near polyosteoarthritis (a five or more joints a venous insufficiently veins is blocked, calegs) and unspecific Review of C1's intereself-management a 4/2020 to July 2021 support with persor survival skills. The should be within an left alone. The asseas having an unstered c1 utilizes a walker support, when need Review of C1's indi (IAPP) dated 11/20 lack of community and prostreets and walking with a walker and sof C1 when in the cC1 as not being abability skills. C1 rectore prevent safety hall activities in the cothreat to his person	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 ausing blood to pool in the ed affective mood disorder.  Insive support assessment (ISMA) dated I, identified C1 as requiring hal safety with community assessment indicated C1 ms length of staff and never essment further identified C1 ady gait and is at risk for falls. I and staff is to provide ded in the community.  Vidual abuse prevention plan /20, identified C1 as having a prientation skills. Staff are to ing decisions when in the vide assistance when crossing the sidewalk. C1 mobilizes taff is to be within arms reach community. The IAPP identified le to demonstrate cognitive quires direction and assistance arards in the community. The 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:		l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		24G010	B. WING		04/13/2021
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 DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTIC
W 331	hospital on 4/6/21, community and have hip. X-rays were consideratified a displace progress note indicated progress note indicated upon hip replacement dust hemiarthroplasty on the light 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 consideration of the did not think the trace of the did not the di	cated C1 was admitted to the after sustaining a fall in the ving severe pain in the right impleted of the right hip and ed 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 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 insupervised in a vehicle,	W 331		

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	
NAME OF PROVIDER OR SUPPLIER  HARRY MEYERING CTR INC				STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMESTEAD ROAD MANKATO, MN 56001	1 04/10/2021		
(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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION ING	COM	TE SURVEY MPLETED	
		24G010	B. WING			C / <b>13/2021</b>
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		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
		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)	11001	
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	<b>y</b> .	
	survey.	intented by the facility prior to		Date of Completion: May 28, 2	121	
W 153	STAFF TREATMEN	IT OF CLIENTS	W 15		· <b>-</b> ·	
** 100	CFR(s): 483.420(d)		** 10	Person responsible:		
		<b>`</b>		Jodi Sapp, Program Director.		
	The facility must ens	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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	BUILDING	(X3) DATE SURVEY COMPLETED
<b>24G010</b> B.	<b>24G010</b> B. WING	
NAME OF PROVIDER OR SUPPLIER  HARRY MEYERING CTR INC	STREET ADDRESS, CITY, STATE, ZIP 109 HOMESTEAD ROAD MANKATO, MN 56001	O4/13/2021
(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 ACTIO 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	

0 = 1 1 1 = 1	10 1 0 1 1 III - D 10 1 II 1 II	WINEBION ND OLIVITORO			CIVID INC	. 0000-0001
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		E SURVEY MPLETED
		040040	D 14/11/0			С
		24G010	B. WING		04/	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 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	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION			E SURVEY IPLETED	
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NAME OF PROVIDER OR SUPPLIER  HARRY MEYERING CTR INC			STREET ADDRESS, CITY, STATE, ZIP CO 109 HOMESTEAD ROAD MANKATO, MN 56001	DE			
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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			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING			E SURVEY IPLETED
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(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 van. DSP-A further a client alone and upon the van. DSP-A further a client alone and upon the van. DSP-A further a client alone and upon the van. DSP-A further a client alone and upon the van. DSP-A further a client alone and upon the van. DSP-A further a client alone in the community van for several facility van for several facil	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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		24G010	B. WING			1	C 13/3034
NAME OF	DDOVIDED OD CUDDUED	240010		OTDEE	T ADDDESS OFF STATE ZID CODE	04/	13/2021
NAME OF PROVIDER OR SUPPLIER  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

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		24G010	B. WING			C / <b>13/2021</b>
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		