DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9VI5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245545**
2.STATE VENDOR OR MEDICAID NO.
(L2) **804740500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIR MEADOW NURSING HOME**
(L4) **BOX 8 300 GARFIELD AVENUE SOUTHEAST**
(L5) **FERTILE, MN** (L6) **56540**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/22/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **42** (L18)
13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 09/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/06/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/11/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245545

October 6, 2016

Ms. Angela Leiting, Administrator
Fair Meadow Nursing Home
Box 8 300 Garfield Avenue Southeast
Fertile, Minnesota 56540

Dear Ms. Leiting:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 21, 2016 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 7, 2016

Ms. Angela Leiting, Administrator
Fair Meadow Nursing Home
Box 8 300 Garfield Avenue Southeast
Fertile, Minnesota 56540

RE: Project Number S5545025

Dear Ms. Leiting:

On July 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 30, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On August 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 22, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 30, 2016, effective July 21, 2016 and therefore remedies outlined in our letter to you dated July 12, 2016, will not be imposed.

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 if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245545 Y1	A. Building B. Wing Y2	8/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0167	Correction	ID Prefix F0176	Correction	ID Prefix F0242	Correction
Reg. # 483.10(g)(1)	Completed	Reg. # 483.10(n)	Completed	Reg. # 483.15(b)	Completed
LSC	06/30/2016	LSC	07/21/2016	LSC	07/21/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	07/21/2016	LSC	07/21/2016	LSC	07/21/2016
ID Prefix F0314	Correction	ID Prefix F0425	Correction	ID Prefix F0441	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.60(a),(b)	Completed	Reg. # 483.65	Completed
LSC	07/21/2016	LSC	07/21/2016	LSC	07/21/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/18/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	09/07/2016	28035	07/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/30/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245545 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	07/18/2016	LSC K0025	07/18/2016	LSC K0056	06/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0062	07/18/2016	LSC K0147	07/05/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	09/07/2016	36536	07/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/28/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9VI5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245545**

2.STATE VENDOR OR MEDICAID NO.
(L2) **804740500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIR MEADOW NURSING HOME**
(L4) **BOX 8 300 GARFIELD AVENUE SOUTHEAST**
(L5) **FERTILE, MN** (L6) **56540**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/30/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NEII 07/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/07/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 12, 2016

Ms. Angela Leiting, Administrator
Fair Meadow Nursing Home
Box 8 300 Garfield Avenue Southeast
Fertile, Minnesota 56540

RE: Project Number S5545025

Dear Ms. Leiting:

On June 30, 2016, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 9, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 9, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 30, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	06/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 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
F 000	INITIAL COMMENTS 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most current complete State survey results were posted and accessible, as required. This had the potential to affect all 39 residents who resided in the facility, family and visitors.	F 167	A copy of the 2015 life safety code survey results were placed in a new 3-ring binder along with the 2015 MDH survey results. The wire holder was cleared of any other equipment and a sign was placed above the holder stating annual MDH and life	6/30/16

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

Electronically Signed | 07/21/2016

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	245545	A. BUILDING _____ B. WING _____	06/30/2016

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F 167	Continued From page 1 Findings include: During the initial tour of the facility on 6/27/16, at 1:35 p.m. posted in a glass encased bulletin board located in the main hallway by the east/west nursing station was a sign which indicated the Minnesota department of health survey results were available in the physical therapy room. The door to the physical therapy area was open and the State survey results were located in a wired holder which was adhered to the wall and positioned about four feet from the floor. In the wired holder was a hand held heat massager which was turned off, but plugged into the electrical socket in the wall. A blue wooden chair and a bed side stand were positioned in front of the wired holder which contained the survey results. The survey results from the last survey dated 5/14/15, were under the hand held heat massager, stapled together and rolled up in the bottom of the wired holder. The 5/14/15, survey results lacked the life safety code deficiencies which had been sited during the 5/14/16, survey. On 6/29/16, 12:06 p.m. director of nursing (DON) confirmed the 5/14/16, State survey results were non-inclusive as the life safety code deficiencies were not included. In addition, the DON stated the State survey results should have been placed in the plastic covered paper holder and at times the therapy room could be busy and the State survey results more difficult to reach. The Federal and State Bill of Rights, [undated] indicated the results of the most recent survey of	F 167	safety code survey results only. Administrator to check one time a week for 2 months for compliance. QAA to review at next quarterly meeting. July payroll insert will remind staff of the placement of survey results. Resident Council agenda for August also includes placement of survey results. Completed 06/30/2016.	

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F 167	Continued From page 2 the facility conducted by Federal or State surveyors and any plan of correction in effect must be readily accessible to residents. Posting of MDH (Minnesota Department of Health) Survey Results policy [undated] indicated the annual results of the MDH survey and the State Fire Marshall inspection would be posted in the black binder located in the therapy room.	F 167		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the ability to self administer nebulizer inhalation medication for 1 of 1 (R20) resident in the sample observed to self administer nebulizer medicaiton without an assessment completed. Findings include: R20's quarterly Minimum Data Set (MDS) dated 4/27/16, indicated R20 had severe cognitive impairment, required extensive assistance with all activities of daily living and had limited range of motion in her upper extremities.	F 176	Self Administration of nebulizer policy reviewed and updated per DON and to be reviewed with QAA Committee next meeting. Education was provided to LPN-C in regards to staying with Resident-20 during entire treatment completed, to remove mask and shut off machine. DON provided education to licensed staff/TMAs at supervisor's meeting on 07/12/16 in regards to this concern. Copy of updated policy provided and reviewed, and to be signed off per charge nurse/TMA. DON to provided education to licensed staff/TMAs that were not present at meeting. DON discussed and re-educated RN Staff of continued appropriate assessments in	7/21/16

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F 176	Continued From page 3 R20's Physician Order dated 6/2/16, revealed an order for Albuterol 2.5 milligrams in three milliliters of saline inhale to be administered via a nebulizer mask four times a day as needed for shortness of breath. The physician had not indicated R20 had the ability to self administer her medications. R20's care plan dated 12/24/13, indicated R20 was at risk for aspiration pneumonia related to sever dysphagia (difficulty swallowing) and history of aspiration pneumonia. The plan directed staff to administer nebulizer treatments as needed. The care plan did not address self administration of nebulizer treatments. During observation on 6/28/16, at 2:11 p.m. R20 was observed in bed with a nebulizer mask secured to her face with an elastic strap. The nebulizer treatment had been completed, yet the machine was still running. R20 was not observed to attempt to remove the mask independently. -At 2:15 p.m. nursing assistant (NA)-A and NA-K entered the room to assist R20 to get out of bed. NA-A was observed to shut the nebulizer machine off and remove the mask. -At 2:20 p.m. NA-A stated she would occasionally shut off the nebulizer machines when directed by the nursing staff. On 6/28/16, at 2:22 p.m. trained medication administration (TMA)-A stated she had just received change of shift report from licensed practical nurse (LPN)-C. She stated LPN-C had informed her that the nebulizer treatment had been started at 1:45 p.m. She stated she assumed the treatment had been completed and had not been directed to follow up with the treatment. She stated a nebulizer treatment	F 176	regards to self administration of medications/self administration of medications as dispensed by charge nurse/TMA, which are reviewed quarterly and prn per primary RNs. DON/designee to review present charts in regards to residents who are able to self administer medications upon admission, which will include reviewing of initial resident self administration of medications form completed by LSW, as well as any residents who are at present time. List of residents who are able to self administer medications after setup per charge nurse/TMAs reviewed per DON/designee. Random audits per DON/designee to be done weekly x4 weeks to ensure medications are not left with residents without a self-administration of medciations assessment completed in chart. Random audits will then be performed per DON/designee montly x6 months. Self administration of medications will be added to care plan review sheet, which IDT meet for quarterly care conference. Results of audits will be reviewed at upcoming QAA committee meetings. R-20 is not to be left alone in regards to self administration of medications related to severe cognitive impairment, requiring extensive assistance with all activities of living, limited ROM in upper extremities. Care plan was updated per primary RN. R-20 prn sheet was updated to say charge nurse/TMAs to set-up/stay with resident during and until entire treatment completed and remove mask and shut off machine. The issue will also be reviewed	

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F 176	Continued From page 4 usually took 5-15 minutes to complete and the staff were to stay with R20 until the treatment had been completed. On 6/28/16, at 2:30 p.m. LPN-C stated she had started the nebulizer treatment at 1:50 p.m. and had instructed NA-A to shut the machine off when it was done. R20's medical record lacked a self administration assessment. On 6/29/16, at 12:00 p.m. registered nurse (RN)-B stated R20 did not have the ability to use her hands due to arthritic changes. She stated R20 did not have the physical ability to remove the nebulizer mask independently, therefore, she could not safely self administer the nebulizer medication. She stated the medication staff were to stay with R20 during the treatment to ensure it had been administered correctly. RN-B stated a nebulizer treatment took approximately 5-15 minutes to administer and staff were to evaluate R20 to ensure the medication was effective. She stated the nursing assistants were not to be shutting the nebulizer treatments off as the resident may require re-evaluation following the treatments. The undated Self Administration of Nebulizer policy directed the staff to complete a self-administration assessment prior to allowing the resident to self administer their own treatment. It also directed the staff to check and return to the room every five minutes to shut off the nebulizer or assist the resident.	F 176	at upcoming Skills Fair on 07/21/2016. Note placed in announcement to be read at report time for each shift x2 weeks. This will also be added to Physician's sheet to be reviewed/signed per primary MD as well. Completion date 07/21/16.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		7/21/16

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F 242	Continued From page 5 The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based observation, interview and document review, the facility failed to ensure the morning routines of each resident matched those of their previous lifestyle or provided with family approval for 2 of 3 residents (R2, R16) who received total morning cares during the hours of sleep. Findings include: R2 was provided total morning cares at 4:30 a.m. without the directive and family's approval for morning cares to be provided during hours of sleep. R2's annual Minimum Data Set (MDS) dated 6/8/16/16, indicated R2's diagnosis included dementia, cardiovascular attack (CVA), hemiplegia, and anxiety and was cognitively impaired. The MDS indicated R2 required extensive staff assistance for dressing, personal hygiene, eating, and toileting. The MDS indicated R2 was non-ambulatory and required total assist from staff for transfers. R2's care plan revised 6/23/16, indicated R2 required staff assist with all activities of daily living.	F 242	Hand washing policy reviewed. Education in regards to hand washing and applying/reapplying gloves was provided to TMA-D and NA-B. All staff will be provided education at Skills Fair on 07/21/16. Policy will be reviewed as well at that time. Hand washing is stressed during orientation of any new employees. Orientation LPN will have new employees repeat hand washing demonstration back to LPN and check off list for hand washing form will be signed off and placed in employee's folder. Random audits will be completed by DON/designee weekly x1 month at random shifts/times. Will audit new employees checklist in regards to hand washing during orientation per DON/designee and will conduct random audits 2 times a month for 6 months. Will report audit results to QAA committee. Completed 07/21/16. Self Determination and Participation Policy reviewed and updated per DON. Current policy will be reviewed at upcoming QAA Committee meeting. Resident 2 was moved back to a private	

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F 242	Continued From page 6 On 6/29/16, at 5:30 a.m. R2 was observed sleeping in her bed, fully dressed. At 6:50 a.m., nursing assistant (NA)-I and NA-J assisted R2 from her bed to the wheelchair via a full body mechanical lift. NA-I stated R2 had received morning cares by the night shift staff at approximately 4:30 a.m. each morning to help the day staff out with their work load. On 6/29/16, at 6:15 a.m. trained medication assistant (TMA)-D stated the night shift was assigned to assist three residents with morning cares on the south wing prior to leaving at 7:00 a.m. and verified R2 was routinely provided morning cares at 4:30 a.m. On 6/30/16, at 8:05 a.m. NA-I stated the night shift provided cares and dressed three residents on the south wing because the south wing's work load was very heavy and the NA's had to have all the residents in the dining room by 9:00 a.m. for breakfast. On 6/30/16, at 8:20 a.m. licensed practical nurse (LPN)-D verified the night shift staff typically completed R2's morning cares at approximately 4:30 a.m. each morning. On 6/30/16, at 9:15 a.m. R2's husband stated he was unaware of his wife being provided morning cares and being dressed at 4:30 a.m. R2's spouse stated R2 had never gotten up that early and maybe that was why she [R2] was so sleepy when he came to visit. R2's husband stated he had not given the facility the permission or had been asked for family's input on providing care for his wife at 4:30 a.m.	F 242	room on East Wing, which was where resident was originally at. Resident 2 total AM cares will be provided no earlier than 6:00 a.m. Resident is unable to verbalize preferences of daily cares r/t difficulties communicating needs and impaired cognition. Upon admission, LSW and Primary RNs will determine preferences. LSW will fill out Customary Routine information, which is gathered upon admission per resident or family members and will be reviewed quarterly and provided on care plan. Resident 16 care plans will be updated as daughter in agreement that early AM cares can be provided, Resident 16 care plan updated per primary RN and documentation provided. Resident's Bill of Rights to be discussed at upcoming Skills Fair scheduled in house on 07/21/2016 to all staff per LSW. Current policy in regards to this issue will be reviewed and signed per charge staff/TMAs. This concern will also be addressed during orientation upon hire. Self Determination and Participation will be added to care plan review sheet, which IDT meet for quarterly care conference. Audits on any future admissions will be audited for completion of Customary Routine information per DON/designee for 3 months, care plans for any future admissions will also be reviewed in regards to provided ADLs in regards to resident or family wishes or requests as able x3 months as well. Resident 2 and Resident 16 care plans are currently updated per primary RNs. Note left in announcement in regards to provide information for staff providing	

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F 242	Continued From page 7 On 6/30/16, at 9:45 a.m. registered nurse (RN)-B verified R2's care plan did not address R2 being provided cares at 4:30 a.m. On 6/30/16, at 10:15 a.m. the director of nursing (DON) confirmed R2's care plan and stated staff should not be providing cares to the residents' that were sleeping. R16 was provided total morning cares at 4:30 a.m. without the directive and family's approval to provide morning cares during hours of sleep. R16's quarterly MDS dated 4/13/16, indicated R16 was diagnosed with dementia and a stroke. The MDS also indicate R16 was cognitively impaired, required extensive staff assistance for dressing, eating, and toileting, was non-ambulatory and required total assist from staff for transfers and personal hygiene. R16's care plan revised 4/19/16, indicated R16 required staff assist with all activities of daily living. On 6/29/16, at 5:30 a.m. R16 was observed sleeping in her bed fully dressed. -At 6:55 a.m. NA-I and NA-J were observed to assist R16 from her bed to the wheelchair via a full body mechanical lift. NA-J stated R16 had received morning cares by the night shift staff at approximately 4:30 a.m. On 6/29/16, at 6:15 a.m. TMA-D stated the night shift was assigned to assist three residents with morning cares on the south wing prior to leaving at 7:00 a.m. and verified R16 was routinely provided morning cares at 4:30 a.m.	F 242	direct care in which Resident can't receive any AM cares prior to 6:00 a.m. Results of audits will be provided at upcoming QAA meetings. Completion date 07/21/2016.	

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F 242	Continued From page 8 On 6/30/16, at 8:20 a.m. LPN-D verified the night shift staff typically completed R16's morning cares at approximately 4:30 a.m. each morning. On 6/30/16, at 9:20 a.m. R2's daughter stated she was unaware of her mother getting dressed and being provided morning cares at 4:30 a.m. R16's daughter stated she had not given the facility the permission or had been asked for family's input on providing care for her mother at 4:30 a.m. On 6/30/16, at 9:45 a.m. RN-A verified R16's care plan did not include a directive to provide morning cares during the hours of sleep. The facility policy, Self Determination and Participation, undated, indicated the facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Gathered information about the resident's personal preference would be documented in the medical record. Family members of the resident shall be included and informed regarding resident choices.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282		7/21/16

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F 282	Continued From page 9 Based on observation, interview and document review, the facility failed to apply a CPAP machine as directed by the care plan for 1 of 3 residents (R26) who utilized a CPAP at night for breathing and required assistance with application. In addition, the facility failed to provide oral hygiene as directed by the care plan for 1 of 6 residents (R47) in the sample who required assistance with oral hygiene. Lastly, the facilty failed to provide timely positioning assistance as directed by the care plan for 1 of 3 residents (R2) who required assistance with positioning. Findings include: R26's CPAP was not placed on R26 at night as directed by the care plan. R26's care plan dated 2/6/16, indicated R26 had altered respiratory status related to sleep apnea (a disorder where a person has one or more pauses in breathing or shallow breathing while sleeping) and utilized a continuous positive airway pressure machine (CPAP) used to help a person with sleep apnea breathe more easily during sleep. The interventions indicated R26's CPAP settings were positive pressure with a nasal pillow and oxygen and directed staff to apply the CPAP every night at bedtime. R26's NA (nursing assistant) care guide dated 6/28/16, indicated R26 had a CPAP machine which was supposed to be setup and started every night at bedtime. The NA's were directed to report when R26 refused to use the CPAP.	F 282	Care Plan Policy and Procedure was reviewed and signed per DON. In regards to not following care plan for Resident 26, which facility failed assistance with application with CPAP at night for breathing. Care plan was reviewed and is correct. Note left in announcement book to read for pm/night shift in regards to this concern. MAR was updated to list number of hours resident is wearing CPAP on each shift. DON did do random audits on 07/19/16 at 4:00 am and on 07/20/2016 at 1:00 am and resident was wearing CPAP properly. Care Plan Policy in regards to this above issue will be reviewed with nursing staff at upcoming Skills Fair at facility on 07/21/2016. Random audits per DON/designee and checking for documentation of hours applied in MAR will be conducted daily x1 week, then weekly x 1 month, then monthly x3 months. Audit results will be reported to QAA committee upcoming. This concern also will be addressed during orientation for nursing. Care Plan Policy and Procedure was reviewed per DON for Resident 47. In regards to Resident 47, proper oral hygiene was not followed according to care plan. Note left in announcement book to read every shift in regards to this concern. Oral care/hygiene is discussed with LPN upon orientation as well. This concern as well will be addressed at upcoming Skills Fair at Facility on 07/21/2016 to all nursing staff. Random audits per DON/designee in regards to oral hygiene provided per care plan for	

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F 282	Continued From page 10 On 6/29/16, at 5:37 a.m. R26 was observed sleeping in the recliner in R26's room. R26 had oxygen on via nasal cannula, however R26's CPAP was not placed. On 6/29/16, at 5:47 a.m. trained medication aide (TMA)-B who worked the night shift confirmed R26 did not currently have a CPAP on nor had R26 had it on during the night time. TMA-A stated R26 often refused to wear the CPAP at night. On 6/29/16, at 11:19 a.m. registered nurse (RN)-A confirmed R26 had a diagnosis of sleep apnea and the care plan directed staff to place the CPAP on R26 at bedtime. RN-A confirmed the NA care guide was an extension of the care plan and R26's NA care guide and written care plan should have been followed. On 6/29/16, at 12:10 p.m. the director of nursing (DON) confirmed R26's care plan and NA care guide were correct regarding R26's CPAP and it was the expectation that R26's care plans be followed. R47 was not provided assistance with oral hygiene as directed by the care plan. R47's care plan dated 6/18/16, indicated R47 had upper and lower dentures and required assist of one staff to complete oral hygiene. On 6/28/16, at 7:05 am. NA-I was observed to	F 282	Resident 47 noted on am shift on 07/01/16 and pm shift 07/05/2016 to be correct. Will continue with b.i.d. oral cares x 1 week, then 2x month for 3 months. Results of audits will be provided to upcoming QAA committee meetings. Care Plan Policy and Procedure was reviewed per DON for Resident 2. Current care plan was reviewed and stated resident is to be on repositioning schedule every 1-1/2 hrs. Resident 2 was recently transferred back to original wing which resident was on prior to renovation of private room. Resident has not noted to have any skin breakdown or pressure ulcers recently. Note left in announcement book to read report for each shift, random audits for Resident 2 in follow-up if care plan is being followed properly for repositioning schedule for this resident or any other residents on specific repositioning schedule to be monitored per DON/designee. Audits were done on 07/19/16 at 4:00 am and on 07/20/16 at 3:00 a.m. with documentation on Toileting/Repositioning to be accurate per observation per DON, continue with daily audits x2 weeks, then 2x a week for 2 months, then monthly for 6 months. This concern will also be addressed at upcoming Skills Fair on 07/21/16 for nursing staff as well during orientation of nursing staff. Audit results will be provided to upcoming QAA committee meetings. Completed 07/21/2016.	

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F 282	Continued From page 11	F 282		

provide R47 morning cares. During the observation, NA-I was observed to hand R47 upper and lower dentures without providing or offering the opportunity to cleanse mouth/ brush remaining teeth prior to the insertion of the dentures. Following the completion of the morning cares, NA-I remained in her room, seated in a wheelchair. At no time did NA-I offer R47 the opportunity to rinse or swab her mouth prior to inserting the clean dentures.

On 6/29/16, at 10:30 a.m. NA-I verified oral hygiene was not completed prior to inserting R47's dentures. NA-I stated she should have offered her oral hygiene.

On 6/29/16, at 10:15 a.m. RN-A verified R47's care plan was correct and oral hygiene should have been provided.

On 6/29/16, at 10:35 a.m. the DON verified R47's care plan was correct and stated oral hygiene should have been provided, as directed.

R2 was not provided assistance with every 1.5 hours repositioning as directed by the care plan.

R2's care plan dated 6/23/16, indicated R2 was at risk for pressure ulcers and directed staff to anticipate R2's cares/needs and to turn and reposition R2 at least every 1 1/2 hours or more often as needed.

On 6/29/16, at 6:50 a.m. NA-I and NA-J were observed to provide R2's morning cares.
-At 6:55 a.m. R2 was transferred from bed via Hoyer lift to the wheelchair and assisted to the dining room by NA-J.
-At 7:45 a.m. until 8:55 a.m. R2 remained in the

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F 282	Continued From page 12 dining room, seated in the wheelchair. -At 8:55 a.m. activity aide-A was observed to wheel R2 to activities in the activity room. -At 9:15 a.m. NA-I wheeled R2 to her room. -At 9:20 a.m. NA-I and NA-J transferred R2 to bed via the hoyer lift. This was two hours and 25 minutes from last repositioning. At this time, NA-I verified R2 should be repositioned 1 1/2 hrs. On 6/30/16, at 10:20 a.m. RN-B. verified R2's care plan was correct and staff should have repositioned R2 every 1 1/2 hours, as directed. On 6/30/16, at 10:30 a.m. the DON verified R2's care plan was correct and R2 should have been provided repositioning assistance every 1 1/2 hours. Fair Meadow Care Plan Policy and Procedure dated 1/16, indicated a written plan of care would be developed for each resident in coordination with all services and individuals involved with the care of the resident. Each department head would be responsible to see that their portion of the resident's care plan was implemented.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		7/21/16

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F 309	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to apply a CPAP breathing machine or document the refusal of the use of the CPAP for 1 of 3 residents (R26) who utilized a CPAP at night which was not applied, as directed. Findings include: R26's Diagnosis Report printed on 6/30/16, identified R26's diagnoses as respiratory failure, sleep apnea (a disorder where a person has one or more pauses in breathing or shallow breathing while sleeping), restless leg syndrome, asthma, and bradycardia (slow heart rate). R26's quarterly Minimum Data Set (MDS) dated 5/18/16, indicated R26 had moderate cognitive impairment and utilized oxygen therapy. R26's Activities Of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 3/14/16, indicated R26 was unable to reposition herself side to side once in bed. In addition, R26 liked to sleep in the recliner when increased shortness of breath was noted. Staff were to assist R26 with placing the CPAP (Continuous Positive Airway Pressure machine used to help a person with sleep apnea breathe more easily during sleep) on at bedtime and taking the CPAP off in the morning.	F 309	A policy in regards to CPAP usage and also one in regards to CPAP cleaning and maintenance was provided and reviewed per DON. Care plan was reviewed and noted that facility did not assist Resident 26 with application with CPAP at night or provide documentation of resident refusing to wear it per night nurse/TMA. Primary RN did provide education to Resident 26 about the benefits/risks of resident refusal of wearing CPAP at night. Note left in announcement book to read for pm/night shift to apply and chart if resident refuses to wear it at night. MAR was updated to list number of hours resident is wearing CPAP on each shift. This concern will be addressed at upcoming Skills Fair on 07/21/16. A policy is provided in regards for application, documentation of number of hours or if resident refuses to wear will be also addressed with nursing staff and upon orientation. Primary RN continues to provide education to Resident 26 as needed. DON/designee will conduct audits of charge nurse/TMA applying CPAP and also providing documentation of Resident 26 or any other residents/new admissions as well. Daily audits x 1 week. Audit results will be reported to QAA Committee. Completed 07/21/16.	

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F 309	Continued From page 14 R26's Physician Orders dated 3/16/16, indicated R26 was to have oxygen on at 2-4 liters to keep oxygen saturations above 90%. R26's care plan dated 2/6/16, identified a focus area for altered respiratory status related to sleep apnea. The interventions identified R26's CPAP settings were positive pressure with a nasal pillow and oxygen. The interventions directed staff to apply the CPAP every night at bedtime. R26's NA (nursing assistant) care guide dated 6/28/16, indicated R26 had a CPAP which was supposed to be setup and started every night at bedtime. The NA's were directed to report when R26 refused to use the CPAP. R26's plan of care note dated 5/25/16, indicted R26's CPAP machine with oxygen was to be worn at night for sleep apnea and the head of bed up 45 degrees when in bed. The staff were directed to document in the medical record when R26 refused the CPAP. R26's nursing notes were reviewed from 5/19/16, through 6/28/16, the only mention of R26's refusal to wear the CPAP was on 6/4/16. R26's 6/2016, Treatment Administration record indicated R26's oxygen saturations consistently remained above 90%. On 6/29/16, at 5:37 a.m. R26 was observed	F 309		

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F 309	Continued From page 15	F 309		

sleeping in the recliner in R26's room. R26 had oxygen on via nasal cannula, however R26's CPAP was not placed. R26 was observed sleeping in this position until 7:16 a.m. which at that time R26 put on the call light and staff arrived and used a mechanical lift to assist R26 onto the commode.

On 6/29/16, at 5:47 a.m. trained medication aide (TMA)-B who worked the night shift stated R26 slept in the recliner all night with the foot of the recliner elevated. TMA-B stated R26 usually didn't get up for the day until after 6:30 a.m. TMA-A confirmed R26 did not currently have a CPAP on nor had R26 had it on during the night time. TMA-A stated R26 often refused to wear the CPAP at night.

On 6/29/16, at 8:37 a.m. TMA-C stated she only worked the day shift and was unsure if R26 was supposed to wear a CPAP during the night. TMA-C stated she hadn't seen R26 wear a CPAP, however R26 always had oxygen on. TMA-C stated R26's status had seemed to decline over the last couple of months and since that time, R26 slept in longer and usually woke up around 7-7:30 a.m.

On 6/29/16, at 11:19 a.m. registered nurse (RN)-A confirmed R26 had a diagnosis of sleep apnea and wore a CPAP during the night time. RN-A stated R26 had been admitted with the CPAP as R26 had used it at home. RN-A stated R26 had had some recent mental status changes and RN-A questioned if R26 needed to have another sleep study completed. RN-A stated she

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F 309	Continued From page 16 was unsure if R26 was having some episodes of hypoxia (deficiency of oxygen reaching the tissues of the body). RN-A confirmed the night nurse/TMA should document in the progress notes when R26 refused to wear the CPAP. RN-A verified if R26 consistently refused to wear the CPAP, staff should have provided R26 and documented the risks and benefits related to refusal to utilize the CPAP. RN-A stated she thought R26 had refused to wear the CPAP more frequently. On 6/29/16, at 12:10 p.m. the director of nursing (DON) confirmed R26's CPAP should be worn at night and if R26 refused to wear the CPAP, staff should have documented the refusal. On 6/30/16, at 8:46 a.m. RN-A stated she had confirmed with R26's family that R26 had used the CPAP for about 15 years. RN-A confirmed she was in the process of retaining the original order for R26's CPAP from R26's primary clinic. RN-A confirmed the R26's CPAP settings had not changed. The only thing new was the facility had purchased a new mask that accommodated the continuous oxygen therapy. No policy related to CPAP care and monitoring was provided.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312		7/21/16

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F 312	Continued From page 17 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral hygiene services as directed by the care plan for 1 of 6 residents (R47) in the sample who required assistance with oral hygiene and was observed to not receive the service. Findings include: R47's significant change Minimum Data Set (MDS) dated 3/21/16, indicated R47 had diagnoses of heart failure and depression. The MDS also indicated R47 had impaired cognition and required extensive assistance for mobility, dressing and personal hygiene. The MDS further indicated R47 had no dental concerns. R47's ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 3/21/16, indicated R47 required extensive assistance with dressing, grooming, and physical assistance with bathing due to weakness and poor coordination. R47's care plan dated 6/18/16, indicated R47 had upper and lower dentures and required assist of one staff to complete oral hygiene.	F 312	Oral Hygiene for acutely ill or dying resident, or a resident with no teeth or dentures policy was reviewed and updated per DON. On 06/29/2016 NA-1 was verbally re-educated on providing oral hygiene properly to Resident 47. Care plan was reviewed and note was correct that oral hygiene was to have been provided. Note left in announcement book in regards to this concern and to be read at each shift report x 2 weeks. All nursing still will be provided education, review of current policy and upcoming Skills Fair at facility on 07/21/2016. This concern is also addressed upon orientation as well. Care plans are reviewed quarterly and updated during care conference and prn per IDT team. DON/designee will conduct random audits involving NA-1 and all other staff providing direct care weekly on different shifts x4 weeks, then x2 a month for 6 months. Results of audits will be provided at upcoming QAA meeting. Completed 07/21/16.	

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F 312	Continued From page 18 On 6/28/16, at 7:05 am. nursing assistant (NA)-I was observed to provide R47 morning cares. During the observation, NA-I was observed to hand R47 upper and lower dentures without providing or offering the opportunity to cleanse mouth/ brush remaining teeth prior to the insertion of the dentures. Following the completion of the morning cares, NA-I remained in her room, seated in the wheelchair. At no time did NA-I offer R47 the opportunity to rinse or swab her mouth out prior to inserting the clean dentures. On 6/29/16, at 10:30 a.m. NA-I verified oral hygiene was not completed prior to inserting R47's dentures. NA-I stated she should have offered her oral hygiene. At 10:15 a.m. RN-A verified R47's care plan was correct and oral hygiene should have been provided, as directed. At 10:35 a.m. the director of nursing (DON) verified R47's care plan and stated oral hygiene should have been provided, as directed. The Oral Hygiene policy for resident's who have no teeth or have dentures, dated 6/2016, directed the staff to provide oral hygiene ever morning and at bedtime.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		7/21/16

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F 314	Continued From page 19 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure every 1.5 hours repositioning was provided as directed by the care plan for 1 of 3 residents (R2) identified at risk for the development of a pressure ulcer and required staff assistance to reposition. Finding include: R2's annual Minimum Data Set (MDS) dated 6/8/16, indicated R2 was diagnosed with cerebrovascular accident (CVA) transient ischemic attack (TIA) and osteoarthritis. The MDS also indicated R2 had impaired cognition, was at risk for the development of pressure ulcers, required a turning and repositioning program and required extensive assistance of staff for bed mobility and transfers. R2's Pressure Ulcer Care Area Assessment (CAA) dated 6/13/16, indicated R2 was at risk of developing pressure ulcers, required extensive assistance for bed mobility and staff were to	F 314	Facility policy in regards to residents who are placed on an individual repositioning schedule was reviewed at Nursing Supervisor's Meeting on 07/12/2016 and Skills Fair on 07/21/2016. Care plan was correct for Resident 2. Resident 2 was to be repositioned every 1-1/2 hrs as is at risk for development of pressure ulcer and required staff assistance to reposition. Verbal education was provided to NA-1 and NA-J at time of incident occurred. Charge nurse at time of duty was also educated and primary RN informed. Resident 2 was placed on different wing as original room was under renovation. Resident 2 was relocated to original room after it was completed. Primary RNs did review all repositioning schedules, note was left in announcements. Random audits in regards to reviewing and random observations are being conducted. Random audits per DON/designee in regards to this issue will be performed weekly at random times/shifts weekly x1 month, then 2x month for the next 3 months. Audit results will be reported to	

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F 314	Continued From page 20 provide repositioning every 1 1/2 hours. R2's Skin Review assessment dated 6/7/16, indicated R2 was at risk for developing pressure ulcers due to impaired mobility, incontinence and cognitive defects, required extensive staff assistance for bed mobility and transfer, and required repositioning assistance ever 1 1/2 hours. R2's Care Plan dated 6/23/16, indicated R2 was at risk for pressure ulcers and directed staff to anticipate R2's cares/needs and to turn and reposition R2 at least every 1 1/2 hours or more often as needed. On 6/29/16, at 6:50 a.m. NA-I and NA-J were observed to provide R2 morning cares. -At 6:55 a.m. both NA's transferred R2 from the bed into the wheelchair via a mechanical full lift. NA-J wheeled R2 to the dining room. - At 7:45 a.m. R2 was observed in dining room seated in the wheelchair, asleep. R2 was observed to remain seated in the wheelchair, in the dining room until 8:55 a.m. -At 8:55 a.m. activity aide-A was observed to wheel R2 to activities in activity room. - At 9:15 a.m. NA-I wheeled R2 to her room. - At 9:20 a.m. NA-I and NA-J transferred R2 to bed via the mechanical lift (two hours and 25 minutes since last repositioning assistance). At this time, NA-I verified R2 should have been positioned every 1.5 hours.	F 314	QAA committee at next meeting. Completed 07/21/2016	

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F 314	Continued From page 21 On 6/30/16, at 10:20 a.m. registered nurse (RN)-B verified R2's care plan was correct and R2 should have been repositioned every 1.5 hours. On 6/30/16, at 10:30 a.m. the director of nursing (DON) verified R2's care plan was correct and stated R2 should have been provided repositioning every 1.5 hours. The facility policy, Repositioning, Toileting schedule, dated 1/16, indicated staff would provide repositioning and also mark the time on their schedule. Staff would provide an opportunity for motion every two hours unless on another individualized schedule and/or if the individual care plan indicates a different plan was more appropriate.	F 314		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		7/21/16

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F 425	Continued From page 22 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered according to manufacturer's recommendations for 1 of 1 resident (R7) who received medication via a metered dose inhaler. Findings include: R7's Physician's Orders dated 6/29/16, included an order for Flovent one inhalation twice a day (rise mouth after each use). On 6/27/16, at 4:45 p.m. licensed practical nurse (LPN)-A was observed to hand R7 a metered dose inhaler. R7 was observed to self administer the inhaler and handed the cartridge back to the LPN. LPN-A did not offer or suggest R7 swish/rinse her mouth. The manufacture's (Glaxo Smith Kline) medication packaging insert dated 12/2014, directed the patients using Flovent to rinse their mouth with water after breathing in the medicine. If further directed the patient to spit out the water	F 425	Inhalation Therapy Policy was reviewed at Supervisor's Meeting on 07/12/2016. It was discussed in regards to F tag 425 received from recent survey. Resident 7 received Flovent inhaler on 06/27/2016 per charge nurse. Verbal education was provided to LPN-A at time incident occurred. Resident-7 does have Self Administration of Medications after setup per charge nurse/TMA. LPN-A did not offer or suggest Resident 7 swish/rinse her mouth with water after using inhaler. The manufacture medication packaging insert directed the patients using Flovent to rinse their mouth with after breathing in the medication, it further directed the patient to spit out the water versus swallowing. Note was placed on Resident 7 MAR in regards to the above concern. A note was also placed on all other residents who received any type of inhaler medication. A note was also left in announcement per Resident 7 primary RN. Charge staff who were present at Skills Fair on 07/21/2016 was provided education. DON/designee did complete random audits of monitoring charge nurse/TMA of providing water rinse after	

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	245545	A. BUILDING _____ B. WING _____	06/30/2016

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F 425	Continued From page 23 verse swallowing. On 6/27/16, at 5:00 p.m. LPN-A verified she had not directed R7 to rinse her mouth following the administration of the medication. On 6/28/16, at 2:30 p.m. registered nurse (RN)-A stated she had reviewed the medication package insert and verified R7 was to be cued to rinse her mouth after the administration of the inhaled medication. The Inhalation Therapy Policy dated 1/2016, directed the staff to administer inhalers according to the physician orders and following the inhalation mouth was to be rinsed with water.	F 425	use of inhalers on 07/21/2016. Audit results to be reported to QAA Committee at next month's meeting. Completion date 07/21/2016.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		7/21/16

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F 441	Continued From page 24 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene was completed for 2 of 6 (R20, R27) residents observed for personal cares. Findings include: R20's quarterly Minimum Data Set (MDS) dated 4/27/16, indicated R20 was diagnosed with a stroke and dementia. The MDS also indicated R20 had severe cognitive impairment, had limited range of motion of upper extremities, and required extensive assistance with all activities of daily living. On 6/29/16, at 6:14 a.m. nursing assistant (NA)-B	F 441	Hand washing policy reviewed. Education in regards to hand washing and applying/reapplying gloves was provided to TMA-D and NA-B. All staff will be provided education at Skills Fair on 07/21/2016. Policy will be reviewed as well at that time. Hand washing is stressed during orientation of any new employees. Orientation LPN will have new employees repeat hand washing demonstration back to LPN and check off list for hand washing form will be signed off and placed in employee's folder. Random audits will be completed by DON/designee weekly x 1 month at random shifts/times. Will audit new	

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F 441	Continued From page 25 was observed to assist R20 with morning cares. NA-B was observed to use a washbasin to provide R20 with a partial bath. -At 6:17 a.m. NA-B provided R20 with perineal cares while wearing gloves. Once NA-B replaced R20's incontinent brief, she removed her gloves and proceeded to dress R20 and allowed her to rest in bed. -At 6:19 a.m. NA-B picked R20's dirty laundry and garbage bags, opened R20's door, walked across the hallway to the utility room, opened the door, placed the bags into the appropriate receptacles, opened the door to the utility room and walked towards the clean laundry closet. At no time was NA-B observed to attempt to wash her hands after completing the perineal care and the removal of her gloves. -At 6:22 a.m. NA-B began to open the clean utility closet. She verified she had not washed her hands. She stated she did not need to wash them as she had worn gloves during the cares and had removed them. She stated she would wash her hands prior to assisting the next resident. NA-B was then observed to return to the utility room and wash her hands. On 6/29/16, at 12:05 p.m. registered nurse (RN)-B stated the direct care staff were to wash their hands after providing personal cares and the removal of gloves. The Hand Washing policy dated 1/2016, directed the direct care staff to wash their hands between resident cares and whenever direct physical contact with the resident was completed. R27's 30 day MDS dated 5/24/16, indicated R27 had cognitive impairment, functional limitation of	F 441	employees checklist in regards to hand washing during orientation per DON/designee, will conduct random audits 2x month for 6 months. Will report audit results to QAA Committee. Completed 07/21/2016.	

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F 441	Continued From page 26 upper and lower extremities, and required extensive assist with toileting and personal hygiene. R27's undated, Admission Skin Monitoring assessment indicated R27 had a rash-red sore groin area. R27's Physician order dated 6/29/16, directed staff to use barrier cream and Tolnoaftate cream (antifungal medication) twice daily until rash was gone, and to keep foley catheter in until rash resolved. On 6/29/2016, at 5:30 a.m. trained medication assistant (TMA)-D was observed to provide R27 a partial bed bath. TMA-D washed her hands and gloved. TMA-D proceeded to provide bathing to R27's upper body. -At 5:40 a.m. TMA-D lowered R27's bed, picked up the water basin from the over the bed table and took it to the sink and drained the water, rinsed out the water basin and refilled it with water. TMA-D was not observed to remove gloves and wash hands. TMA-D turned to return the basin to the over bed table and in doing so, spilled water from the basin onto the floor. TMA-D obtained paper towels from the sink area and proceeded to wipe up the water from the floor with her same gloved hands. TMA-D obtained additional paper towels and continued to wipe up the water on the floor. TMA-D proceeded to open R27's room door with her same gloved hand and asked staff in the hall to bring in additional towels to finish wiping the water up from the floor. With the same gloved hands, TMA-D obtained a wash cloth, dipped it in the wash basin and proceeded	F 441		

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F 441	Continued From page 27 to provide R27 with perineal cares. TMA-D was not observed to remove her gloves and wash her hands after wiping up the floor and providing perineal cares to R27. On 6/29/2016, at 5:59 a.m. TMA-D verified she did not remove her gloves and wash her hands after cleaning up the spilled water from the floor and before or after providing R27 personal cares and stated she should have done so. On 6/29/2016 at 11:35 a.m. the director of nursing (DON) confirmed R27 had skin issues and stated the TMA should have removed her gloves and washed her hands. The DON also stated the facility had training on hand washing and it was her expectation that staff provide good pericare and appropriate hand washing and gloving. The facility's Hand Washing Policy, dated 1/16, directed staff to wash hands after contact with environmental surfaces or equipment in the immediate vicinity of the resident.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 465	Maintenance Supervisor, Lionel	7/18/16

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F 465	Continued From page 28 review, the facility failed to ensure the warming cabinet was safely maintained. This had the potential to affect all 39 residents who resided in the facility and who had the potential to utilize a blanket from the warmer. Findings include: During the initial facility tour on 6/27/16, at 1:35 p.m. the outside digital temperature reading on the warming cabinet in the physical therapy area read 138 degrees Fahrenheit (F). Two signs were posted on the door of the warming cabinet which indicated the warming cabinet should not exceed 135 degrees F. On 6/27/16, at 4:37 p.m. the warming cabinet temperature read 138 degrees F. On 6/28/16, at 8:33 a.m. the warming cabinet temperature read 137 degrees F. On 6/28/16, at 2:31 p.m. the warming cabinet temperature read 138 degrees F. On 6/28/16, at 2:37 p.m. the maintenance manager (MM) verified the warming cabinet temperature read 138 degrees F and that this was the temperature of the inner chamber of the warming cabinet. MM stated the maintenance department did not have on their radar to monitor the temperatures of this piece of equipment. MM proceeded to lower the temperature of the	F 465	Sandness, lowered the temperature on the cabinet on 06/28/16 to ensure it was below 135 degrees. The policy was updated by the Administrator and rehab staff were given copies of the updated policy. An updated policy was also hung on the warmer. All staff were instructed to double check the temperature before removing a blanket from a warmer at a staff meeting on 07/21/16. Maintenance staff has added the blanket warmer to their routine monthly maintenance checklist. A temperature log will be kept on the cabinet below the unit. QAA will be updated quarterly. Completion date 07/18/16.	

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F 465	Continued From page 29 warming cabinet using the outside dial at the top of the warming cabinet as MM stated according to the signage on the door, the temperature shouldn't exceed 135 degrees F. On 6/28/16, at 2:45 p.m. rehabilitation coordinator (RC) confirmed blankets were kept in this warming cabinet and often the warm blankets were provided to residents. RC verified according to the signage on the warming cabinet door, the temperature should not exceed 138 degrees F. RC was unaware of any residents being burned from the warm blankets. RC confirmed the rehabilitation staff did not have a log or monitor the temperature of the warming cabinet routinely. On 6/28/16, at 2:47 p.m. occupational therapist (OT)-A confirmed she had created the signage that was currently taped on the door of the warming cabinet which indicated the temperature of the warming cabinet should not exceed 135 degrees F. OT-A verified this temperature parameter had been taken directly from the manufacturer's manual. OT-A confirmed the warming cabinet temperature should not exceed 135 degrees F. On 6/28/16, at 3:13 p.m. the director of nursing (DON) confirmed there had been no burns related to the blankets in the warming cabinet. The DON's expectation was that temperature parameters would be followed according to the manufacture guidelines with regards to the warming cabinet.	F 465		

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F 465	Continued From page 30 Use of heat for comfort policy [undated] indicated warm blankets may be utilized for comfort measures. The chamber of the warming cabinet should not exceed 135 degrees F. No policy related to the maintenance and monitoring of the warming cabinet was provided. In addition, the manufacture guidelines for this warming cabinet were not provided.	F 465		

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	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Fair Meadow Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/21/2016

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

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K 000	Continued From page 1 and Angela.kappenman@ state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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" 1999 edition 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 1999 edition with quick response heads. Hazardous areas have automatic fire detection that is on the	K 000		

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K 000	Continued From page 2 fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility also has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 42 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 1 resident room door and the proper latching on 2 corridor doors according to NFPA 101 LSC (00) section 19.3.6.3.1 and 19.3.6.3.2 This deficient practice could affect the safety of 16 of the 39 residents and an undetermined amount of staff	K 018	Maintenance Supervisor, Lionel Sandness, made adjustments to strike plate on rooms 40 and 42 to ensure proper latching. Completed 06/29/16. Maintenance Supervisor, Lionel Sandness, installed fire/smoke certified	7/18/16

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K 018	Continued From page 3 and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 8:10 am to 11:45 am on 06/28/2016 observations and staff interview revealed: 1. Resident room doors 40 & 42 did not latch properly. 2. Resident room door 36 did not fit tightly in the frame. This deficient condition was verified by the Maintenance Engineer	K 018	adhesive gasketing to door frame on room 36 to ensure a tight fit. Completed 07/18/16. Door fittings will be checked quarterly by Maintenance Supervisor.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper construction of 1 of 3 smoke barrier walls according to the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 16 of 39 residents and an undetermined amount of staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On the facility tour between 8:10 am to 11:45 am	K 025	Maintenance Supervisor, Lionel Sandness, filled penetrations in the smoke barrier with cement and caulking. Completion date 07/18/16.	7/18/16

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(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
K 025	Continued From page 4 on 06/28/2016 observations and staff interview revealed penetrations above the ceiling in the smoke barrier in the south wing. This deficient condition was verified by the Maintenance Engineer	K 025		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow the system being placed out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents and an undetermined amount of visitors and staff of the facility. Findings include: On the facility tour between 8:10 am to 11:45 am on 06/28/2016 observations and staff interview revealed two types of sprinkler heads, standard and quick response in the housekeeping storage	K 056	New sprinkler head was installed in the housekeeping storage room on the East Wing by ACE Fire Protection so all sprinkler heads were the same. Completed 06/29/16. Maintenance Supervisor to monitor.	6/29/16

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	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2016**

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K 056	Continued From page 5 room of the east wing This deficient condition was verified by the Maintenance Engineer	K 056		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system would function properly in the event of a fire and could negatively affect an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:10 am to 11:45 am on 06/28/2016 observations and staff interview revealed the height of storage was within 18 inches of the sprinkler deflector in the kitchen storage room. This deficient condition was verified by the Maintenance Engineer	K 062	All items were removed from the top shelf by kitchen staff. Dietary Manager re-educated dietary staff that items cannot be on the top shelf. Dietary Manager to monitor. Completed 07/18/16.	7/18/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in	K 147		7/5/16

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K 147	Continued From page 6 accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview with the staff, the facility was using an electrical devices in a manner that is not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:10 am to 11:45 am on 06/28/2016 observations and staff interview revealed two power strips plugged together in the PT office room 161. This deficient condition was verified by the Maintenance Engineer	K 147	Maintenance Supervisor, Lionel Sandness, removed one power strip from the PT office. Therapy staff was instructed that two power strips plugged together is not safe and not allowed. Completed 07/05/16.	

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 12, 2016

Ms. Angela Leiting, Administrator
Fair Meadow Nursing Home
Box 8 300 Garfield Avenue Southeast
Fertile, Minnesota 56540

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5545025

Dear Ms. Leiting:

The above facility was surveyed on June 27, 2016 through June 30, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home 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 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order.

This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at (218) 308-2104, or email: lyla.burkman@state.mn.us**.

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 if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	06/30/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 27, 28, 29, 30th 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to apply a CPAP machine as directed by the care plan for 1 of 3 residents (R26) who utilized a CPAP at night for breathing and required assistance with application. In addition, the facility failed to provide oral hygiene as directed by the care plan for 1 of 6 residents (R47) in the sample who required assistance with oral hygiene. Lastly, the facilty failed to provide timely positioning assistance as directed by the care plan for 1 of 3 residents (R2) who required assistance with positioning. Findings include: R26's CPAP was not placed on R26 at night as directed by the care plan.	2 565	CORRECTED	7/21/16

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2 565	Continued From page 3 R26's care plan dated 2/6/16, indicated R26 had altered respiratory status related to sleep apnea (a disorder where a person has one or more pauses in breathing or shallow breathing while sleeping) and utilized a continuous positive airway pressure machine (CPAP) used to help a person with sleep apnea breathe more easily during sleep. The interventions indicated R26's CPAP settings were positive pressure with a nasal pillow and oxygen and directed staff to apply the CPAP every night at bedtime. R26's NA (nursing assistant) care guide dated 6/28/16, indicated R26 had a CPAP machine which was supposed to be setup and started every night at bedtime. The NA's were directed to report when R26 refused to use the CPAP. On 6/29/16, at 5:37 a.m. R26 was observed sleeping in the recliner in R26's room. R26 had oxygen on via nasal cannula, however R26's CPAP was not placed. On 6/29/16, at 5:47 a.m. trained medication aide (TMA)-B who worked the night shift confirmed R26 did not currently have a CPAP on nor had R26 had it on during the night time. TMA-A stated R26 often refused to wear the CPAP at night. On 6/29/16, at 11:19 a.m. registered nurse (RN)-A confirmed R26 had a diagnosis of sleep apnea and the care plan directed staff to place the CPAP on R26 at bedtime. RN-A confirmed	2 565		

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2 565	Continued From page 4 the NA care guide was an extension of the care plan and R26's NA care guide and written care plan should have been followed. On 6/29/16, at 12:10 p.m. the director of nursing (DON) confirmed R26's care plan and NA care guide were correct regarding R26's CPAP and it was the expectation that R26's care plans be followed. R47 was not provided assistance with oral hygiene as directed by the care plan. R47's care plan dated 6/18/16, indicated R47 had upper and lower dentures and required assist of one staff to complete oral hygiene. On 6/28/16, at 7:05 am. NA-I was observed to provide R47 morning cares. During the observation, NA-I was observed to hand R47 upper and lower dentures without providing or offering the opportunity to cleanse mouth/ brush remaining teeth prior to the insertion of the dentures. Following the completion of the morning cares, NA-I remained in her room, seated in a wheelchair. At no time did NA-I offer R47 the opportunity to rinse or swab her mouth prior to inserting the clean dentures. On 6/29/16, at 10:30 a.m. NA-I verified oral hygiene was not completed prior to inserting R47's dentures. NA-I stated she should have offered her oral hygiene. On 6/29/16, at 10:15 a.m. RN-A verified R47's care plan was correct and oral hygiene should have been provided.	2 565		

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2 565	Continued From page 5 On 6/29/16, at 10:35 a.m. the DON verified R47's care plan was correct and stated oral hygiene should have been provided, as directed. R2 was not provided assistance with every 1.5 hours repositioning as directed by the care plan. R2's care plan dated 6/23/16, indicated R2 was at risk for pressure ulcers and directed staff to anticipate R2's cares/needs and to turn and reposition R2 at least every 1 1/2 hours or more often as needed. On 6/29/16, at 6:50 a.m. NA-I and NA-J were observed to provide R2's morning cares. -At 6:55 a.m. R2 was transferred from bed via Hoyer lift to the wheelchair and assisted to the dining room by NA-J. -At 7:45 a.m. until 8:55 a.m. R2 remained in the dining room, seated in the wheelchair. -At 8:55 a.m. activity aide-A was observed to wheel R2 to activities in the activity room. -At 9:15 a.m. NA-I wheeled R2 to her room. -At 9:20 a.m. NA-I and NA-J transferred R2 to bed via the hoyer lift. This was two hours and 25 minutes from last repositioning. At this time, NA-I verified R2 should be repositioned 1 1/2 hrs. On 6/30/16, at 10:20 a.m. RN-B. verified R2's care plan was correct and staff should have repositioned R2 every 1 1/2 hours, as directed. On 6/30/16, at 10:30 a.m. the DON verified R2's care plan was correct and R2 should have been provided repositioning assistance every 1 1/2 hours. Fair Meadow Care Plan Policy and Procedure dated 1/16, indicated a written plan of care would	2 565		

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2 565	Continued From page 6 be developed for each resident in coordination with all services and individuals involved with the care of the resident. Each department head would be responsible to see that their portion of the resident's care plan was implemented. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could schedule an inservice to discuss the importance of following the care plan for residents. The quality assurance committee could randomly audit resident records to ensure compliance. The Director of Nursing could review and revise policies and procedures for care delivery systems and provide additional training to involved staff. A designated staff could monitor the system to assure care plans are being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by:	2 905		7/21/16

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2 905	Continued From page 7 Based on observation, interview and document review, the facility failed to ensure every 1.5 hours repositioning was provided as directed by the care plan for 1 of 3 residents (R2) identified at risk for the development of a pressure ulcer and required staff assistance to reposition. Finding include: R2's annual Minimum Data Set (MDS) dated 6/8/16, indicated R2 was diagnosed with cerebrovascular accident (CVA) transient ischemic attack (TIA) and osteoarthritis. The MDS also indicated R2 had impaired cognition, was at risk for the development of pressure ulcers, required a turning and repositioning program and required extensive assistance of staff for bed mobility and transfers. R2's Pressure Ulcer Care Area Assessment (CAA) dated 6/13/16, indicated R2 was at risk of developing pressure ulcers, required extensive assistance for bed mobility and staff were to provide repositioning every 1 1/2 hours. R2's Skin Review assessment dated 6/7/16, indicated R2 was at risk for developing pressure ulcers due to impaired mobility, incontinence and cognitive defects, required extensive staff assistance for bed mobility and transfer, and required repositioning assistance ever 1 1/2 hours. R2's Care Plan dated 6/23/16, indicated R2 was at risk for pressure ulcers and directed staff to	2 905	CORRECTED	

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2 905	Continued From page 8 anticipate R2's cares/needs and to turn and reposition R2 at least every 1 1/2 hours or more often as needed. On 6/29/16, at 6:50 a.m. NA-I and NA-J were observed to provide R2 morning cares. -At 6:55 a.m. both NA's transferred R2 from the bed into the wheelchair via a mechanical full lift. NA-J wheeled R2 to the dining room. - At 7:45 a.m. R2 was observed in dining room seated in the wheelchair, asleep. R2 was observed to remain seated in the wheelchair, in the dining room until 8:55 a.m. -At 8:55 a.m. activity aide-A was observed to wheel R2 to activities in activity room. - At 9:15 a.m. NA-I wheeled R2 to her room. - At 9:20 a.m. NA-I and NA-J transferred R2 to bed via the mechanical lift (two hours and 25 minutes since last repositioning assistance). At this time, NA-I verified R2 should have been positioned every 1.5 hours. On 6/30/16, at 10:20 a.m. registered nurse (RN)-B verified R2's care plan was correct and R2 should have been repositioned every 1.5 hours. On 6/30/16, at 10:30 a.m. the director of nursing (DON) verified R2's care plan was correct and stated R2 should have been provided repositioning every 1.5 hours. The facility policy, Repositioning, Toileting	2 905		

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2 905	Continued From page 9 schedule, dated 1/16, indicated staff would provide repositioning and also mark the time on their schedule. Staff would provide an opportunity for motion every two hours unless on another individualized schedule and/or if the individual care plan indicates a different plan was more appropriate. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident Care Plans are followed by staff for timely positioning of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral hygiene services as directed by the care plan for 1 of 6	2 920	CORRECTED	7/21/16

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2 920	Continued From page 10 residents (R47) in the sample who required assistance with oral hygiene and was observed to not receive the service. Findings include: R47's significant change Minimum Data Set (MDS) dated 3/21/16, indicated R47 had diagnoses of heart failure and depression. The MDS also indicated R47 had impaired cognition and required extensive assistance for mobility, dressing and personal hygiene. The MDS further indicated R47 had no dental concerns. R47's ADL [activities of daily living] Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 3/21/16, indicated R47 required extensive assistance with dressing, grooming, and physical assistance with bathing due to weakness and poor coordination. R47's care plan dated 6/18/16, indicated R47 had upper and lower dentures and required assist of one staff to complete oral hygiene. On 6/28/16, at 7:05 am. nursing assistant (NA)-I was observed to provide R47 morning cares. During the observation, NA-I was observed to hand R47 upper and lower dentures without providing or offering the opportunity to cleanse mouth/ brush remaining teeth prior to the insertion of the dentures. Following the completion of the morning cares, NA-I remained in her room, seated in the wheelchair. At no time did NA-I offer R47 the opportunity to rinse or	2 920		

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2 920	Continued From page 11 swab her mouth out prior to inserting the clean dentures. On 6/29/16, at 10:30 a.m. NA-I verified oral hygiene was not completed prior to inserting R47's dentures. NA-I stated she should have offered her oral hygiene. At 10:15 a.m. RN-A verified R47's care plan was correct and oral hygiene should have been provided, as directed. At 10:35 a.m. the director of nursing (DON) verified R47's care plan and stated oral hygiene should have been provided, as directed. The Oral Hygiene policy for resident's who have no teeth or have dentures, dated 6/2016, directed the staff to provide oral hygiene ever morning and at bedtime. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and revise policies and procedures related to the provision of oral hygiene cares. The DON or designee could education staff and develop a monitoring system to ensure compliance. The quality assurance committee could randomly audit resident's cares to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		

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21375	Continued From page 12	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene was completed for 2 of 6 (R20, R27) residents observed for personal cares. Findings include: R20's quarterly Minimum Data Set (MDS) dated 4/27/16, indicated R20 was diagnosed with a stroke and dementia. The MDS also indicated R20 had severe cognitive impairment, had limited range of motion of upper extremities, and required extensive assistance with all activities of daily living. On 6/29/16, at 6:14 a.m. nursing assistant (NA)-B was observed to assist R20 with morning cares. NA-B was observed to use a washbasin to provide R20 with a partial bath. -At 6:17 a.m. NA-B provided R20 with perineal cares while wearing gloves. Once NA-B replaced R20's incontinent brief, she removed her gloves and proceeded to dress R20 and allowed her to rest in bed. -At 6:19 a.m. NA-B picked R20's dirty laundry and garbage bags, opened R20's door, walked across the hallway to the utility room, opened the door, placed the bags into the appropriate receptacles, opened the door to the utility room and walked	21375	CORRECTED	7/21/16

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21375	Continued From page 13 towards the clean laundry closet. At no time was NA-B observed to attempt to wash her hands after completing the perineal care and the removal of her gloves. -At 6:22 a.m. NA-B began to open the clean utility closet. She verified she had not washed her hands. She stated she did not need to wash them as she had worn gloves during the cares and had removed them. She stated she would wash her hands prior to assisting the next resident. NA-B was then observed to return to the utility room and wash her hands. On 6/29/16, at 12:05 p.m. registered nurse (RN)-B stated the direct care staff were to wash their hands after providing personal cares and the removal of gloves. The Hand Washing policy dated 1/2016, directed the direct care staff to wash their hands between resident cares and whenever direct physical contact with the resident was completed. R27's 30 day MDS dated 5/24/16, indicated R27 had cognitive impairment, functional limitation of upper and lower extremities, and required extensive assist with toileting and personal hygiene. R27's undated, Admission Skin Monitoring assessment indicated R27 had a rash-red sore groin area. R27's Physician order dated 6/29/16, directed staff to use barrier cream and Tolnoaftate cream (antifungal medication) twice daily until rash was gone, and to keep foley catheter in until rash	21375		

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21375	Continued From page 14 resolved. On 6/29/2016, at 5:30 a.m. trained medication assistant (TMA)-D was observed to provide R27 a partial bed bath. TMA-D washed her hands and gloved. TMA-D proceeded to provide bathing to R27's upper body. -At 5:40 a.m. TMA-D lowered R27's bed, picked up the water basin from the over the bed table and took it to the sink and drained the water, rinsed out the water basin and refilled it with water. TMA-D was not observed to remove gloves and wash hands. TMA-D turned to return the basin to the over bed table and in doing so, spilled water from the basin onto the floor. TMA-D obtained paper towels from the sink area and proceeded to wipe up the water from the floor with her same gloved hands. TMA-D obtained additional paper towels and continued to wipe up the water on the floor. TMA-D proceeded to open R27's room door with her same gloved hand and asked staff in the hall to bring in additional towels to finish wiping the water up from the floor. With the same gloved hands, TMA-D obtained a wash cloth, dipped it in the wash basin and proceeded to provide R27 with perineal cares. TMA-D was not observed to remove her gloves and wash her hands after wiping up the floor and providing perineal cares to R27. On 6/29/2016, at 5:59 a.m. TMA-D verified she did not remove her gloves and wash her hands after cleaning up the spilled water from the floor and before or after providing R27 personal cares and stated she should have done so. On 6/29/2016 at 11:35 a.m. the director of nursing (DON) confirmed R27 had skin issues and stated	21375		

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21375	Continued From page 15 the TMA should have removed her gloves and washed her hands. The DON also stated the facility had training on hand washing and it was her expectation that staff provide good pericare and appropriate hand washing and gloving. The facility's Hand Washing Policy, dated 1/16, directed staff to wash hands after contact with environmental surfaces or equipment in the immediate vicinity of the resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could in-service employees responsible for the infection control program to provide in-services for hand washing to ensure hand hygiene safety and cleanliness is provided. The DON or designee could implement a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and	21426		7/21/16

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21426	Continued From page 16 unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure two-step tuberculosis skin testing (TST) was completed timely for 3 of 5 nursing assistants (NA-F, NA-G and NA-H) upon hire, as required. Findings include: The facility's Tuberculosis Testing for Employees policy dated 1/2016, directed the staff to receive a two step TST upon hire. The bottom of the TST documentation sheet directed the staff "If results are negative, perform the second step in one to three weeks." NA-F was hired on 2/1/16. The TST testing documentation indicated NA-F received the first test on 2/1/16. The second step TST was administered on 4/10/16.	21426	CORRECTED	

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21426	Continued From page 17 NA-G was hired on 1/22/16. The TST testing documentation indicated NA-G received the first step TST on 1/22/16. The second step TST was completed on 3/12/16. NA-H was hired on 1/2/16. The TST testing documentation indicated NA-H received the first step TST on 1/22/16. The second step TST was completed on 3/25/16. On 6/20/16, at 8:30 a.m. the director of nursing reviewed the aforementioned employees TST results. She verified the employees did not receive the second step TST's as directed by the facility policy. She stated each of the employees may have had special circumstances which prevented them from receiving the second step TST timely, but verified there was no documentation indicating why they did not receive them as directed. She confirmed the second step TST was to be completed within three weeks as directed by the policy. SUGGESTED METHOD OF CORRECTION: The DON or infection control preventionist could ensure the facility policies reflect current standards, and practices as directed by the center for disease control related to tuberculosis testing of employees. An audit procedure could be implemented, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one	21426		

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21426	Continued From page 18 (21) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the ability to self administer nebulizer inhalation medication for 1 of 1 (R20) resident in the sample observed to self administer nebulizer medicaiton without an assessment completed. Findings include: R20's quarterly Minimum Data Set (MDS) dated 4/27/16, indicated R20 had severe cognitive impairment, required extensive assistance with all activities of daily living and had limited range of motion in her upper extremities. R20's Physician Order dated 6/2/16, revealed an order for Albuterol 2.5 milligrams in three milliliters of saline inhale to be administered via a nebulizer mask four times a day as needed for shortness of breath. The physician had not indicated R20 had the ability to self administer her medications.	21565	CORRECTED	7/21/16

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21565	Continued From page 19 R20's care plan dated 12/24/13, indicated R20 was at risk for aspiration pneumonia related to sever dysphagia (difficulty swallowing) and history of aspiration pneumonia. The plan directed staff to administer nebulizer treatments as needed. The care plan did not address self administration of nebulizer treatments. During observation on 6/28/16, at 2:11 p.m. R20 was observed in bed with a nebulizer mask secured to her face with an elastic strap. The nebulizer treatment had been completed, yet the machine was still running. R20 was not observed to attempt to remove the mask independently. -At 2:15 p.m. nursing assistant (NA)-A and NA-K entered the room to assist R20 to get out of bed. NA-A was observed to shut the nebulizer machine off and remove the mask. -At 2:20 p.m. NA-A stated she would occasionally shut off the nebulizer machines when directed by the nursing staff. On 6/28/16, at 2:22 p.m. trained medication administration (TMA)-A stated she had just received change of shift report from licensed practical nurse (LPN)-C. She stated LPN-C had informed her that the nebulizer treatment had been started at 1:45 p.m. She stated she assumed the treatment had been completed and had not been directed to follow up with the treatment. She stated a nebulizer treatment usually took 5-15 minutes to complete and the staff were to stay with R20 until the treatment had been completed. On 6/28/16, at 2:30 p.m. LPN-C stated she had started the nebulizer treatment at 1:50 p.m. and had instructed NA-A to shut the machine off when it was done.	21565		

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21565	Continued From page 20 R20's medical record lacked a self administration assessment. On 6/29/16, at 12:00 p.m. registered nurse (RN)-B stated R20 did not have the ability to use her hands due to arthritic changes. She stated R20 did not have the physical ability to remove the nebulizer mask independently, therefore, she could not safely self administer the nebulizer medication. She stated the medication staff were to stay with R20 during the treatment to ensure it had been administered correctly. RN-B stated a nebulizer treatment took approximately 5-15 minutes to administer and staff were to evaluate R20 to ensure the medication was effective. She stated the nursing assistants were not to be shutting the nebulizer treatments off as the resident may require re-evaluation following the treatments. The undated Self Administration of Nebulizer policy directed the staff to complete a self-administration assessment prior to allowing the resident to self administer their own treatment. It also directed the staff to check and return to the room every five minutes to shut off the nebulizer or assist the resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee ensure the appropriate assessments are conducted to ensure the safe administration of medications. The DON could ensure the staff were educated on the importance of the assessment process. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place. The DON could could random audits to ensure medication is not left with residents unless	21565		

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21565	Continued From page 21 deemed safe by the interdisciplinary team. Results of these audits could then be presented at the quarterly QA&A meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21580	MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements Subp. 7. Administration requirements. The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered according to manufacturer's recommendations for 1 of 1 resident (R7) who received medication via a metered dose inhaler. Findings include: R7's Physician's Orders dated 6/29/16, included an order for Flovent one inhalation twice a day (rise mouth after each use). On 6/27/16, at 4:45 p.m. licensed practical nurse (LPN)-A was observed to hand R7 a metered dose inhaler. R7 was observed to self administer	21580	CORRECTED	7/21/16

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21580	Continued From page 22 the inhaler and handed the cartridge back to the LPN. LPN-A did not offer or suggest R7 swish/rinse her mouth. The manufacture's (Glaxo Smith Kline) medication packaging insert dated 12/2014, directed the patients using Flovent to rinse their mouth with water after breathing in the medicine. If further directed the patient to spit out the water verse swallowing. On 6/27/16, at 5:00 p.m. LPN-A verified she had not directed R7 to rinse her mouth following the administration of the medication. On 6/28/16, at 2:30 p.m. registered nurse (RN)-A stated she had reviewed the medication package insert and verified R7 was to be cued to rinse her mouth after the administration of the inhaled medication. The Inhalation Therapy Policy dated 1/2016, directed the staff to administer inhalers according to the physician orders and following the inhalation mouth was to be rinsed with water. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or pharmacist could in-service all employees responsible for inhalation medication administration to follow facility policies and manufacturer recommendation to safely administer medications to residents. The director of nursing or designee could conduct random observational audits to ensure compliance.	21580		

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	00460	A. BUILDING: _____ B. WING _____	06/30/2016

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21580	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21580		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the warming cabinet was safely maintained. This had the potential to affect all 39 residents who resided in the facility. Findings include: During the initial facility tour on 6/27/16, at 1:35 p.m. the outside digital temperature reading on the warming cabinet in the physical therapy area read 138 degrees Fahrenheit (F). Two signs were posted on the door of the warming cabinet which indicated the warming cabinet should not exceed 135 degrees F. On 6/27/16, at 4:37 p.m. the warming cabinet temperature read 138 degrees F.	21685	CORRECTED	7/21/16

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21685	Continued From page 24 On 6/28/16, at 8:33 a.m. the warming cabinet temperature read 137 degrees F. On 6/28/16, at 2:31 p.m. the warming cabinet temperature read 138 degrees F. On 6/28/16, at 2:37 p.m. the maintenance manager (MM) verified the warming cabinet temperature read 138 degrees F and that this was the temperature of the inner chamber of the warming cabinet. MM stated the maintenance department did not have on their radar to monitor the temperatures of this piece of equipment. MM proceeded to lower the temperature of the warming cabinet using the outside dial at the top of the warming cabinet as MM stated according to the signage on the door, the temperature shouldn't exceed 135 degrees F. On 6/28/16, at 2:45 p.m. rehabilitation coordinator (RC) confirmed blankets were kept in this warming cabinet and often the warm blankets were provided to residents. RC verified according to the signage on the warming cabinet door, the temperature should not exceed 138 degrees F. RC was unaware of any residents being burned from the warm blankets. RC confirmed the rehabilitation staff did not have a log or monitor the temperature of the warming cabinet routinely. On 6/28/16, at 2:47 p.m. occupational therapist (OT)-A confirmed she had created the signage that was currently taped on the door of the warming cabinet which indicated the temperature	21685		

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21685	Continued From page 25 of the warming cabinet should not exceed 135 degrees F. OT-A verified this temperature parameter had been taken directly from the manufacturer's manual. OT-A confirmed the warming cabinet temperature should not exceed 135 degrees F. On 6/28/16, at 3:13 p.m. the director of nursing (DON) confirmed there had been no burns related to the blankets in the warming cabinet. The DON's expectation was that temperature parameters would be followed according to the manufacture guidelines with regards to the warming cabinet. Use of heat for comfort policy [undated] indicated warm blankets may be utilized for comfort measures. The chamber of the warming cabinet should not exceed 135 degrees F. No policy related to the maintenance and monitoring of the warming cabinet was provided. In addition, the manufacture guidelines for this warming cabinet were not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise policy and procedures related to the monitoring and maintenance of the warmer. The director of nursing or designee could provide staff education and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

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21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the	21830		7/21/16

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21830	Continued From page 27 resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social	21830		

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21830	Continued From page 28 service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based observation, interview and document review, the facility failed to ensure the morning routines of each resident matched those of their previous lifestyle or provided with family approval for 2 of 3 residents (R2, R16) who received total morning cares during the hours of sleep. Findings include: R2 was provided total morning cares at 4:30 a.m. without the directive and family's approval for morning cares to be provided during hours of sleep. R2's annual Minimum Data Set (MDS) dated 6/8/16/16, indicated R2's diagnosis included dementia, cardiovascular attack (CVA), hemiplegia, and anxiety and was cognitively impaired. The MDS indicated R2 required extensive staff assistance for dressing, personal hygiene, eating, and toileting. The MDS indicated R2 was non-ambulatory and required total assist from staff for transfers. R2's care plan revised 6/23/16, indicated R2 required staff assist with all activities of daily living.	21830	CORRECTED	

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21830	Continued From page 29 On 6/29/16, at 5:30 a.m. R2 was observed sleeping in her bed, fully dressed. At 6:50 a.m., nursing assistant (NA)-I and NA-J assisted R2 from her bed to the wheelchair via a full body mechanical lift. NA-I stated R2 had received morning cares by the night shift staff at approximately 4:30 a.m. each morning to help the day staff out with their work load. On 6/29/16, at 6:15 a.m. trained medication assistant (TMA)-D stated the night shift was assigned to assist three residents with morning cares on the south wing prior to leaving at 7:00 a.m. and verified R2 was routinely provided morning cares at 4:30 a.m. On 6/30/16, at 8:05 a.m. NA-I stated the night shift provided cares and dressed three residents on the south wing because the south wing's work load was very heavy and the NA's had to have all the residents in the dining room by 9:00 a.m. for breakfast. On 6/30/16, at 8:20 a.m. licensed practical nurse (LPN)-D verified the night shift staff typically completed R2's morning cares at approximately 4:30 a.m. each morning. On 6/30/16, at 9:15 a.m. R2's husband stated he was unaware of his wife being provided morning cares and being dressed at 4:30 a.m. R2's spouse stated R2 had never gotten up that early and maybe that was why she [R2] was so sleepy when he came to visit. R2's husband stated he had not given the facility the permission or had been asked for family's input on providing care for his wife at 4:30 a.m. On 6/30/16, at 9:45 a.m. registered nurse (RN)-B verified R2's care plan did not address R2 being	21830		

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21830	Continued From page 30 provided cares at 4:30 a.m. On 6/30/16, at 10:15 a.m. the director of nursing (DON) confirmed R2's care plan and stated staff should not be providing cares to the residents' that were sleeping. R16 was provided total morning cares at 4:30 a.m. without the directive and family's approval to provide morning cares during hours of sleep. R16's quarterly MDS dated 4/13/16, indicated R16 was diagnosed with dementia and a stroke. The MDS also indicate R16 was cognitively impaired, required extensive staff assistance for dressing, eating, and toileting, was non-ambulatory and required total assist from staff for transfers and personal hygiene. R16's care plan revised 4/19/16, indicated R16 required staff assist with all activities of daily living. On 6/29/16, at 5:30 a.m. R16 was observed sleeping in her bed fully dressed. -At 6:55 a.m. NA-I and NA-J were observed to assist R16 from her bed to the wheelchair via a full body mechanical lift. NA-J stated R16 had received morning cares by the night shift staff at approximately 4:30 a.m. On 6/29/16, at 6:15 a.m. TMA-D stated the night shift was assigned to assist three residents with morning cares on the south wing prior to leaving at 7:00 a.m. and verified R16 was routinely provided morning cares at 4:30 a.m. On 6/30/16, at 8:20 a.m. LPN-D verified the night shift staff typically completed R16's morning cares at approximately 4:30 a.m. each morning.	21830		

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21830	Continued From page 31 On 6/30/16, at 9:20 a.m. R2's daughter stated she was unaware of her mother getting dressed and being provided morning cares at 4:30 a.m. R16's daughter stated she had not given the facility the permission or had been asked for family's input on providing care for her mother at 4:30 a.m. On 6/30/16, at 9:45 a.m. RN-A verified R16's care plan did not include a directive to provide morning cares during the hours of sleep. The facility policy, Self Determination and Participation, undated, indicated the facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Gathered information about the resident's personal preference would be documented in the medical record. Family members of the resident shall be included and informed regarding resident choices. SUGGESTED METHOD OF CORRECTION: The director of nursing [DON] or designee could develop a procedure to ensure resident daily schedule preferences related to the timing of morning cares were assessed, care planned and implemented. DON or designee could educate all staff about honoring resident choices. DON or designee could audit for continued compliance and report results to the facility quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		