DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 19, 2025

Administrator
Fair Meadow Nursing Home
300 GARFIELD AVENUE SOUTHEAST
FERTILE, MN 56540

RE: CCN: 245545
Cycle Start Date: September 10, 2025

Dear Administrator:

On November 26, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 25, 2025

Administrator
Fair Meadow Nursing Home

300 GARFIELD AVENUE SOUTHEAST
FERTILE, MN 56540

RE: CCN:245545
Cycle Start Date: September 10, 2025

Dear Administrator:

On September 10, 2025, 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 skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section

above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or
Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 10, 2025(three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 10, 2026(six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have

one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Meadow Nursing Home	**300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 56540**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 9/8/25 through 9/10/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		10/02/2025
F0000	INITIAL COMMENTS On 9/8/25 through 9/10/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		10/02/2025
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review,	F0554	F0554 Resident Self Admin Meds-Clinically Appropriate To ensure that all residents who want to self-administer their medication or nebulizer treatments are comprehensively assessed for the ability or safety to administer medication and or nebulizer treatments. The Self-Administration of Medications Policies and Procedures, the Self Administration of Medication Assessment Form, and the Self Administration of Medication by Resident's Weekly Log reviewed and	10/31/2025

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 reverse for further 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.

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

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F0554 SS = D	Continued from page 1 the facility failed to comprehensively assess for ability or safety and then care plan the self-administration of medication for 1 of 1 resident (R36) observed to have medication prepared by staff and then left with him to take on his own. Findings include: R36's admission Minimum Data Set (MDS) assessment dated 7/10/25, identified R36 had intact cognition. Diagnoses included disorder of the circulatory system, aneurysm of iliac artery and lower extremity and chronic obstructive pulmonary disease (COPD). R36's care plan with last review date 9/3/25, identified R36 admitted to the facility on 7/10/25. A focus for altered respiratory status was identified with difficult breathing at times. Interventions included to administer medications and puffers as ordered. However, the care plan lacked any evidence R36 had been assessed or approved to administer nebulized medications independently. On 9/9/25, at 3:33 p.m., licensed practical nurse (LPN)-A prepared R36's medications for administration from a mobile cart in the hallway. LPN-A opened a box labeled Ipratropium 0.5 milligrams (mg) and albuterol sulfate 5 mg inhalation solution and removed one plastic vial of the medication. R36's corresponding electronic medication administration record (MAR) present via computer on the mobile cart, directed to inhale orally via nebulizer four time per day for COPD. LPN-A entered R36's room and poured the vial of medication into R36's nebulizer medication chamber, turned on the nebulizer machine and handed R36 the nebulizer mouthpiece to begin inhaling. LPN-A instructed R36 to ring if he had any trouble and exited the room. LPN-A returned to the medication cart and signed off the medication as administered. R36's medical record lacked evidence R36 was comprehensively assessed for safety with the self-administration of his nebulized medications. During interview on 9/9/25, at 3:56 p.m. LPN-A stated R36 administered his nebulized medications independently. LPN-A stated she also worked night shift and R36 had three different nebulized medications ordered to be administered during the night. Night shift nurse just brought all three of the ordered nebulizer medications to R36 and left them in his room for him to administer one after the other on his own. The nurse would check back with him later, when they brought in his oral medications, to ensure he had administered all of them. R36 was capable of bringing the nebulizer to his mouth and administering the nebulized medication correctly or he would be able to tell the staff if he was having any issues. Typically, there would be a self-administration assessment completed to ensure it was safe for R36 to self-administer the medications. LPN-A had just assumed there had been an assessment completed. During	F0554	Continued from page 1 updated by the DON. An audit of all residents with nebulizer treatments were completed for self-administration to determine if the resident want to self-administer and to comprehensively assess resident's ability and to safely self-administer the nebulizer treatments. Audit and assessment completed by the RN/ Unit Coordinator after the LPN set up the nebulizer for the resident's assessment on 10.1.25. Physician orders for self-administration of nebulizer treatments were obtained for R 2045 and for R2041. Residents MAR/TAR, medical record, care sheet, and care plans were updated by the RN/Unit Coordinator on 10.1.25. The self-administer orders are under Special Instructions on the MAR. Resident #36 was discharged to his home on Wednesday 9/10/25 at 11:05 am. The comprehensive self-administration assessment was not completed prior to his discharge home with his wife. Education Inservice Nurses Meeting is scheduled for 10/21/2025. Self-administration comprehensive assessment must be completed first before allowing resident to self-administer their nebulizer treatment (or medication) Education on updated forms and policy Random audits will be completed by DON or RN/Unit Coordinator: daily for 1 week, 3 times for 1 week, 2 times for 1week, 1 time for 1 week. Audits will be reviewed for compliance or the need to continue audits and reviewed at IDT and QA&A meeting. Compliance date: 10/31/2025	

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F0554 SS = D	Continued from page 2 interview on 9/10/25, at 4:00 p.m. registered nurse (RN)-A stated she was responsible for completing resident assessments, including an assessment for ability and safety of resident to self-administer medications. RN-A stated R36 was high functioning and capable of administering his nebulized medications, however, she had not completed a formal assessment and order for the self-administration of the medications. She had not been aware he was doing the nebulized medications independently and so the assessment had been missed. When interviewed on 9/10/25, at 4:30 p.m. the director of nursing (DON) stated if a resident requested to self-administer medications it was the facility's policy to complete a self-administration of medication assessment to ensure they could do so correctly and safely, then it would be noted on the MAR and care planned. The facility's undated policy Self Administration of Medications identified on admission the resident would be asked if they would like to self-administer any medication. If the response was affirmative, the resident would need to demonstrate the ability, cognitively, physically and visually to safely complete the task. When a resident requested to self-administer medications, they would be assessed to determine the ability to do so safely for themselves and other residents. The assessment would be completed by a member of the interdisciplinary team using the facility's assessment form. The resident would need to demonstrate the ability to administer the medication, know the name of the medications, what it was used for, the main side effects of the medication. The resident would also need to be able to physically and visually complete the task.	F0554		
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and	F0604	F0604 Free from Physical Restraints To ensure the facility addresses the residents' right to be free from physical restraints for the purpose of discipline or convenience that are not required to treat the residents' medical symptoms. When the use of a restraint is indicated, the facility uses the least restrictive alternative for the least amount of time and re-evaluates the need for the restraint. Facility wide assessment on restraint use was completed by the DON on 10/2/25. All residents using a physical restraint were assessed for the necessity of continued use or discontinued use by the RN/Unit Coordinator with the appropriate assessment documentation completed on the restraint form, and the updated physician order for continued use or discontinued use was obtained. Updates were made to the resident TAR, care sheet, and care plan when the	10/31/2025

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F0604 SS = D	Continued from page 3 exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a defined perimeter mattress (DPM) was not used in a manner to restrain residents while in bed for 1 of 3 residents (R14) reviewed for restraints. Findings include: R14's quarterly Minimum Data Set (MDS) dated 7/16/25, identified R14 had a severe cognitive impairment, diagnoses that included bipolar disorder, epilepsy, and vascular dementia and identified R14 used an "other" restraint while in bed daily. R14's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 1/31/25, identified R14 had impaired cognitive function/impaired thought processes related to dementia. R14's cognitive assessment indicated severe impairment. R14 was able to make her needs known and was understood and understood others. R124's Behavioral Symptoms CAA dated 1/31/25, identified R14 had a potential to demonstrate behaviors related to vascular dementia, bipolar disorders, a history of depression with psychosis, and a generalized anxiety disorder. Behaviors noted during look back period: resistive to cares, hitting out at staff, not wanting to get up in the morning or have breakfast. Staff were directed to provide redirection; leave R14, if safe, and return later; meet R14's needs with toiletings, food, drink, and repositioning and continue to observe. However, the CAA failed to identify R14's DPM and/or interventions used prior to implementing a	F0604	Continued from page 3 restraint was started or discontinued. Residents found to have no falls in the quarter were assessed to have a restraint free trial period with discontinued restraint orders obtained from the physician. Facility's restraint policies and procedures will be reviewed and updated as appropriate (Physical Restraints, Chemical and Physical Restraints, Consent for use of Physical Restraints) by the DON. Residents' assessment form for continued need or discontinued use of the restraints will be completed by the resident's RN/Unit Coordinator quarterly and annually, or at the time of the resident's MDS-ARD review. At the residents' quarterly care conference, the residents' assessment for continued need or discontinued use will be discussed with the family. Appropriate updates will be made to the residents' care plan, care sheet, and the medical record documentation at the time of the quarterly and annual assessments. Physician orders will be received for continued or discontinued use of the restraint. Consent forms and signatures will be obtained addressing the necessity for the need of continued use of the restraint. R14s restraint assessment for the DPM mattress was completed by the RN/MDS Coordinator during residents MDS-ARD review. Resident's last fall was 7/14/25. The determination to discontinue use of the DPM mattress was on 10/2/25. The residents' need for the low bed, floor mats and auto brakes on the wheelchair remained appropriate. Trial for d/c of the DPM mattress started 10/2/24 with physician order to discontinue DPM mattress, and continued use of the low bed, floor mats and auto breaks on the wheelchair was obtained. Family was informed of the trial for discontinued DPM mattress with continued use of floor mats and auto breaks on the wheelchair and consent form were mailed to family for signature on 10/3/25. Random audits will be completed by DON or RN/Unit Coordinator: daily for 1 week, 3 times for 1 week, 2 times for 1week, 1 time for 1 week. Audits will be reviewed for compliance or the need to continue audits and reviewed at IDT and QA&A meeting. Completion date 10/31/25	

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F0604 SS = D	Continued from page 4 DPM. R14's care plan reviewed 7/23/25, identified R14 was at high risk for falls related to history stroke with weakness, vascular dementia with forgetfulness, hypertension, history of dizziness, and, at times, R14 was unaware of safety needs, confusion, gait/balance problems. R14 had a history of recurrent falls related to self-transfers and needed to be frequently reminded to ring for assist related to history of not ringing call light for staff assist. R14 needed staff assist with transfers, bed mobility, toileting, and other activities of daily living every day. Staff were directed R14 used a DPM on R14's bed and mats on the floor for safety related to history of self-transfers with falls in the past while in bed. R14's bed should be in low position. When R14 swung her legs out of bed, R14 was ready to get up. Staff assist with mechanical stand-up lift for transfers R14 was unable to walk. Review need for any restraints on annual and/or comprehensive assessments. R14's medical record failed to identify a restraint assessment. R14's physician order dated 11/8/22, identified R14 used assistive devices: 2 short side rails on top left and right DPM mattress with mats on the floor by R14's bed for safety. However, the physician order failed to identify a medical need for a restraint. During an observation on 9/8/25 at 7:13 p.m., R14 was lying in bed on her right side towards wall. A DPM was on R14'a bed and a mat was lying on the floor next to R14's bed. During an observation on 9/9/25 at 1:30 p.m., R14 was lying in bed on her back. A lap blanket was covering to her chest. R14 had her eyes closed and had rhythmic deep breathing. R14 was lowered to the floor with a DPM and a mat on the floor next to RI14's bed. During an interview on 9/9/25 at 3:20 p.m., licensed practical nurse (LPN)-C stated R14 hadn't tried to get out of her wheelchair on her own in a in a long time. Sometimes, R14 would try to get out of her bed but R14 had a mattress with a lip on it so R14 just could get her feet out but that was it. R14 hadn't done that in a really long time either. R14 used to be more active, but not anymore. "Like I said", R10 "had that lip on her mattress and can't get out of it." During an interview on 9/9/25 at 3:25 p.m., nursing assistant (NA)-A R14 was usually chill and calm. R15	F0604		

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F0604 SS = D	Continued from page 5 has her bad days sometimes. R14 would refuse to get up and wanted to fuss. That was about it. R14 would sit up at the side of the bed but that was it. R14 was unable to get out of bed because of the DPM. NA-A could not recall the last time R14 had a fall from bed. During an interview on 9/9/25 at 4:07 p.m., the social work designee (SSD) stated nursing performed the restraint assessments every quarter and annually. SSD stated R14 did not utilize a restraint that SSD was aware of. During an interview on 9/9/25 at 4:10 p.m., RN-B stated R14 used a DPM on her bed. R14 had the DPM before RN-B started working at the facility. R14's physician signed the restraint order for the DPM and the DPM was implemented in the fall of 2019. RN-B stated she did not know if a restraint assessment had been completed for R14, but RN-B knew R14 needed the DPM because R14 could no longer walk and would try to get out of bed and fall. RN-B stated she has walked past R14's room and R14 had her feet sticking out of her bed. RN-B would know that's when it was time to get R14 up. RN-B stated R14 did use a low bed with a mat on the floor so the likelihood of injury from a fall was slight, however, RN-B continued to state R14 required a DPM to prevent R14 from getting out of bed. During an interview on 9/10/25 at 3:02 p.m., RN-B stated, in 2018, R14 had a low bed with mats on the floor, a bed alarm and poor cognition so a DPM was the safest alternative for R14 because R14 was climbing out of bed. "But that was a long time ago." RN-B stated, in RN-B's opinion, R14 could fall and injure herself. R14 had not fallen out of bed since the DPM was implemented in 2019. Per MDS coding guidelines, R14's DPM was identified as a restraint because R14 was not able to get out of bed on her own because it was not safe for her do so. RN-B stated she knew staff got R14 up when she was restless because it was a risk or if R14 was awake and exhibited behaviors. However, RN-B had not done a formal restraint assessment for R14 nor had considered possible alternatives to a restraint for R14. During an interview with the director of nursing (DON) and administrator on 9/10/25 at 4:14 p.m., the DON stated restraints were to be assessed quarterly and addressed in the care conference. Staff should be doing the same for not only R14's DPM but all residents with a DPM to make sure all restraints were reviewed to ensure documentation was complete and trials off were attempted. Staff were also expected to utilize all possible alternatives prior to initiating a restraint.	F0604		

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Fair Meadow Nursing Home	**300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 56540**

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F0604 SS = D	Continued from page 6 The administrator stated it should have been and didn't happen. The facility policy Use of Restraints revised 1/3/23, identified restraints shall only be used for· the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for, discipline or staff convenience, or for the prevention of falls. "Physical Restraints" are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts-normal access to one's body. 13. The following safety guidelines shall be implemented and documented while a resident is in restraints: a. Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident. b. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. Restraints with locking devices shall not be used. c. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. d. The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. e. Restrained residents must be repositioned at least every two (2) hours on all shifts.	F0604		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F0689	F0689 Free of Accident Hazards To ensure the resident environment remains free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents residents are assessed by nursing and or therapy for interventions to be used. R23 requires maximal assistance with her transfers and ambulation of l person assist and full wheeled walker with all transfers, and to ambulate with moderate assist of 1 with full wheeled walker, gait belt and wheelchair to follow in hallway.	10/31/2025

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F0689 SS = D	Continued from page 7 accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions for safe transfers were implemented for 1 of 5 residents (R23) observed during staff assisted transfers. Findings include: R23's quarterly Minimum Data Set (MDS) dated 8/13/25, identified moderate cognitive impairment. R23 required maximal assistance with transfers and ambulation. Diagnoses included depression, hypertension, osteoporosis, osteoarthritis, muscle weakness, and low back pain. R23's care plan with review date 8/20/25, identified R23 had a self-care performance deficit and a goal was listed to maintain her current level of function in all activities of daily living (ADLs) and mobility. Interventions included to transfer with maximal assist of one and a full wheeled walker with all transfers and to ambulate with moderate assist of one with FWW, gait belt and wheelchair to follow in the hallways. On 9/9/25, at 2:30 p.m. R23 was observed seated in her wheelchair in a common area near the nurse's station. Nursing assistant (NA)-A approached R23 and wheeled her wheelchair next to a nearby recliner, locking the wheelchair brakes. NA-A directed R23 to lift her arms up in the air then NA-A wrapped her arms around R23 just below her armpits. NA-A lifted R23 into a standing position, pivoted her toward the recliner and then sat R23 down into the recliner. A gait belt to assist with the resident transfer was not used. When interviewed on 9/9/23, at 2:35 p.m. NA-A stated it had been such a close transfer, and she would not use a gait belt to transfer a resident when the transfer was so close and did not require steps. NA-A would definitely use a gait belt when walking with a resident. When NA-A had assisted R23 to sit in the recliner, it was such a close transfer, so she just grabbed her around her torso and helped her stand and into the recliner. The wheelchair and recliner had been so close that no gait belt was required. NA-A stated she did not think it would bother R23 to raise her arms and be transferred in that manner. During interview on 9/9/23, at 3:14 p.m. licensed practical nurse (LPN)-A stated staff always transferred R23 with a gait belt and assist of one. Even if it was	F0689	Continued from page 7 NA A failed to use the gait belt when she was assisting R23 with a transfer as observed by the surveyor. DON provided immediate documented education and counseling to NA A on the necessity to use the gait belt and the proper way to transfer R23, and to use a gait belt for all residents' transfers, NAA was instructed to follow the resident care sheet. The education counseling was completed on 9/9/25. Nursing (CNA) Meeting 9/23/25 instructed staff to use the gait belts with all transfers and ambulation and to remove the gait belt after the transfer was completed. Gait belt policy reviewed by the DON and was made available in the Communication Book for nursing staffs' review. Random audits completed by DON or designee on resident transfers and use of the gait belts will be daily for 1 week, 3 times for 1 week, 2 times for 1 week, 1 time for 1 week. Audits will be reviewed for compliance or the need to continue audits and reviewed at IDT and QA&A meeting. Completion date 10/31/25	

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F0689 SS = D	Continued from page 8 a close transfer, a gait belt would be required. Any resident that needed any type of staff assistance would need to have a gait belt on for the transfer. During interview on 9/10/23, at 4:30 p.m. the director of nursing (DON) stated any time staff assisted a resident to transfer, they were to use a gait belt. Any resident that needed assistance with transfers needed a gait belt and all the staff were aware of that. NA-A should have used a gait belt when transferring R23. Not using a gait belt and grabbing her around the torso to transfer could have injured R23's shoulders or caused her pain. There would have been nothing to grab a hold of, if R23 were to have started to fall during the transfer. The facility policy Wheelchair Transfer dated 1/3/23, directed staff to apply a gait/transfer belt around the resident's waist. Stand in front of the resident and position self to ensure safety of self and resident during transfer. Staff were to grasp the transfer belt at the resident's side with an underhand grasp. On count of three gradually assist resident to a standing position while continuing to grasp the transfer belt. Assist the resident to pivot and lower the resident into the chair. Remove the transfer belt.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F0690	F0690 Bowel/Bladder/Catheter, UTI To ensure residents who are incontinent of bladder receive the appropriate treatment and services to prevent urinary infections and to restore continence to the extent possible the facility will obtain and follow the physicians' orders and the manufactures guidelines for the indwelling urinary catheter. All residents with indwelling urinary catheters MARs were audited for current physician orders by the DON. The manufactures guidelines are readily available for reference as appropriate. Residents MAR and care plans were updated and physician orders obtained by the medical records LPN 10/1/25. R 21 physician's order for his indwelling catheter was updated 9/12/25, new order is "Change foley catheter every 90 days, 16 French with 30cc ballon" per Dr. Ian Glidden. Manufactures Guidelines were obtained from McKesson 9/12/25. Nurses and TMAs informed of the new catheter order and instructed on the resident MAR.	10/31/2025

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F0690 SS = D	Continued from page 9 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a physician order for indwelling urinary catheter for 1 of 1 residents (R21) reviewed for urinary catheter. Findings include: R21's significant change Minimum Data Set (MDS) dated 8/8/25, identified R21 had a moderate cognitive impairment and diagnoses that included obstructive and reflux uropathy (a blockage in the urinary tract making it difficult to urinate), dementia, and benign prostatic hyperplasia (BPH) (an enlarged prostate). R21 used an indwelling urinary catheter. R21's physician order dated 6/8/22, directed to change foley catheter every 90 days. However, the physician order failed to identify type or size of urinary catheter. R21's care plan revised 12/27/23, identified R21 used an indwelling urinary catheter for obstructive uropathy and BPH. R21 required staff assistance with catheter care and emptying of the urinary bag. R21 used a 16 French (fr) urinary catheter with a 10 milliliter (ml) balloon. During an observation on 9/10/25 at 7:38 a.m., nursing assistant (NA)-B provided catheter care to R21. During an interview on 9/10/25 at 10:30 a.m., registered nurse (RN)-B provided a stock 14 fr urinary catheter with a 30 ml balloon. RN-B stated she would only put in 10 ml of saline into the balloon to match R21's order because it wasn't putting in more saline than what the balloon would hold. RN-B then stated R21's urinary catheter physician order was in R21's care plan, however, the care plan was not a physician order. "But that's how staff knew what size to use."	F0690	Continued from page 9 DON provide nursing staff with a reference note on the catheter size and number of CCs used for ballon size, and that the McKesson's Manufacturers Guidelines for catheters was available for nursing staff review in the Communication Book. More in-depth education on the Manufacturers Guidelines catheters, correct catheter and ballon size, and number of CCs to fill the ballon will be addressed at the 10/21/25 Nursing Meeting. Random audits of catheter insertion and catheter orders will be completed by the DON or designated RN per "routine scheduled catheter change". Audits will be reviewed for compliance or the need to continue audits and reviewed at IDT and QA&A meeting. Completion date 10/31/25	

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F0690 SS = D	Continued from page 10 During an interview on 9/10/25 at 10:59 a.m., the director of nursing (DON) stated staff were expected to follow the physician orders for urinary catheters and to enter the order into the electronic medical record (EMR) in the physician orders. The care plan was an extension of the order, so all staff were aware how to care for the catheter. When the catheter was changed, nursing was expected to document type and size, how much saline was removed, how much saline was used, was the balloon intact etc. A full description of the procedure. The DON also stated using a 30 ml balloon with only 10 cc of saline was not following the order because the 30 ml balloon would expand and not work accordingly. During a telephone interview on 9/10/25 at 2:16 p.m., nurse practitioner (NP)-A stated R21's urinary catheter should be changed every 90 days due to an increased risk and history of urinary tract infection. However, staff should have an order for foley catheter 16 fr. with a 10 ml balloon and were expected to follow physician order. The facility policy Prevent of Catheter Associated UTIs revised 5/15/23, identified the urinary catheter insertion procedure but failed to identify the need for a physician order.	F0690		
F0711 SS = B	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is NOT MET as evidenced by:	F0711	To re-enforce that the nursing staff are educated on the timely process and expectation to ensure the doctor is following the regulations for timely physician visits and progress notes education was provided on October 21 ,2025 meeting and will again in the Nurses Meeting scheduled for November 18,2025. Our plan of correction for F0711 will be reviewed at our QA&A Meeting scheduled for November 18, 2025. To ensure the doctors and nurse practitioners are following the regulations for the timely physician visits and progress notes our physicians and nurse practitioners have signed Fair Meadows Policies and Procedures for Attending Physicians. The LPN/Medical Records Receptionist's job description has been updated and signed to ensure the alignment of care with the resident's care team, to ensure the residents' charts are updated and free of errors while maintaining a professional relationship with our providers. Our LPN/Medical Records HUC schedules the doctor's rounds based on the resident's clinical record of the	11/18/2025

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F0711 SS = B	Continued from page 11 Based on interview and document review, the facility failed to ensure a complete medical record was maintained to include the physician progress notes during routine visits for 4 of 14 residents (R2, R10, R32, R39) reviewed in the sample . Findings include: R2's quarterly Minimum Data Set (MDS) dated 6/11/25, identified R2 was cognitively intact and had diagnoses that included atrial fibrillation (irregular heartbeat), major depressive disorder, morbid obesity and lymphedema (tissue swelling). R2's medical record identified an Order Summary Report signed by R2's physician and dated 9/3/24. However, R2's medical record failed to identify a physician progress note dated 9/3/24. A facility list was provided and identified the following residents had missing signed visit notes. R10's quarterly MDS dated 7/9/25, identified R10 had a moderate cognitive impairment and diagnoses that included cerebral palsy, epilepsy, and morbid obesity. R10's medical record failed to identify a physician progress note dated 6/11/25. R32's comprehensive MDS dated 8/29/25, identified R32 had a moderate cognitive impairment and diagnoses that included Alzheimer's disease, type 2 diabetes, and dementia. R32's medical record failed to identify a physician progress note dated 6/11/25. R39's quarterly MDS dated 7/24/25, identified R39 had a moderate cognitive impairment and diagnoses that included hypertension, insomnia, weakness, and osteoarthritis. R39's medical record failed to identify a physician progress noted dated 8/1/25. During an interview on 9/10/25 at 1:44 p.m., licensed practical nurse (LPN)-D stated she was responsible for the facility's medical records. LPN-D provided a word document containing a physician progress note for R2 dated 9/3/24. LPN-D stated R2's physician had recently resigned from her former clinic and did not have access to the medical record to document anything into R2's medical record. LPN-D called R2's physician that morning to remind the physician there were missing	F0711	Continued from page 11 last visit recorded in PCC and informs the doctors and nurse practitioners of their scheduled visit(s). The Physician Information Flow Sheet is used to track the date the resident was seen by the physician and tracks the physician orders and progress notes. The Doctor Rounds Sheet is completed during the physicians' visit and the LPN/Medical Records HUC then enters the new orders into the resident's medical record in PCC. Then the LPN/Medical Records HUC gives a copy of the Doctor's Round Sheet to the cart nurse(s) and the RN unit coordinators. The Physicians Flow Sheets and Doctor Rounds Sheets are filed in the medical records office for review as needed. The Nurses Meeting and QA&A scheduled for November 18, 2025, date of completion is November 18, 2025.	

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F0711 SS = B	Continued from page 12 physician progress notes and the notes needed to be completed. Whenever a medical provider made rounds at the facility, LPN-D would provide a list of residents that needed evaluation and would wait for the completed physician progress note. Once received, LPN-D would ensure the physician progress note was scanned into the resident medical record. LPN-D stated the physician visit had been conducted more than a year prior, but R2's physician kept handwritten notes for review. From those notes, R2's physician was able to type the physician progress note the morning of 9/10/25. LPN-D stated she frequently reminds physicians of missing notes verbally but does not document any type of reminder. "It's more of a frustration." At that time, LPN-D provided a list of residents with missing documentation and stated she had never formally brought the concern to administration. During an interview with the director of nursing (DON) and the administrator on 9/10/25 at 4:07 p.m., the administrator stated she was aware R2's physician had "some" missing documentation out there but was unaware of how long it had been occurring or how extensive. The administrator stated this concern should have been brought forward timelier, within 3 months, so reminders could be documented, and the facility could ensure all resident medical records were complete. The facility policy Physician Visits revised 1/4/23, identified during routine visits, the physician must: a. Review the resident's total program of care, including medications and treatment, at each visit required. b. Write, sign and date progress notes at each visit.	F0711		
F0712 SS = D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4)	F0712	To ensure the physician visits and frequency happens timely per regulations the LPN Medical Record HUC was provided with written education by the Administrator on 11/13/2025. LPN Medical Record HUC has been involved from the time the deficiency and had been brought to our attention and has been actively involved in all corrections. LPN Medical Record HUC has personally educated each provider regarding the need and the expectations of the required timely visits, as well as encouraging a concrete schedule for their nursing home scheduled visit(s). LPN Medical Record HUC was educated at the October 21, 2025, Nurses Meeting.	11/18/2025

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F0712 SS = D	Continued from page 13 and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure long term residents received routine physician visits consistently every 60 days as required for 1 of 5 residents (R2) reviewed for unnecessary medications. Findings include: R2's quarterly Minimum Data Set (MDS) dated 6/11/25, identified R2 was cognitively intact and had diagnoses that included atrial fibrillation (irregular heartbeat), major depressive disorder, morbid obesity and lymphedema (tissue swelling). R2's medical record identified R2 was evaluated by a medical provider on 8/13/24, 11/19/24, 1/14/25, 2/26/25, 4/15/25, 6/11/25 and 8/29/25. During an interview on 9/10/25 at 1:44 p.m., licensed practical nurse (LPN)-D stated she was responsible to ensure residents were evaluated by a medical provider every 60 days. R2 was not seen timely and LPN-D stated she did not have an explanation why. LPN-D stated she keeps a handwritten schedule every month with the provider schedules, and which residents needed evaluation. However, LPN-D disposed of the handwritten schedule after the provider visit was complete. During an interview with the director of nursing (DON) and the administrator on 9/10/25 at 4:07 p.m., the DON stated staff were expected to ensure residents were evaluated by a medical provider every 60 days. This should have been tracked and brought forward to administration. The facility policy Physician Visits revised 1/4/23, identified the resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least every 60 thereafter, a physician visit is considered timely if it occurs not later than 10 days after the date the visit was	F0712	Continued from page 13 LPN Medical Record HUC participated in all QA&A Meetings and will be attending the Nurses Meeting on November 18, 2025. Attachments are included on the portal. Completion date as of November 18,2025	

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F0712 SS = D	Continued from page 14 required. Physician orders must be signed and dated at every routine visit.	F0712		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders which resulted in a medication error rate 9.09% (percent) for 1 of 7 residents (R11) observed to receive mediations during the survey. Findings include: R11's Order Summary Report, dated 8/28/25, identified R11's current physician-ordered medications and treatments. This included an order for potassium chloride extended release 10 milliequivalent (meq) by mouth two times per day, and vitamin D3 25 micrograms (mcg) give two tablets by mouth in the morning, both with start dates 8/26/25. On 9/10/25, at 9:23 a.m. registered nurse (RN)-B prepared R11's medications at a mobile medication cart in the hallway by the nurses' station. RN-B reviewed R11's electronic Medication Administration Record (MAR) which outlined the same order for potassium and vitamin D3 as listed on R11's Order Summary Report (dated 8/26/25). However, RN-B removed an opened bottle of potassium chloride 10 meq tablets and placed two tablets into the medication cup with R11's other oral medications. RN-B then removed an opened bottle of vitamin D3 25 mcg and placed one tablet into the medication cup with R11's other oral medications. RN-B removed an opened bottle of oxybutynin 5 milligram (mg) tablets and placed one tablet into the medication cup with R11's other oral medications. RN-A placed the non-gel or capsule medications into a separate medication cup and started to place the medications into the pill crusher. RN-B was stopped by the surveyor (SA) and asked to review all medications she had prepared to ensure the SA had recorded the medications	F0759	F0759 Medication Error To prevent medication errors and ensure medications are administered to the correct resident per the physician orders all nurses and TMAs will be required to review and sign the facility's Medication Errors Policy. Medication Errors Policy will be reviewed and updated by the DON. Nurses and TMAs are instructed to read the residents MAR carefully, to check the MAR and the medication labels when dispensing the medication, and when returning the medication to med cart. Nurses and TMAs are instructed to use the triple check medication administration method taught in nursing school. Nurses and TMAs are instructed to not administer medication if the medication is not listed on the residents' MAR and to consult the Charge Nurse, Unit Manager or DON. Nurses and TMAs are instructed that at the end of the shift each nurse if to double check the MAR for missed signatures, to check each unit dose Med Card for missed med punches. Nurses and TMAs are instructed to report a medication error to the Unit Manager. Nurses and TMAs are instructed they are responsible for completing a Med Error report when it occurs or if found from the previous shift and route the form to the DON. DON provide RN B with education on the "Rights of Medication Administration", Medication Error Policy on 9/10/25 (11:00 am). Resident #11 Order Summary Report of 8/28/25 and current physician orders were reviewed by medical records LPN; resident currently does not have orders for Oxybutynin. Nurses/TMA Inservice/Education Meeting scheduled for 10/21/25. Rights of Medication Administration	10/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Meadow Nursing Home	**300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 56540**

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F0759 SS = D	Continued from page 15 correctly. Apon review of the medications, RN-B took out a potassium tablet, stating R11 was only supposed to have one tablet and not the two tablets that were prepared and RN-B retrieved the open vitamin D3 bottle and placed an additional vit D3 tablet into R11's prepared medication cup, stating R11 was supposed to receive two tablets of vitamin D3 and not just the one tablet that had been prepared. RN-B then proceeded to crush the medications that could be crushed and put the crushed medications into a cup with vanilla pudding. RN-B took the crushed medications, and other prepared medications and brought them to R11's room where she administered the prepared medications. Immediately following R11's current physician orders were reviewed. R11's Order Summary Report dated 8/28/25, did not include an order for the medication oxybutynin. During interview on 9/10/25, at 10:00 a.m. RN-B stated she is not sure if she would have caught the incorrect doses of potassium and vitamin D3 if the SA had not stopped and asked to review, she may have. RN-B agreed she would have crushed all the crushable tablets and not be able to identify them once they were crushed if the SA had not stopped her to review them, which would have then been administered to R11. RN-B reviewed the medication bottles in the medication cart and observed R11 did have an opened bottle of oxybutynin 5 mg tablets in her drawer. RN-B stated she must have prepared one tablet in with the other medications for R11 in error. RN-B stated she had been nervous and working too quickly in preparing R11's medications that morning and should have slowed down and reviewed and compared the medications to R11's MAR more closely. RN-B stated she had filled out a medication error report form for the medication error of administering the oxybutynin medication without a current order. When interviewed on 9/10/25, at 4:30 p.m. the director of nursing (DON) stated she expected staff to read resident's MAR's closely and to check it with the medication bottles and double check to prevent medication errors. Staff were to follow the seven rights of medication administration guidelines. The facility policy Medication Administration, dated 5/25/23, directed staff to compare medicine listed on the residents MAR with label on the medication container when taking the medication from the cart, when removing the medication from the container and when returning the medication to the cart for three checks. Staff were to follow the eight rights of medication pass. Right patient, right medication, right	F0759	Continued from page 15 Medication Errors Policy Random audit of medication pass completed by the DON or designated RN: daily for 1 week, 3 times for 1 week, 2 times for 1 week, 1 time for 1 week. Audits will be reviewed for compliance or the need to continue audits and reviewed at IDT and QA&A meeting. Completion date: 10/31/25	

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F0759 SS = D	Continued from page 16 dose, right time, right route, right documentation, right reason and right response. Staff were not to administer a medication if it was not listed on the residents MAR, and to check with the charge nurse or unit manager.	F0759		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	F0880 Infection Prevention Facility's infection prevention and control (IPCP) program includes a system for identifying and preventing the transmission of communicable diseases and infections. The facility will perform tracking and trending of all residents displaying signs and symptoms of potential infectious transmissible organisms in a timely and ongoing manner and implement transmission-based precautions to prevent the spread of infection to other residents/persons in the facility. The form "Testing Symptomatic Residents" will be used for all residents who are experiencing signs and symptoms of respiratory illness. All residents experiencing signs and symptoms of respiratory illness consistent with COVID-19 will be placed in "transmission-based precautions". Resident will be tested for COVID-19 immediately. If the results are negative resident will be tested again in 48 hours per physician order. The DON, Infection Prevention, family, Medical Director and attending Physician will be notified of symptoms and test results. If the residents' Rapid Antigen Test is negative and symptoms have not improved, a PCR (COVID-19, Influenza A & B, RSV) will be obtained, and the resident will remain in transmission-based precautions until the results of the PCR are received. The DON, Infection Prevention, Medical Director, attending Physician, and family will be notified of PCR results. If the Rapid Antigen Test is positive for COVID-19 then the resident will be placed on "Enhanced Respiratory Precautions" in their resident room per the 10-day COVID-19 requirement. Daily respiratory assessments will be completed by RN/LPN. During the time of TBP, if the residents' symptoms are not improving or deteriorating, the Physician will be informed and an order obtained for transfer to the ER for further evaluation. The DON, Infection Preventionist, Medical Director and family will be informed.	10/31/2025

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F0880 SS = D	Continued from page 17 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to perform timely tracking and trending of potential infectious symptoms to prevent the spread of transmissible organisms in a timely and ongoing manner; including a failure to implement timely transmission-based precautions (TBP) and testing for respiratory illness according to the Centers for Disease Control (CDC) for 3 of 3 residents (R10, R21, R39) who were displaying COVID-19 symptoms. Findings include: The facility NON-COVID Illness tracker dated August 2025, identified the following: unit, resident name, room number, infection type, body of infection, diagnostics, treatment, transmission-based precautions and illness resolution. The tracker also identified the following: On 8/2/25, R39 exhibited a runny nose, cough, and slight sore throat. R39’s rapid antigen	F0880	Continued from page 17 At the Nursing Meeting (RN, LPN,TMA, CNA) on 9/23/25, education was provided on: All Respiratory Signs and Symptoms, Transmission-Based Precautions, Rapid Antigen COVID-19 testing requirements (#1 test immediately and if negative then #2 test is 48 hours after the first negative test), and when to obtain PCR (for COVID-19, Influenza A & B, RSV). Communication Book updated with Respiratory Signs & Symptoms Information Sheet. Facility's COVID Policy & Procedures was reviewed and updated 9/30/25. Infection Preventionist will monitor the Nursing 24-72-hour Summary Report 3 times a week for residents experiencing respiratory signs and symptoms and that appropriate measures were implemented. Random audits of the Nursing 24-72-hour Summary Report and the Testing Systematic Resident Form which will indicate if it is COVID-19, RSV or Influenza A or B, or non-COVID illness, the audits will be completed 3 times weekly for 4 weeks, 2 times weekly for 2 weeks, 1 time for 1 week. Audits will be reviewed for compliance or the need to continue audits and reviewed at IDT and QA&A meeting. Compliance date 10/31/25	

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F0880 SS = D	Continued from page 18 COVID-19 test was negative and R39 with provided comfort for his symptoms. However, the tracker failed to identify if R39 had a confirmatory negative rapid antigen test and/or was placed into transmission-based precautions until the confirmatory test was collected. On 828/25, R21 exhibited dry heaves, fatigue, runny nose, and cough. R21's rapid antigen COVID-19 test was negative and R21 with provided comfort for his symptoms. However, the tracker failed to identify if R21 had a confirmatory negative rapid antigen test and/or was placed into transmission-based precautions until the confirmatory test was collected. On 8/31/25, R10 exhibited cough, congestion, and sore throat. R10's rapid antigen COVID-19 test was negative and R10 with provided comfort for his symptoms. However, the tracker failed to identify if R10 had a confirmatory negative rapid antigen test and/or was placed into transmission-based precautions until the confirmatory test was collected.R39's quarterly Minimum Data Set (MDS) dated 7/24/25, identified R39 had a moderate cognitive impairment and diagnoses that included heart failure. R39's nursing progress notes identified the following: On 8/28/25 at 9:05 a.m., R39 was observed to be sitting in his wheelchair by the medication cart, R39 had a runny nose with clear drainage. This staff asked R39 how he was feeling R39 and stated, " I don't feel good." R39 complained of runny nose with clear nasal drainage, productive cough with grey phlegm and a slight sore throat. R39 denied having a headache or body aches. Lungs were auscultated (listened to) and were clear throughout. Rapid COVID-19 antigen test completed and R39 tested negative for COVID-19. However, the note failed to identify if R39 was placed into transmission-based precautions until a confirmatory rapid antigen test was collected. On 8/29/25 at 11:05 a.m., R39 was complaining of cold symptoms. R39 had a congested, loose, productive cough that R39 said he could give a sputum sample of, if needed. Gave R39 a cup to expectorate into so staff can see what sputum looks like. Lungs were clear, R39 had a loud murmur. On 8/30/25 at 9:58 a.m., R39's rapid COVID-19 antigen test performed, and results were negative. R39 to continue to remain in room until temp was within normal limits, however, the note failed to identify if R39 was in transmission-based precautions. R21's comprehensive MDS dated 8/20/25, identified R21 had a mild cognitive impairment and diagnoses that included peripheral vascular disease, dementia and chronic kidney disease. R21's nursing progress notes identified the following: On 8/28/25 at 8:40 a.m., staff reported R21 had dry	F0880		

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F0880 SS = D	Continued from page 19 heaves that morning. R21 was alert and sitting up at the side of his bed, R21 stated " I don't feel good." R21 complained of feeling tired, runny nose with clear nasal drainage, and of a productive cough. R21 stated he was able to cough up yellowish phlegm. R21 denied having a headache, sore throat or body aches. Rapid COVID-19 test completed and R21 tested negative for COVID-19. Will continue to monitor. On 8/29/25 at 11:39 a.m., R21 had been weak, easily fatigued, and noted confusion. Vitals: temperature 97.6 degrees F, pulse 64, respirations 22, and oxygen saturations 96% on room air. However, R21's bp was low- 85/59 auto, 80/62 manual. Encouraged R21 to drink fluids and monitored for continued concerns. When R21 got back to his room, R21 needed moderate assist of 1 to transfer from wheelchair to recliner. At 1:50 p.m., R21 participated in a small group game of rummy in the activity room with activity staff. At 1:54 p.m., R21 attended church in the activity room. At 3:11 p.m., R21 came to activity room this afternoon for ice cream cone social with other residents and staff. On 8/30/25 at 10:17 a.m., R21's rapid COVID-19 antigen test performed, and results were negative R10's quarterly MDS dated 7/9/25, identified R10 had a moderate cognitive impairment and diagnoses that included cerebral palsy, epilepsy, and morbid obesity. R10's nursing progress notes identified the following: On 8/31/25 at 7:57 a.m., R10 was showing signs of cough, congestion, and a dry/sore throat. A rapid COVID-19 antigen test which was negative and R10 did not have a fever at this time. However, the note failed to identify if R10 was placed into transmission-based precautions until a confirmatory test could be collected. At 4:14 p.m., R10 complained of congestion: Lungs auscultated and were clear throughout with no adventitious breath sounds (abnormal breath sounds) noted. R10 reported a moist cough with phlegm production which R10 swallowed. R10 educated her on the risks versus benefits of not expelling mucus could result in worsening respiratory conditions. She denied shortness of breath (sob), sore throat, and runny nose. R10 also reported she was congested and not tired. She had allergy medication scheduled every evening. On 9/2/25 at 3:20 p.m., R10 participated in playing word scramble with staff and peers in the activity room. At 4:15 p.m., R10 participated in a group activity passing around the conversation ball in the activity room. On 9/3/25 at 1:13 p.m., R10 participated in a group exercise this morningDuring an interview on 9/9/25 at 11:13 a.m., licensed practical nurse (LPN)-A stated she started her role as the facility's infection preventionist at the end of July 2025. LPN-A performed the facility's surveillance monitoring on Fridays and	F0880		

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F0880 SS = D	Continued from page 20 another nurse covered for her the other days. The facility's nurses had a good team approach and put notes in the electronic medical record and called LPN-A whenever a resident was ill, including weekends, evenings and nights. The nurses had the ability to test for COVID-19 and to place any symptomatic resident into transmission-based precautions at any time. During an interview on 9/9/25 at 11:48 a.m., registered nurse (RN)-A stated R10, R21 and R39 were not placed into transmission-based precautions when they exhibited signs and symptoms of COVID-19 because their COVID-19 rapid antigen tests were negative. R21 went out on a facility planned outing and was "played out" but improved on his own. The residents "had a runny nose for a few days and were tired out." RN-A stated she would place a resident in transmission-based precautions if he/she was coughing or had a positive COVID-19 test, but really any respiratory illness should. Typically, if a resident had a cough, staff would ask the resident to remain in his/her room, but staff would not put on any personal protective equipment (PPE) before entering the room unless the resident tested positive for COVID-19. RN-A stated she was unaware a confirmatory test was required when a rapid antigen test was used. During an interview on 9/9/25 at 12:12 p.m., RN-B stated she would put a resident in transmission-based precautions when the resident had a fever, were actively vomiting or were positive for COVID-19. RN-B stated she was unaware a resident needed to be placed into transmission-based precautions until a confirmatory negative rapid antigen test was collected. During an interview on 9/9/25 at 12:14 p.m., the director of nursing (DON) stated she expected staff to follow facility policy and procedure to protect other residents, staff and the community from potential illness. The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 3/18/24, identified the decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with symptoms of COVID-19 can be made based upon having negative results from at least one viral test. - If using NAAT (molecular) (A Nucleic Acid Amplification Test is a type of viral diagnostic test for SARS-CoV-2, the virus that causes COVID-19. NAATs	F0880		

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F0880 SS = D	Continued from page 21 detect genetic material (nucleic acids). NAATs for SARS-CoV-2 specifically identify the RNA (ribonucleic acid) sequences that comprise the genetic material of the virus), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT. - If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. - If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgment and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions. The facility COVID-19 policy revised 5/12/23, identify it was the policy of the facility to minimize exposure to respiratory pathogens and promptly identify residents with clinical features and an epidemiologic risk for COVID-19 and to adhere to Federal and State/local recommendations. A resident with suspected COVID-19: Immediate infection prevention and control measures will be put into place. Symptoms may vary in severity. If symptoms are mild and do not require transfer to the hospital: - Place resident in isolation in his/her room with door closed on Special Precautions – including Contact and Droplet Transmission Based Precautions. - Notifications and Communication: - Contact and inform the residents physician when a resident exhibits symptom consistent with Covid-19 - Contact and inform DON and/or Infection Preventionist to notify of suspected case. - Contact and inform resident representative to update on status. - Contact and inform the facility Medical Director of suspected or confirmed case of Covid-19 in facility. - Rapid Antigen testing will be performed as ordered by MD.	F0880		

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F0880 SS = D	Continued from page 22 However, the policy failed to direct staff on actions taken when Rapid Antigen testing was negative, and a confirmatory test was required.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/09/2025. At the time of this survey, Fair Meadow Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:	K0000		11/08/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Meadow Nursing Home	300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 56540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	Continued from page 1 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Inspected as one building: Fair Meadow Nursing Home is a 1-story building, without a basement, and constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1972 the south wing was added to the original building and was determined to be of Type II (111) construction. The south wing is separated with at least a 2 hour fire barrier from an apartment building. The facility is divided into 4 separate smoke zones by 30 minute fire barriers. The facility has a fire alarm system with smoke detection throughout the corridor system and in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" with automatic fire department notification. The building is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems with quick response heads. Hazardous areas have automatic fire detection that is on the fire alarm system. The facility has a capacity of 41 beds and had a census of 37 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by	K0000		
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with	K0353	K0353: Facility will ensure that the annual maintenance, inspection, and testing of the facility's sprinkler system is done within the required time frame by Johnson Controls.	11/08/2025

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K0353 SS = F	Continued from page 2 NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/09/2025 at 11:17am, it was revealed by a review of available documentation the facility failed to perform the annual sprinkler system testing. The last documented annual inspection was dated 08/05/2024 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	Continued from page 2 Fair Meadow's Environmental Services Director will schedule the date for the annual sprinkler system maintenance inspection, and testing in advance of the due date that the last annual inspection was completed. Fair Meadow had scheduled the annual sprinkler system maintenance inspection for 8/19/2025, this was Johnson Control's only available date for the month of August 2025. Johnson Control called and stated they had to cancel the 8/19/2025 scheduled appointment for the facility's annual sprinkler system maintenance, inspection, and testing and rescheduled the annual sprinkler system maintenance, inspection, and testing for 9/18/2025. The facility's annual sprinkler system maintenance, inspection and testing was completed by Kyle Lajimodiere, Johnson Control on 9/18/2025. Copy of the 9/18/2025 Annual Sprinkler Systems Inspection Report is attached.	
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.	K0761	K0761 To ensure facility's compliance with re-certification of the fire doors and the door rating tags, the facility administrator and environmental services director contacted Fargo Glass & Paint Company, Fargo, ND, regarding their failure to complete the re-certification and to schedule a date to have the re-certification scheduled and completed this October 2025.	11/08/2025

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K0761 SS = F Bldg. 01	Continued from page 3 Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/09/2025 at 12:27pm, it was revealed by observation that the fire doors and/or fire door frames were missing door rating tags in all the existing fire walls throughout the facility. In 2024 the facility added new fire door hardware and at the time of installation the fire door were required to be re-certified to meet life safety code compliance. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0761	Continued from page 3 The new fire door hardware installation was completed by the Fargo Glass & Paint Company, Fargo N.D, on 10/1 & 2/2024. Last 9/13/2024, Fargo Glass & Paint committed to the project of the fire door hardware installation and re-certification for compliance of the 2024 life safety K tag citation. The project cost was $28,603.50. Upon being informed 9/9/10 that the facility was out of compliance because the re-certification door rating tags were missing, the environmental services director immediately reached out to Fargo Glass & Paint Co. requesting a scheduled date with the next week to complete the re-certification of the altered fire doors. Several attempts were made during the next two weeks to reach Fargo Glass & Paint for an explanation why the re-certification of the fire doors was not completed at the time of installation and to have the re-certification of the altered doors scheduled. The initial and only response during that two period from Jeff Vanyo, Fargo Sales, was “I'm working on it” and he would not return phone calls placed during that period. On 9/24/2025 Jeff Vanyo, Fargo Glass & Paint was again contacted and this time he informed the environmental services director, Fargo Glass & Paint did not have anyone to complete the re-certification of the fire door rating tags compliance regarding their installation of the fire door hardware, and the facility would have to schedule and assume the additional cost of re-certification. On 9/26/25 Fair Meadow’s administrator emailed a letter Management Team of Fargo Glass & Paint Company, regarding their failure to complete re-certification upon installation of the fire door hardware. The email requested a call to the administrator no later than noon Tuesday 9/30/25. No response was received. On 10/1/2025 Fair Meadow’s administrator called Dan Martin, CEO's, direct phone line (701-271-2448), voice message was left requesting a return call. No response was received. Fair Meadow administrator is trying to locate a fire door certification company in upper Minnesota, Wisconsin, North Dakota that certifies wood fire doors, the door companies that were found and have been contacted only certify metal fire door.	

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K0761 SS = F Bldg. 01		K0761	Continued from page 4 Fair Meadow administrator had reached out to the Fire Departments in Virginia, Hibbing and Duluth, MN to see if they knew of resources to contact. Fair Meadow administrator will continue to work on the plan of correction for the compliance of re-certification & door rating tags for the alteration to the facility's fire doors for a completion date of 11/7/2025.	