DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 17, 2024

Administrator
Fair Meadow Nursing Home
300 Garfield Avenue Southeast
Fertile, MN 56540

RE: CCN: 245545
Cycle Start Date: August 27, 2024

Dear Administrator:

On October 9, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 17, 2024

Administrator
Fair Meadow Nursing Home
300 Garfield Avenue Southeast
Fertile, MN 56540

Re: Reinspection Results
Event ID: EUVX12

Dear Administrator:

On October 9, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 27, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2024

Administrator
Fair Meadow Nursing Home
300 Garfield Avenue Southeast
Fertile, MN 56540

RE: CCN: 245545
Cycle Start Date: August 27, 2024

Dear Administrator:

On August 27, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 27, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 27, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	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
E 000	Initial Comments On 8/25/24 to 8/27/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance.	E 000		
F 000	INITIAL COMMENTS On 8/25/24 to 8/27/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not	F 604		10/3/24

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

Electronically Signed | 09/13/2024

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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F 604	Continued From page 1 required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based observation, interview and document review, the facility failed to ensure a comprehensive reassessment was completed to ensure seat belt use was still warrented for identified medical symptoms; and failed to release the seatbelt according to care planned interventions for 1 of 1 residents (R9) reviewed for restraints. Findings include: R9's quarterly Minimum Data Set (MDS) dated 8/7/24, identified R9 had a severe cognitive impairment, had diagnoses that included	F 604	To ensure R-9□s seat belt restraint when sitting up in her wheelchair is warranted as identified for her medical symptoms. Physical Restraint Elimination Assessment Form of 8/7/2024 was reviewed and update 9/9/2024 to reflect the addition of R-9□s antianxiety medication, Trileptal. This increased R9□s score to 36 as a Poor Candidate for Elimination of the seat belt restraint. R9□s Physical Restraint Elimination Assessment will be completed, reviewed	

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F 604	Continued From page 2 Alzheimer's disease, anxiety disorder, and psychotic disorder with delusions. R9 used a chair that prevented rising every day, and did not identify a trunk restraint. R9 used antipsychotic and antianxiety medications. R9's care plan revised 6/19/22, identified R9 required use of physical restraints: seat belt in a tilt-in-place wheelchair for positioning related to Alzheimer's dementia and R9 leaned forward in her wheelchair. Fall at home prior to admit with Fracture. R9 was continually reaching to her feet or leaning over in wheelchair attempting to fix her pants. R9 was a seamstress and did a lot of sewing for work. R9 continued to think she is sewing, hemming up her pants or picking up pins, etcetera. R9 had poor safety awareness. OT provided with new tilt and space type excessive leaning to be used as needed to assist with eating, hair cares, family visits. R9's family representative was aware. The care plan directed the following: - Discuss and record with R9/family/caregivers, the risks, and benefits of the restraint, when the restraints should be applied, routines while restrained and any concerns or issues regarding restraint use. - Ensure R9 was positioned correctly with proper body alignment while restraint was being used: seatbelt in wheelchair daily. Remove seatbelt with care, meals as able, one-on-one with staff, activities, toileting, etc. Fill out restraint release form every shift. - Seatbelt released with repositioning, 1:1 visit when calm, with toileting, when in bed and walking, etc. Document restraint use and release as per facility protocol. - Ensure valid consent on chart prior to initiating restraint.	F 604	by 2 RNs for accuracy, and reviewed quarterly at resident□s care conference (R9 is the only resident with a Physical Restraint Elimination Assessment). Education to the RN□s and Unit Coordinators on accuracy of completing the Physical Restraint Elimination Assessment Form was completed by the DON. R-9□s Comprehensive Assessment Summary was updated, by the DON, to reflect accurate documentation of the seat belt restraint, medical symptom(s) for restraint use, time and frequency of the restraint use and release, specific areas of direct monitoring, what determines continued or discontinued use of restraint. A Restraint-Physical Comprehensive (Quarterly Annual Evaluation) was added to forms in Point Click Care to be completed quarterly, annually, or with significant change, and will be reviewed at R9□s care conference and with family/responsible party. The Physical Restraint Elimination Form and Comprehensive Assessment Summary will be updated as needed and with a significant change in R9□s condition, reviewed quarterly and with family/responsible party at R9□s care conference, and documented in Point Click Care. Education on accuracy of completing R9□s Comprehensive Assessment and Physical Restraint Elimination Form	

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F 604	Continued From page 3 - Evaluate/record continuing risks/benefits of restraint; alternatives to restraint, need for ongoing use, reason for restraint use. Staff were to chart time seatbelt was off. - R9 needed a safe environment with adequate, glare-free light; floors that are even and free from spills or clutter; call light or alarm system; personal items within reach; bed in low position when locked. - R9 needed opportunities for restraint-free time and physical activity daily. Walking, toileting, transfers in and out of bed to rest. When sleeping or not restless place in wheelchair, etc. Per restraint committee, R9 was to have an activity staff remove during 1:1 visit, document time off and how tolerated. - R9 needed to have restraint applied daily. Seatbelt released: with repositioning, with 1:1 visit when calm, with toileting, when in bed, and walking, etc. Document restraint use and release as per facility protocol. Fill out restarting release form every shift. Family signed consent form. R9 used a tilt-in-space wheelchair with a footrest. Assure R9's hips were equally aligned in chair and all the way back. Calf pad placed over footrests when R9 was sitting up in her wheelchair. Do not turn your back on R9 if seat belt was off. Restraint reduction committee to look at ways to help reduce use of restraints and possible discontinue if able. Review quarterly/as needed. Nursing rehab to have her stretch daily on bed in therapy room. Try during activities to take seat belt off during 1:1 and observe closely as able and report skin breakdown. - Monitor/document/report to MD PRN changes regarding effectiveness of restraint, less restrictive device, if appropriate; any negative or adverse effects noted, including decline in mood, change in behavior, decrease in ADL	F 604	pertaining to medical symptom(s) for restraint use, proper use of and release of seat belt restraint, time and frequency of the restraint use and release, monitoring behaviors that determine continued or discontinued use of restraint, documentation of identified behaviors when in wheelchair with seat belt restraint for the Unit Coordinators, RNs, LPNs, TMAs, CNAs, provided by the DON. Education on documentation of identified behaviors when resident is sitting in wheelchair provided to nursing staff by Social Service Designee. Social Service Designee will audit behavior charting for identification of behaviors when R9 is sitting in wheelchair with seat belt on. Revision of Restraint Reason & Release Form was completed to reflect the specific monitoring of the restraint, type of restraint, time and frequency of use and release of restraint, and who provided the monitoring for R9 and/or for other residents with a restraint. Education to nursing staff on the revised Restraint Reason & Release Form completed by the DON. Medical Records Lpn Clerk, completed an audit of all residents to identify residents with restraints, type of restraints, like residents with seat belt restraints, for review and update of assessments and care plans as needed. Audit determined	

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F 604	Continued From page 4 self-performance, decline in cognitive ability or communication, contracture formation, skin breakdown, signs/symptoms of delirium, falls/accidents/injuries, agitation and/or weakness. The undated nurse aide care sheet, identified R9 used a seatbelt when in wheelchair but provided no other direction for staff, such as when it should be used and released. R9's Order Summary Report dated 3/2/21, identified a physician order for Assistive Device: Seat belt on rocking wheelchair (agitation, hallucination, increased restless, leaning, falls) for resident safety. Shoulder strap as needed to help with proper positioning. Remove for care, toileting, 1-1 with staff. R9's physician visit notes 10/10/23 through 7/17/24, failed to address R9's need for continued physical restraint. R9's Physical Restraint Elimination Assessment form dated 8/7/24, identified the following categories of evaluation: ambulation, weight bearing, sitting balance, ADLs (bathing dressing, grooming), physical limitations, orientation, comprehension, behavior/mood, activity participation and medication therapy. The form included the following scoring: 0-20 priority candidate, 21-35 good candidate and 35 plus poor candidate. R9 was complete bedrest/chairbound, non-weight bearing, leaned to the side, forward and backward, required total assist of two, had a history of falls, was legally blind, was disoriented to person place and time, was combative and severely agitated, unable to actively participate in activities and was currently	F 604	there were no other residents with seat belt restraints. Audits r/t behavior charting and accuracy for restraint release will be completed; daily for 1 week, 3 times a week for 4 weeks, 2 times a week for 3 weeks, 1 time a week for 1 week. Audits will be reviewed for compliance or the need to continue audits and reviewed at QA&A meeting.	

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F 604	Continued From page 5 taking antipsychotics. R9's score was 31 indicating R9 was a good candidate for restraint elimination. However, the assessment identified R9's score was "good" but R9 was not a candidate for restraint reduction or elimination program because R9 wore a seatbelt when sitting up in her wheelchair, video monitoring, used when R9 was in her room, with her bed in low position with a mat on the floor, but did not include supporting information to the frequency of the medical symptoms while seated in the chair warranting continued use without trialing a restraint reduction. R9 was legally blind with a diagnosis of Alzheimer's disease, delirium, psychotic disorder. R9 was unaware of safety or had poor safety awareness The assessment lacked the length of time the restraint is anticipated to be used to treat the medical symptom, the identification of who may apply the restraint, where and how the restraint is to be applied and used, the time and frequency the restraint should be released, and who may determine when the medical symptom has resolved in order to discontinue use of the restraint; the type of specific direct monitoring and supervision provided during the use of the restraint, including documentation of the monitoring; the identification of how the resident may request staff assistance and how needs will be met during use of the restraint, such as for re-positioning, hydration, meals, using the bathroom and hygiene; and the resident's record includes ongoing re-evaluation (based on supporting data) for the need for a restraint and is effective in treating the medical symptom. R9's Behavior/Mood sheets identified the following: - February 2024, R9 exhibited crying/weepy,	F 604		

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F 604	Continued From page 6 taking off clothes, kicking, hitting, punching, picking at things not there, talking to herself, crawling out of bed, wakeful at night, hallucinating, difficulty with transfers, calling staff names, refusing cares, and screaming x 6. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair. - March 2024, R9 exhibited crying/weeping and kicking, hitting, punching x 1. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair. - April 2024, R9 exhibited no behaviors. - May 2024, R9 exhibited taking clothes off x 2, throat punching during cares x 1, picking at things not there, talking to herself, crawling out of bed, and screaming x 1. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair. - June 2024, R9 exhibited no behaviors. - July 2024, kicking, hitting, punching, and calling staff names x 3. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair. During an interview on 8/25/24 at 1:14 p.m., family member (FM)-A stated R9 had a history of falls. R9 used a low bed with a mat on the floor and used a seatbelt when she was in her wheelchair. FM-A stated the seatbet was used so R9 couldn't fall out of her wheelchair and FM-A was ok with that because it kept R9 safe. During an observation on 8/25/24 at 5:22 p.m., R9's seatbelt was not released during the supper meal with nursing assistant (NA)-G seated immediately next to R9. - At 6:58 p.m., R9 continued to sit in her wheelchair in her room. R9's seatbelt was	F 604		

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F 604	Continued From page 7 snuggly fastened over her waist. R9 was quiet, with her head hanging down and her eyes were closed. R9's hands were clasped and lying in her lap. - At 7:26 p.m., R9 continued to sit in her wheelchair with her seatbelt on. R9 exhibited no agitation and sat quietly upright in her wheelchair. On 8/26/24 at 9:22 a.m., NA-C and NA-F assisted R9 with morning cares. R9 was transferred from bed to her wheelchair using a full body mechanical lift. Once R9 was in the wheelchair, NA-F immediately fastened R9's seatbelt. R9 was cooperative with cares. NA-F stated R9 always used a seatbelt. All day, every day. Staff didn't do "anything" with it except buckle it, but staff did lay R9 down every 2 hours or so for a check and change. NA-F pushed R9's wheelchair to the common area by the front desk. R9 sat quietly upright in her wheelchair and exhibited no agitation or behaviors. - At 9:53 a.m., NA-F pushed R9's wheelchair to R9's room to assist R9 to eat breakfast. NA-F did not remove R9's seatbelt even though NA-F sat immediately next to R9. R9 sat quietly upright in her wheelchair while eating. R9 exhibited no agitation or behaviors. - At 9:54 a.m., NA-D entered the room and told NA-F she could assist R9 to eat. NA-D sat down next to R9 and began assisting R9 to eat but did not remove R9's seatbelt. R9 sat quietly eating and occasionally responded when spoken to. R9 exhibited no agitation or behaviors. - At 10:22 a.m., NA-D assisted R9 to activities. R9's seatbelt continued to remain fastened. R9 sat quietly upright in her wheelchair and exhibited to agitation or behaviors. During an observation on 8/26/24 at 4:14 p.m.,	F 604		

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	245545	A. BUILDING _____ B. WING _____	08/27/2024

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F 604	Continued From page 8 NA-B and registered nurse (RN)-A assisted R9 from her bed to her wheelchair using a full body mechanical lift. Once R9 was in her wheelchair, RN-A immediately fastened R9's seatbelt and RN-A pushed R9's wheelchair to the common area by the front desk. R9 sat quietly, upright and responded well when others greeted her. R9 exhibited no agitation or behaviors. During an interview on 8/26/24 at 4:31 p.m., NA-B stated R9's seatbelt was a safety measure because R9 was always "fidgeting". If R9 was in her wheelchair, R9 had to always have the seatbelt on. The seatbelt was to prevent R9 from falling in case staff couldn't see it. There was no time frame for removal of the seatbelt and there was no time when it wasn't needed. NA-B then stated the seatbelt was removed when staff laid her down to check for incontinence, but as soon as R9 was back in her wheelchair the seatbelt was put back on. - At 4:35 p.m., NA-B stated she had to change her answer because R9's seatbelt was checked every 30 minutes and removed every 2 hours. During an interview on 8/26/24 at 4:40 p.m., licensed practical nurse (LPN)-A stated R9's seatbelt was removed every 2 hours. R9 used the seatbelt all day, every day. The seatbelt was also removed when R9 was in reach; usually at the supper table because staff were sitting right next to R9. Staff did not remove the seatbelt when R9 was sitting at the common area even though staff were "right here but I'm busy" and R9 just got up from bed and the seatbelt can be on for 2 hours. R9 was observed sitting quietly upright in her wheelchair. R9 was quiet and exhibited no agitation or behaviors. - At 5:00 p.m., R9 was observed sitting in her	F 604		

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F 604	Continued From page 9 wheelchair with the supper table directly in front of her with the seatbelt fastened. R9 was upright and exhibited no agitation or behaviors. During an observation on 8/27/24 at 8:13 a.m., R9 was assisted to the dining room to eat her breakfast meal. Upon arrival, a clothing protector was placed on R9 but R9's seatbelt remained fastened. Activity aide (AA)-C sat down immediately next to R9 and assisted R9 to eat. R9 required total assistance and sat quietly eating; occasionally making sewing motions with her hands. During an interview on 8/27/24 at 8:45 a.m., AA-B stated staff tried to remove R9's seatbelt approximately every 2 hours depending on R9's mood. No, R9's seatbelt was not removed during breakfast but R9 had just gotten up. During an interview on 8/27/24 at 8:47 a.m., AA-C stated she did not undo R9's seatbelt even though she was seated right next to R9 because staff never remove it during meals. During an interview on 8/27/24 at 10:59 a.m., RN-A stated a restraint assessment was completed quarterly for R9's seatbelt. There really hadn't been any changes with R9. The last assessment was completed on 8/7/24, and was deemed necessary due to R9's severe agitation. R9 wasn't always severely agitated but sometimes could be a "handful" with cares. Staff determined R9 needed the seatbelt because R9 leaned way off to the side of her wheelchair and would lean down to fidget with her socks and shoes. RN-A did not believe R9 was top heavy enough to tip over her wheelchair but could tumble out of the wheelchair if not wearing the	F 604		

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F 604	Continued From page 10 seatbelt. RN-A then stated RN-A had worked at the facility for more than 3 years and R9 had never fallen out of the wheelchair during that time. Staff were able to release the seatbelt when sitting by her; like at meals or during activities. RN-A stated staff were expected to follow care planned interventions to ensure the least restrictive intervention as well as to keep R9 safe. During an interview on 8/27/24 at 11:22 a.m., the assistant director of nursing (ADON) stated she would expect staff to check R9's seatbelt every 30 minutes to ensure it was not too tight. The seatbelt should have also been removed during meals and 1:1 activity. Staff were expected to be aware of R9's safety. The facility policy Use of Restraints revised 1/3/23, identified restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. 1. "Physical Restraints" are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot, remove a device in the same way the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a	F 604		

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F 604	Continued From page 11 restraint. 3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. 4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in, bed; bed rail assessments done on admit, readmit, quarterly, & sig. changes. Some residents use bedrails for repositioning. b. Tucking sheets so tightly that a bed-bound resident cannot move. c. Placing a resident in a chair that prevents the resident from rising; and d. Placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising. 5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: a. Treat the medical symptom. b. Protect the resident's safety; and c. Help the resident attain the highest level of his/her physical or psychological well-being. 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.	F 604		

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F 604	Continued From page 12 7. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or resident representative. The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom). b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. 8. Orders for restraints will not be enforced for longer than twelve (12) hours unless the resident's condition requires continued treatment. 9. Reorders are issued only after a review of the resident's condition by his or her physician. 10. The following safety guidelines shall be implemented and documented while a resident is in restraints: a. Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident. b. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. Restraints with locking devices shall not be used. c.A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. d. The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. e. Restrained residents must be repositioned at least every two (2) hours on all shifts. 11. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether	F 604		

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F 604	Continued From page 13 they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. 12. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). 13. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. 14. Documentation regarding the use of restraints shall include: a. Full documentation of the episode leading to the use of the physical restraint. This includes not only the resident symptoms but also the conditions, circumstances, and environment associated with the episode. b. A description of the resident's medical symptoms (i.e., an indication or a characteristic of a physical or psychological condition) that warranted the use of restraints. c. How the restraint use benefits the resident by addressing the medical symptom. d. The type of the physical restraint used. e.The length of effectiveness of the restraint time; and f. Observation, range of motion and repositioning flow sheets.	F 604		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		10/3/24

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F 689	Continued From page 14 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to comprehensively assess and develop interventions for safety while using a golf cart off campus for 1 of 1 (R23) resident reviewed for safe use of a motorized golf cart. Findings include: R23's quarterly Minimum Data Set (MDS) dated 6/12/24, identified R23 had moderate cognition and was independent or needed supervision with activities of daily living (ADL). R23 had upper extremity impairment on one side and no lower extremity impairment. R23's diagnoses included Parkinson's disease with dyskinesia (mild to severe uncontrolled muscle movements). R23's progress notes dated 2/26/24 through 8/27/24, identified multiple occasions of R23 independently leaving the facility on his golf cart and driving to appointments, town, the store, and other activities. The notes identified the resident kept his cell phone on his person, however, the notes failed to identify if R23 was safe while driving the golf cart. R23's medical record lacked an assessment for safe use of a motorized golf cart to include and evaluation and analysis of the the potential hazards and risks and eliminate them, if possible and, if not possible, reduce them as much as possible. R23's care plan dated 8/25/24, failed to identify a	F 689	To ensure resident(s) safety while using a motorized golf cart off the facility premises the Powered Golf Cart Policy and Procedure was implemented 8.27.2024. Resident(s) are evaluated and assessed for their physical and mental ability and demonstrate the ability for safe operation of a motorized golf cart. The Golf Cart Skills Test Assessment for outdoor environments includes the resident(s) evaluation of and ability for safe operating skills, analysis of potential hazards and risks, elimination or reduction of hazards and risks. The Golf Cart Skills Test Assessment for using the motorized golf cart must be completed by a licensed therapist prior to the resident(s) initial use, minimally on a quarterly basis, or 2 times between the months of February to October, whichever is first. A change in condition will warrant a reassessment to determine if resident can safely operate the motorized golf cart. The Golf Cart Skills Test Assessment for outdoor environments was completed with R-23 on 8/27/2024 by Physical Therapist and the Passing results were reviewed with R-23 on 8/27/2024. R-23□s medical record and care plan were updated, and family notified of the completed assessment, and interventions	

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F 689	Continued From page 15 focus, goals, or interventions for safe use of a cart. On 8/25/24 at 1:37 p.m., R23 stated he drove his golf cart every day. R23 told the nurses when he was leaving, where he was going and the approximate time he would be returning. R23 also stated he brought his cell phone with him whenever he left the facility. On 8/27/24 at 8:39 a.m., nursing assistant (NA)-E stated R23 took his golf cart independently and was a very safe driver. NA-E stated she had ridden with R23 in the past and felt comfortable with his driving. On 8/27/24 at 8:45 a.m., activities aide (AA)-A stated R23 used a walker at the facility, was steady on his feet and needed very little assistance with ADL's. R23 had a motorized golf cart for the summer months, had a current drivers license, and drove the golf cart independently. R23 also brought his cell phone with him when he drove his cart and was able contact the facility if he needed anything. AA-A stated she had observed R23 driving the golf cart safely. On 8/27/24 at 8:50 a.m., the social services designee (SSD) stated R23 had the golf cart since his admission in 2021, and used the golf cart in the warmer months. The SSD stated she had not completed an assessment to determine if R23 was safe while using the golf cart, and was unable to find a previous assessment in R23's medical record. - At 9:00 a.m., AA-B entered the room and stated	F 689	to have his cell with him, inform staff of when leaving, his destination and his returns after using the golf cart. Education to Rehab Coordinator and activity staff on the requirements for the Golf Cart Skills Test Assessment, the reassessment periods and safety goals for R-23 and resident(s) using a motorized golf cart completed by the administrator. Golf Cart Audit completed by Medical Records LPN to determine if other like residents operate a motorized golf cart. Audit found no other resident(s) in the facility who utilize or operate a motorized golf cart. Activity staff will audit for safety interventions, resident signing out and reporting to staff on golf cart outings to be completed; daily for 1 week, 3 times for 4 week, and 2 times for 3 weeks, 1 time for 1 wwek. Audits will be reviewed for compliance or the need to be continued and reviewed at QA&A.	

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F 689	Continued From page 16 R23 had been driving his golf cart for many years and had assumed another staff member completed an assessment to determine if R23 could safely drive the golf cart. AA-B had not looked in his chart to ensure an assessment was there and had not completed one herself. Further, AA-B stated R23 had a drivers license and was supposed to complete an OT evaluation to drive his truck but the resident's family didn't want him driving the truck. The family approved the golf cart and R23 was satisfied driving the cart. An assessment to determine safe operation, including physical and cognitive ability including a safety plan was requested but not received from the facility. On 8/27/24 at 12:20 p.m., the assistant director of nursing (ADON) stated the facility had not assessed R23 for physical or mental ability for safe operation of and had not implemented interventions to ensure R23's safe return after leaving the facility or driving his golf cart. The facility did not have a policy regarding motorized golf cart use. The ADON stated R23 should be assessed at least yearly and as needed, and the golf cart use and safety plan should be added to the residents care plan.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/3/24

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F 880	Continued From page 17 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 18 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to use personal protective equipment and follow hand hygeine guidelines for a resident known to have a multi-drug resistant organism (MDRO) for 1 of 1 residents (R5) reviewed for activities of daily living (ADLs). Findings include: The Centers for Disease Control and Prevention (CDC) Transmission-Based Precautions dated 4/3/24, identified Transmission-Based Precautions were the second tier of basic infection control and were used in addition to Standard Precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions were needed to prevent infection transmission.	F 880	A system is in place for preventing, identifying, and reporting to control infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services. Corrective action for R5s wound culture identified as an MDRO; the Infection preventionist will provide education to nursing staff and support staff on contact precautions which includes safely entering and exiting a room with all PPE required for contact precautions, or any transmission-based precautions. Care plan and care sheet were reviewed to identify the need for contact precautions. The care plan and care sheet were audited and corrected.The	

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F 880	Continued From page 19 Recommendations detailed the use of contact precautions for residents with known or suspected infections that represented an increased risk for contact transmission; wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment; and donning personal protective equipment (PPE) upon room entry and properly discarding before exiting the patient room is done to contain pathogens. R5's annual Minimum Data Set (MDS) dated 7/17/24, identified R5 had a moderate cognitive impairment, had diagnoses that included diabetes mellitus, and required extensive assistance with all care areas. R5's care plan revised 7/23/24, identified R5 had potential impairment to skin integrity related to rheumatoid arthritis, decreased mobility, arthritis, osteoporosis, diabetes, use of Coumadin (blood thinner), easily bruised, incontinence of bowels and bladder. The care plan directed staff to turn and reposition R5 every 2-3 hours, keep skin clean and dry, and to report changes to nursing. However, the care plan did not identify R5's contact precautions. The facility's undated, untitled care sheet, identified R5 required extensive to total assist with all care areas. R5 required a full body mechanical lift for transfers and daily preferences such as bedtime. However, the care sheet failed to identify if R5 had an infection and/or if R5 required transmission-based precautions. R5's nursing progress notes identified the following: - 8/11/24 at 2:37 p.m., R5 had a blister on the left	F 880	care plan and care sheet will be reviewed quarterly during care conferences and updated as needed. Infection Preventionist will educate all nursing staff and support staff on the importance of hand hygiene. Hand hygiene audits will include applying and removal of gloves, washing hands and the use of hand sanitizer. Infection Preventionist will audit all residents to determine if there are any like residents who require contact precautions. Charge staff and RNs will be given a Dr. Rounding sheet providing information on medications, cultures, and sensitivity results for the day. All charge staff will be educated on reporting medications, cultures, and sensitivity results to oncoming shifts. Signs are posted on resident entry door regarding precautions and indicate the PPE requirements before entering. Infection preventionist will audit staff on PPE providing care to residents placed on contact and enhanced barrier precautions and hand hygiene. Audits will be completed; daily for 1 week, 3 times for 4 week, and 2 time for 3 week, 1 time for 2 weeks. Audits will be reviewed for compliance or the need to be continued and reviewed at QA&A.	

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	245545	A. BUILDING _____ B. WING _____	08/27/2024

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F 880	Continued From page 20 side of her groin right under her labia (the major externally visible portions of the vulva). The blister had a white head with a red ring around it, no drainage noted, and R5 stated that it was not painful. - 8/13/24 at 3:28 p.m., on the left side of R5's labia was a 2 centimeter (cm) by 3 cm raised boil-like area, with thick drainage. R5 complained of tenderness with cares. Infection control nurse and primary registered nurse (RN) came to look at area well. R5 was placed on contact precautions. R5's physician notified. - 8/15/24 at 1:32 p.m., R5's left side of labia continued to be draining purulent drainage. Tender with cares. Thick core remained in center. Noted left buttock cheek/infragluteal fold (where buttock and upper thigh meets) noted a red induration area measured 1 cm. around. No head to it. Tender when touched. Will watch closely, chart and report. Reported to cart nurse, primary RN. R5's physician order dated 8/16/24 at 11:38 a.m., identified doxycycline 100 milligrams by mouth twice daily for 10 days. R5's wound culture dated 8/19/24, identified methicillin-resistant staphylococcus aureus (MRSA). The CDC's Appendix A: Type and Duration dated 8/26/24, identified Multidrug-resistant organisms (MDROs), infection or colonization e.g., MRSA (an infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections)) required contact and standard precautions. MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact	F 880		

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F 880	Continued From page 21 Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. During an observation on 8/25/24 at 6:54 p.m., R5 was sitting in her wheelchair in her room with a lap blanket covering to her waist. R5 was hollering out, "come here." Signage on R5's room door identified R5 was on contact precautions and required a gown and gloves on entry. There was a 3-drawer plastic cart containing gowns, gloves, and masks next to her door. Nursing assistant (NA)-A entered R5's room without putting on a gown or gloves and was standing next to R5 with her wheelchair and blanket brushing against NA-A clothing. NA-A reassured R5 and stated it was still early to go to bed. R5 agreed and NA-A offered a drink of water. NA-A picked up an ice water glass from R5's overbed table and gave R5 a drink. NA-A placed the glass back on R5's overbed table and exited the room where NA-A then used hand sanitizer. During an interview on 8/25/24 at 7:41 p.m., NA-E stated R5 just started needing contact precautions due to "that labia thing." Staff needed to wear a gown and gloves whenever staff were going to be in direct contact with R5. "Like cares or whenever you're going to touch her." If staff were just dropping off linens and were not going to touch anything in R5's room, staff probably wouldn't need the gown or gloves but would need to either wash their hands or use hand sanitizer. If giving a drink of water, yes, staff needed to wear a gown or gloves to not get anything on their own clothes. During an interview on 8/25/24 at 7:43 p.m., NA-A	F 880		

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F 880	Continued From page 22 stated a gown, and gloves was only needed if providing cares for R5. Otherwise, the gown and gloves were not needed. During an observation on 8/26/24 at 2:52 p.m., NA-F and NA-B entered R5's room after donning a gown, gloves, and mask. - At 2:53 p.m., NA-G rolled R5 to the right and removed R5's soiled brief. R5 had feces on her skin and NA-G proceeded to clean R5's skin with a disposable wipe. There was a circled area approximately 1 inch in diameter on R5's left infragluteal fold. The area was scabbed and without any covering. - At 2:54 p.m., NA-G stated she was going to put "salve" on R5's bottom. NA-G removed her gloves and applied new gloves but did not wash her hands. NA-G obtained a tube of zinc oxide ointment and placed a small amount in her left gloved hand. NA-A smeared the ointment between R5's buttocks and folds then removed her left glove. NA-A did not wash her hands nor applied new gloves and proceeded to apply and fasten a clean brief to R5, pull up R5's pants and position R5 in bed. - At 2:56 p.m., NA-G gave R5 a drink of water. NA-B removed the gown and gloves and exited R5's room. In the hallway, NA-B used hand sanitizer. - At 2:58 p.m., NA-G removed her gloves, used hand sanitizer, then removed her gown. During an interview on 8/26/24 at 3:06 p.m., NA-B and NA-G stated they hadn't been doing contact precautions for R5 for "maybe a week." NA-G stated they did not know why R5 needed precautions other than R5 had a boil her on bottom. NA-G and NA-B stated they did not know R5 had an infection nor what kind of infection it	F 880		

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F 880	Continued From page 23 was. NA-G stated she did not wash her hands after removing the glove soiled with feces and worked with R5 without applying clean gloves. NA-B and NA-G reviewed the contact precautions sign and NA-G then stated, "No one explained." During an interview on 8/26/24 at 3:09 p.m., licensed practical nurse (LPN)-A stated she would have to look up charting to know why R5 was on contact precautions. R5 had had multiple wounds in the past and R5 was being given an antibiotic for a "boil" in R5's groin and another "boil" on the back of R5's leg. Staff were applying warm packs to the areas, but there was no dressing covering. LPN-A stated she did not know if the areas were cultured or if the wounds were identified with a specific organism. Staff were directed to gown, gloves and mask when working with R5, so staff didn't take any "germs out of the room with you". Staff were expected to wash their hands whenever going from clean to soiled to clean again. Staff were also expected to put on gloves whenever they were touching R5. Additionally, LPN-A stated she would tell staff to wash their hands with soap and water but to also use hand sanitizer afterward "just to be safe". LPN-A stated "they routinely say a culture was done, the person was started on an antibiotic and here you go. They don't tell us much other than that." During an interview on 8/27/24 at 10:53 a.m., registered nurse (RN)-A stated R5 had one area on the left groin that tested positive for MRSA. The wound was in progress of resolving. R5 was on contact precautions and staff were directed to "gown up" whenever entering R5 room. Staff should gown and glove even while providing a drink of water. Staff were expected to wash their hands or use hand sanitizer. Staff have had	F 880		

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F 880	Continued From page 24 training on contact precautions during meetings, it was passed on during report and there should be information in the communication book. During an interview on 8/27/24 at 11:13 a.m., the assistant director of nursing (ADON) stated she was aware R5 tested positive for MRSA and R5 had been placed on contact precautions to prevent the spread of infection. Staff received education why R5 was on contact precautions and what PPE to wear especially during cares. The ADON stated the staff were expected to follow guidelines regarding all the types of precautions and it was the same for all who walked into R5's room. The facility Infection Prevention and Control Program Policy and Procedure revised 5/12/23, identified hand hygiene was a primary means of preventing the transmission of infection. Hand hygiene was to be performed after removing gloves and after contact with a resident's mucuous membranes and bodily fluids and excretions. The policy and procedure also identified Transmission-Based Precautions were used for residents who were known to be or suspected of being infected or colonized with infectious agents, including pathogens that required addtional control measures to prevent transmission. Contact precautions included the following staff direction: - Contact precautions are intended to prevent transmission of nosocomial infections that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE. - Contact Precautions are often used in addition to Standard Precautions: - Acute infection with Methicillin-Resistant	F 880		

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F 880	Continued From page 25 Staphylococcus Aureus (MRSA) or Vancomycin-Resistant Enterococcus (VRE). - Includes a gown and gloves upon entering (i.e., before making contact with the resident or resident's environment). - Prior to leaving the resident's room, the PPE is removed and hand hygiene is performed. - High Contact Care Activity Consists of: - Dressing - Bathing/Showering - Transferring - Providing Hygiene - Changing briefs or assisting with toileting - Wound care: any skin opening requiring a dressing	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		10/3/24

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F 883	Continued From page 26 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide education on immunizations per Center for Disease Control and Prevention (CDC) guidance for 3 of 5	F 883	Facilities influenza and pneumococcal policy and procedure were reviewed and updated on 9/12/2024.	

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F 883	Continued From page 27 residents (R15, R22, R24) reviewed for immunizations. Findings include: R15's quarterly Minimum Data Set (MDS) dated 5/29/24 identified they were 100 years old with a diagnosis of a history of COVID-19. R15's immunization record dated 8/27/24, identified pneumococcal polysaccharide vaccine (PPSV23) was given on 7/18/05, and the pneumococcal conjugate vaccine (PCV13) on 4/6/16. R15's medical record did not include evidence R15 or R15's representative received education regarding pneumococcal vaccine booster and there was no indication R15 was offered the pneumococcal vaccine per CDC guidance. R22's significant change MDS dated 7/31/24, identified they were 94 years old with diagnosis of chronic pulmonary edema (fluid in the lungs). R22's immunization record dated 8/27/24, identified pneumococcal polysaccharide vaccine (PPSV23) was given on 10/10/13, and the pneumococcal conjugate vaccine (PCV13) on 9/30/15. R22's medical record did not include evidence R22 or R22's representative received education regarding pneumococcal vaccine booster and there was no indication R22 was offered the pneumococcal vaccine per CDC guidance. R36's quarterly MDS dated 7/24/24, identified they were 78 years old with a diagnosis of congestive heart failure.	F 883	Infection preventionist provides the vaccine information sheet and the consent/decline form on influenza and pneumococcal vaccines to all residents or family representative on admission. Infection preventionist will update the Vaccine Preference Form to include that education is provided to resident or resident representative, whether they consent or decline. R15□s resident representative was emailed the VIS dated 5/12/2023 on 8/27/2024 along with the consent and decline form. Resident representative returned the consent/decline form indicating consent to receive PCV 20. R22- Residents Vaccine Preference Form provided on admission did not reflect the decline or consent preference for the pneumococcal vaccine. Resident was admitted to hospice care 7/24/24, resident expired on 9/7/24. On page 27 of the SOD references R15, R 22, R 24 as the 3 reviewed for immunizations. Page 28 references: R36 as a 78-year-old with CHF. Resident R36 is noted on the resident sample list as a 98-year-old and has a diagnosis of CHF but is not listed as one that was reviewed for immunizations. From the sample resident list, R24 is a 78-year-old who does not have CHF. R36□s last pneumococcal vaccine was	

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F 883	Continued From page 28 R36's immunization record dated 8/27/24, identified pneumococcal polysaccharide vaccine (PPSV23) was given on 2/13/12. There was no evidence R36 received or was offered the PCV13. R36's medical record did not include evidence R36 or R36's representative received education regarding pneumococcal vaccine booster and there was no indication R36 was offered the pneumococcal vaccine per CDC guidance. During an interview on 8/27/24 at 11:00 a.m., licensed practical nurse (LPN)-B, the infection preventionist, stated when residents come due for immunizations, she would notify the resident or their representative and notify provider and provide education as needed. LPN-B identified education regarding the PCV20 immunization was not sent to family or representative unless they asked about it. During an interview on 8/27/24 at 12:00 p.m. the director of nursing (DON) stated the resident, or their representative should have been educated about the PCV20 and documented in the resident's medical record. The expectation was the CDC guidance would be followed. The facility's Infection Prevention and Control Program policy dated 5/12/23, regarding pneumococcal vaccination documentation identified, resident or representative was provided education regarding the benefits and potential side effects of pneumococcal immunizations. The CDC guidance dated 9/22/23, directed based on shared clinical decision-making (between resident/resident representative and provider) they need to decide whether to administer one	F 883	PCV 20 on 10/31/2023 and would not be eligible for another pneumococcal vaccine until 2028. On 10/31/2023 R36 had the most updated pneumococcal vaccine available at that time. R24□s last pneumococcal was PCV 13 on 11/23/2021 and had a PPV23 on 2/13/2012. R24 would not be eligible for PCV 20 until 11/24/2026 based upon the PneumoRecsVaxAdvisor. PCV 20 is recommended at least 5 years after the last pneumococcal vaccine dose. A Pneumococcal Vaccine in-house clinic is scheduled for 9/19/2024 for all eligible and consenting residents. Education provided by administrator with the Infection preventionist addressed; Vaccine Preference Form provided on admission must be reviewed for completion and verified that education was provided to resident and/or responsible representative, and that any eligible vaccines were offered. Infection preventionist will complete the (new) admission Vaccine Preference Form with resident and / or responsible party upon admission. Resident and resident responsible party will be informed of vaccine(s) resident is eligible for based on CDC recommendations. Audit of the will be completed for accurate completion of Vaccine Preference Form by the administrator or designee daily for 1 week, and for all new admission over	

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F 883	Continued From page 29 dose of PCV20 at least 5 years after the last pneumococcal vaccination. This would have included providing education to the resident/resident representative.	F 883	the course of 1 month. Audits will be reviewed for compliance and the need to continue audits and will be reviewed at QA&A.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2024

Administrator
Fair Meadow Nursing Home
300 Garfield Avenue Southeast
Fertile, MN 56540

Re: State Nursing Home Licensing Orders
Event ID: EUVX11

Dear Administrator:

The above facility was surveyed on August 25, 2024, through August 27, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

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

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	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) COMPLETE DATE
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: On 8/25/24 to 8/27/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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. 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 535	MN Rule 4658.0300 Subp. 5 A-D Use of Restraints Subp. 5. Physical restraints. At a minimum, for a resident placed in a physical restraint, a nursing home must also: A. develop a system to ensure that the restrained resident is monitored at the interval specified in the written order from the physician; B. assist the resident as often as necessary for the resident's safety, comfort, exercise, and elimination needs; C. provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed; and D. release the resident from the restraint as quickly as possible. This MN Requirement is not met as evidenced by: Based observation, interview and document review, the facility failed to ensure a comprehensive reassessment was completed to ensure seat belt use was still warrented for identified medical symptoms; and failed to release the seatbelt according to care planned interventions for 1 of 1 residents (R9) reviewed for restraints. Findings include: R9's quarterly Minimum Data Set (MDS) dated 8/7/24, identified R9 had a severe cognitive	2 535	Corrected	10/3/24

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2 535	Continued From page 3 impairment, had diagnoses that included Alzheimer's disease, anxiety disorder, and psychotic disorder with delusions. R9 used a chair that prevented rising every day, and did not identify a trunk restraint. R9 used antipsychotic and antianxiety medications. R9's care plan revised 6/19/22, identified R9 required use of physical restraints: seat belt in a tilt-in-place wheelchair for positioning related to Alzheimer's dementia and R9 leaned forward in her wheelchair. Fall at home prior to admit with Fracture. R9 was continually reaching to her feet or leaning over in wheelchair attempting to fix her pants. R9 was a seamstress and did a lot of sewing for work. R9 continued to think she is sewing, hemming up her pants or picking up pins, etcetera. R9 had poor safety awareness. OT provided with new tilt and space type excessive leaning to be used as needed to assist with eating, hair cares, family visits. R9's family representative was aware. The care plan directed the following: - Discuss and record with R9/family/caregivers, the risks, and benefits of the restraint, when the restraints should be applied, routines while restrained and any concerns or issues regarding restraint use. - Ensure R9 was positioned correctly with proper body alignment while restraint was being used: seatbelt in wheelchair daily. Remove seatbelt with care, meals as able, one-on-one with staff, activities, toileting, etc. Fill out restraint release form every shift. - Seatbelt released with repositioning, 1:1 visit when calm, with toileting, when in bed and walking, etc. Document restraint use and release as per facility protocol. - Ensure valid consent on chart prior to initiating restraint.	2 535		

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2 535	Continued From page 4 - Evaluate/record continuing risks/benefits of restraint; alternatives to restraint, need for ongoing use, reason for restraint use. Staff were to chart time seatbelt was off. - R9 needed a safe environment with adequate, glare-free light; floors that are even and free from spills or clutter; call light or alarm system; personal items within reach; bed in low position when locked. - R9 needed opportunities for restraint-free time and physical activity daily. Walking, toileting, transfers in and out of bed to rest. When sleeping or not restless place in wheelchair, etc. Per restraint committee, R9 was to have an activity staff remove during 1:1 visit, document time off and how tolerated. - R9 needed to have restraint applied daily. Seatbelt released: with repositioning, with 1:1 visit when calm, with toileting, when in bed, and walking, etc. Document restraint use and release as per facility protocol. Fill out restarting release form every shift. Family signed consent form. R9 used a tilt-in-space wheelchair with a footrest. Assure R9's hips were equally aligned in chair and all the way back. Calf pad placed over footrests when R9 was sitting up in her wheelchair. Do not turn your back on R9 if seat belt was off. Restraint reduction committee to look at ways to help reduce use of restraints and possible discontinue if able. Review quarterly/as needed. Nursing rehab to have her stretch daily on bed in therapy room. Try during activities to take seat belt off during 1:1 and observe closely as able and report skin breakdown. - Monitor/document/report to MD PRN changes regarding effectiveness of restraint, less restrictive device, if appropriate; any negative or adverse effects noted, including decline in mood, change in behavior, decrease in ADL self-performance, decline in cognitive ability or	2 535		

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2 535	Continued From page 5 communication, contracture formation, skin breakdown, signs/symptoms of delirium, falls/accidents/injuries, agitation and/or weakness. The undated nurse aide care sheet, identified R9 used a seatbelt when in wheelchair but provided no other direction for staff, such as when it should be used and released. R9's Order Summary Report dated 3/2/21, identified a physician order for Assistive Device: Seat belt on rocking wheelchair (agitation, hallucination, increased restless, leaning, falls) for resident safety. Shoulder strap as needed to help with proper positioning. Remove for care, toileting, 1-1 with staff. R9's physician visit notes 10/10/23 through 7/17/24, failed to address R9's need for continued physical restraint. R9's Physical Restraint Elimination Assessment form dated 8/7/24, identified the following categories of evaluation: ambulation, weight bearing, sitting balance, ADLs (bathing dressing, grooming), physical limitations, orientation, comprehension, behavior/mood, activity participation and medication therapy. The form included the following scoring: 0-20 priority candidate, 21-35 good candidate and 35 plus poor candidate. R9 was complete bedrest/chairbound, non-weight bearing, leaned to the side, forward and backward, required total assist of two, had a history of falls, was legally blind, was disoriented to person place and time, was combative and severely agitated, unable to actively participate in activities and was currently taking antipsychotics. R9's score was 31 indicating R9 was a good candidate for restraint	2 535		

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2 535	Continued From page 6 elimination. However, the assessment identified R9's score was "good" but R9 was not a candidate for restraint reduction or elimination program because R9 wore a seatbelt when sitting up in her wheelchair, video monitoring, used when R9 was in her room, with her bed in low position with a mat on the floor, but did not include supporting information to the frequency of the medical symptoms while seated in the chair warranting continued use without trialing a restraint reduction. R9 was legally blind with a diagnosis of Alzheimer's disease, delirium, psychotic disorder. R9 was unaware of safety or had poor safety awareness The assessment lacked the length of time the restraint is anticipated to be used to treat the medical symptom, the identification of who may apply the restraint, where and how the restraint is to be applied and used, the time and frequency the restraint should be released, and who may determine when the medical symptom has resolved in order to discontinue use of the restraint; the type of specific direct monitoring and supervision provided during the use of the restraint, including documentation of the monitoring; the identification of how the resident may request staff assistance and how needs will be met during use of the restraint, such as for re-positioning, hydration, meals, using the bathroom and hygiene; and the resident's record includes ongoing re-evaluation (based on supporting data) for the need for a restraint and is effective in treating the medical symptom. R9's Behavior/Mood sheets identified the following: - February 2024, R9 exhibited crying/weepy, taking off clothes, kicking, hitting, punching, picking at things not there, talking to herself, crawling out of bed, wakeful at night,	2 535		

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2 535	Continued From page 7 hallucinating, difficulty with transfers, calling staff names, refusing cares, and screaming x 6. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair. - March 2024, R9 exhibited crying/weeping and kicking, hitting, punching x 1. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair. - April 2024, R9 exhibited no behaviors. - May 2024, R9 exhibited taking clothes off x 2, throat punching during cares x 1, picking at things not there, talking to herself, crawling out of bed, and screaming x 1. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair. - June 2024, R9 exhibited no behaviors. - July 2024, kicking, hitting, punching, and calling staff names x 3. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair. During an interview on 8/25/24 at 1:14 p.m., family member (FM)-A stated R9 had a history of falls. R9 used a low bed with a mat on the floor and used a seatbelt when she was in her wheelchair. FM-A stated the seatbet was used so R9 couldn't fall out of her wheelchair and FM-A was ok with that because it kept R9 safe. During an observation on 8/25/24 at 5:22 p.m., R9's seatbelt was not released during the supper meal with nursing assistant (NA)-G seated immediately next to R9. - At 6:58 p.m., R9 continued to sit in her wheelchair in her room. R9's seatbelt was snuggly fastened over her waist. R9 was quiet, with her head hanging down and her eyes were closed. R9's hands were clasped and lying in her lap.	2 535		

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2 535	Continued From page 8 - At 7:26 p.m., R9 continued to sit in her wheelchair with her seatbelt on. R9 exhibited no agitation and sat quietly upright in her wheelchair. On 8/26/24 at 9:22 a.m., NA-C and NA-F assisted R9 with morning cares. R9 was transferred from bed to her wheelchair using a full body mechanical lift. Once R9 was in the wheelchair, NA-F immediately fastened R9's seatbelt. R9 was cooperative with cares. NA-F stated R9 always used a seatbelt. All day, every day. Staff didn't do "anything" with it except buckle it, but staff did lay R9 down every 2 hours or so for a check and change. NA-F pushed R9's wheelchair to the common area by the front desk. R9 sat quietly upright in her wheelchair and exhibited no agitation or behaviors. - At 9:53 a.m., NA-F pushed R9's wheelchair to R9's room to assist R9 to eat breakfast. NA-F did not remove R9's seatbelt even though NA-F sat immediately next to R9. R9 sat quietly upright in her wheelchair while eating. R9 exhibited no agitation or behaviors. - At 9:54 a.m., NA-D entered the room and told NA-F she could assist R9 to eat. NA-D sat down next to R9 and began assisting R9 to eat but did not remove R9's seatbelt. R9 sat quietly eating and occasionally responded when spoken to. R9 exhibited no agitation or behaviors. - At 10:22 a.m., NA-D assisted R9 to activities. R9's seatbelt continued to remain fastened. R9 sat quietly upright in her wheelchair and exhibited to agitation or behaviors. During an observation on 8/26/24 at 4:14 p.m., NA-B and registered nurse (RN)-A assisted R9 from her bed to her wheelchair using a full body mechanical lift. Once R9 was in her wheelchair, RN-A immediately fastened R9's seatbelt and RN-A pushed R9's wheelchair to the common	2 535		

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2 535	Continued From page 9 area by the front desk. R9 sat quietly, upright and responded well when others greeted her. R9 exhibited no agitation or behaviors. During an interview on 8/26/24 at 4:31 p.m., NA-B stated R9's seatbelt was a safety measure because R9 was always "fidgeting". If R9 was in her wheelchair, R9 had to always have the seatbelt on. The seatbelt was to prevent R9 from falling in case staff couldn't see it. There was no time frame for removal of the seatbelt and there was no time when it wasn't needed. NA-B then stated the seatbelt was removed when staff laid her down to check for incontinence, but as soon as R9 was back in her wheelchair the seatbelt was put back on. - At 4:35 p.m., NA-B stated she had to change her answer because R9's seatbelt was checked every 30 minutes and removed every 2 hours. During an interview on 8/26/24 at 4:40 p.m., licensed practical nurse (LPN)-A stated R9's seatbelt was removed every 2 hours. R9 used the seatbelt all day, every day. The seatbelt was also removed when R9 was in reach; usually at the supper table because staff were sitting right next to R9. Staff did not remove the seatbelt when R9 was sitting at the common area even though staff were "right here but I'm busy" and R9 just got up from bed and the seatbelt can be on for 2 hours. R9 was observed sitting quietly upright in her wheelchair. R9 was quiet and exhibited no agitation or behaviors. - At 5:00 p.m., R9 was observed sitting in her wheelchair with the supper table directly in front of her with the seatbelt fastened. R9 was upright and exhibited no agitation or behaviors. During an observation on 8/27/24 at 8:13 a.m., R9 was assisted to the dining room to eat her	2 535		

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2 535	Continued From page 10 breakfast meal. Upon arrival, a clothing protector was placed on R9 but R9's seatbelt remained fastened. Activity aide (AA)-C sat down immediately next to R9 and assisted R9 to eat. R9 required total assistance and sat quietly eating; occasionally making sewing motions with her hands. During an interview on 8/27/24 at 8:45 a.m., AA-B stated staff tried to remove R9's seatbelt approximately every 2 hours depending on R9's mood. No, R9's seatbelt was not removed during breakfast but R9 had just gotten up. During an interview on 8/27/24 at 8:47 a.m., AA-C stated she did not undo R9's seatbelt even though she was seated right next to R9 because staff never remove it during meals. During an interview on 8/27/24 at 10:59 a.m., RN-A stated a restraint assessment was completed quarterly for R9's seatbelt. There really hadn't been any changes with R9. The last assessment was completed on 8/7/24, and was deemed necessary due to R9's severe agitation. R9 wasn't always severely agitated but sometimes could be a "handful" with cares. Staff determined R9 needed the seatbelt because R9 leaned way off to the side of her wheelchair and would lean down to fidget with her socks and shoes. RN-A did not believe R9 was top heavy enough to tip over her wheelchair but could tumble out of the wheelchair if not wearing the seatbelt. RN-A then stated RN-A had worked at the facility for more than 3 years and R9 had never fallen out of the wheelchair during that time. Staff were able to release the seatbelt when sitting by her; like at meals or during activities. RN-A stated staff were expected to follow care planned interventions to ensure the least	2 535		

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2 535	Continued From page 11 restrictive intervention as well as to keep R9 safe. During an interview on 8/27/24 at 11:22 a.m., the assistant director of nursing (ADON) stated she would expect staff to check R9's seatbelt every 30 minutes to ensure it was not too tight. The seatbelt should have also been removed during meals and 1:1 activity. Staff were expected to be aware of R9's safety. The facility policy Use of Restraints revised 1/3/23, identified restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. 1. "Physical Restraints" are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot, remove a device in the same way the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. 3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. 4. Practices that inappropriately utilize equipment	2 535		

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2 535	Continued From page 12 to prevent resident mobility are considered restraints and are not permitted, including: a. Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in, bed; bed rail assessments done on admit, readmit, quarterly, & sig. changes. Some residents use bedrails for repositioning. b. Tucking sheets so tightly that a bed-bound resident cannot move. c. Placing a resident in a chair that prevents the resident from rising; and d. Placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising. 5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: a. Treat the medical symptom. b. Protect the resident's safety; and c. Help the resident attain the highest level of his/her physical or psychological well-being. 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. 7. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or resident representative. The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom). b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for	2 535		

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	00460	A. BUILDING: _____ B. WING _____	08/27/2024

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2 535	Continued From page 13 the use of the restraint. 8. Orders for restraints will not be enforced for longer than twelve (12) hours unless the resident's condition requires continued treatment. 9. Reorders are issued only after a review of the resident's condition by his or her physician. 10. The following safety guidelines shall be implemented and documented while a resident is in restraints: a. Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident. b. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. Restraints with locking devices shall not be used. c.A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. d. The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. e. Restrained residents must be repositioned at least every two (2) hours on all shifts. 11. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. 12. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). 13. Care plans shall also include the measures taken to systematically reduce or eliminate the	2 535		

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2 535	Continued From page 14 need for restraint use. 14. Documentation regarding the use of restraints shall include: a. Full documentation of the episode leading to the use of the physical restraint. This includes not only the resident symptoms but also the conditions, circumstances, and environment associated with the episode. b. A description of the resident's medical symptoms (i.e., an indication or a characteristic of a physical or psychological condition) that warranted the use of restraints. c. How the restraint use benefits the resident by addressing the medical symptom. d. The type of the physical restraint used. e.The length of effectiveness of the restraint time; and f. Observation, range of motion and repositioning flow sheets. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop, review, and/or revise policies and procedures for assessing/reassessing for use of seat belts used as restraints; audit residents who use seatbelts and ensure there is a comprehensive assessment and interventions developed; then monitor to ensure interventions are implemented; and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 535		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		10/3/24

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2 830	Continued From page 15 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to comprehensively assess and develop interventions for safety while using a golf cart off campus for 1 of 1 (R23) resident reviewed for safe use of a motorized golf cart. Findings include: R23's quarterly Minimum Data Set (MDS) dated 6/12/24, identified R23 had moderate cognition and was independent or needed supervision with activities of daily living (ADL). R23 had upper extremity impairment on one side and no lower extremity impairment. R23's diagnoses included Parkinson's disease with dyskinesia (mild to severe uncontrolled muscle movements). R23's progress notes dated 2/26/24 through 8/27/24, identified multiple occasions of R23 independently leaving the facility on his golf cart and driving to appointments, town, the store, and other activities. The notes identified the resident kept his cell phone on his person, however, the	2 830	corrected	

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2 830	Continued From page 16 notes failed to identify if R23 was safe while driving the golf cart. R23's medical record lacked an assessment for safe use of a motorized golf cart to include and evaluation and analysis of the the potential hazards and risks and eliminate them, if possible and, if not possible, reduce them as much as possible. R23's care plan dated 8/25/24, failed to identify a focus, goals, or interventions for safe use of a cart. On 8/25/24 at 1:37 p.m., R23 stated he drove his golf cart every day. R23 told the nurses when he was leaving, where he was going and the approximate time he would be returning. R23 also stated he brought his cell phone with him whenever he left the facility. On 8/27/24 at 8:39 a.m., nursing assistant (NA)-E stated R23 took his golf cart independently and was a very safe driver. NA-E stated she had ridden with R23 in the past and felt comfortable with his driving. On 8/27/24 at 8:45 a.m., activities aide (AA)-A stated R23 used a walker at the facility, was steady on his feet and needed very little assistance with ADL's. R23 had a motorized golf cart for the summer months, had a current drivers license, and drove the golf cart independently. R23 also brought his cell phone with him when he drove his cart and was able contact the facility if he needed anything. AA-A stated she had observed R23 driving the golf cart safely.	2 830		

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2 830	Continued From page 17 On 8/27/24 at 8:50 a.m., the social services designee (SSD) stated R23 had the golf cart since his admission in 2021, and used the golf cart in the warmer months. The SSD stated she had not completed an assessment to determine if R23 was safe while using the golf cart, and was unable to find a previous assessment in R23's medical record. - At 9:00 a.m., AA-B entered the room and stated R23 had been driving his golf cart for many years and had assumed another staff member completed an assessment to determine if R23 could safely drive the golf cart. AA-B had not looked in his chart to ensure an assessment was there and had not completed one herself. Further, AA-B stated R23 had a drivers license and was supposed to complete an OT evaluation to drive his truck but the resident's family didn't want him driving the truck. The family approved the golf cart and R23 was satisfied driving the cart. An assessment to determine safe operation, including physical and cognitive ability including a safety plan was requested but not received from the facility. On 8/27/24 at 12:20 p.m., the assistant director of nursing (ADON) stated the facility had not assessed R23 for physical or mental ability for safe operation of and had not implemented interventions to ensure R23's safe return after leaving the facility or driving his golf cart. The facility did not have a policy regarding motorized golf cart use. The ADON stated R23 should be assessed at least yearly and as needed, and the golf cart use and safety plan should be added to the residents care plan.	2 830		

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2 830	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could develop policies and procedures related to motorized vehicles to ensure proper assessment and interventioins are being implemented. They could staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
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 use personal protective equipment and follow hand hygeine guidelines for a resident known to have a multi-drug resistant organism (MDRO) for 1 of 1 residents (R5) reviewed for activities of daily living (ADLs). Findings include: The Centers for Disease Control and Prevention (CDC) Transmission-Based Precautions dated 4/3/24, identified Transmission-Based	21375	Corrected	10/3/24

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21375	Continued From page 19 Precautions were the second tier of basic infection control and were used in addition to Standard Precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions were needed to prevent infection transmission. Recommendations detailed the use of contact precautions for residents with known or suspected infections that represented an increased risk for contact transmission; wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment; and donning personal protective equipment (PPE) upon room entry and properly discarding before exiting the patient room is done to contain pathogens. R5's annual Minimum Data Set (MDS) dated 7/17/24, identified R5 had a moderate cognitive impairment, had diagnoses that included diabetes mellitus, and required extensive assistance with all care areas. R5's care plan revised 7/23/24, identified R5 had potential impairment to skin integrity related to rheumatoid arthritis, decreased mobility, arthritis, osteoporosis, diabetes, use of Coumadin (blood thinner), easily bruised, incontinence of bowels and bladder. The care plan directed staff to turn and reposition R5 every 2-3 hours, keep skin clean and dry, and to report changes to nursing. However, the care plan did not identify R5's contact precautions. The facility's undated, untitled care sheet, identified R5 required extensive to total assist with all care areas. R5 required a full body mechanical lift for transfers and daily preferences such as bedtime. However, the care sheet failed to identify if R5 had an infection and/or if R5	21375		

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21375	Continued From page 20 required transmission-based precautions. R5's nursing progress notes identified the following: - 8/11/24 at 2:37 p.m., R5 had a blister on the left side of her groin right under her labia (the major externally visible portions of the vulva). The blister had a white head with a red ring around it, no drainage noted, and R5 stated that it was not painful. - 8/13/24 at 3:28 p.m., on the left side of R5's labia was a 2 centimeter (cm) by 3 cm raised boil-like area, with thick drainage. R5 complained of tenderness with cares. Infection control nurse and primary registered nurse (RN) came to look at area well. R5 was placed on contact precautions. R5's physician notified. - 8/15/24 at 1:32 p.m., R5's left side of labia continued to be draining purulent drainage. Tender with cares. Thick core remained in center. Noted left buttock cheek/infragluteal fold (where buttock and upper thigh meets) noted a red induration area measured 1 cm. around. No head to it. Tender when touched. Will watch closely, chart and report. Reported to cart nurse, primary RN. R5's physician order dated 8/16/24 at 11:38 a.m., identified doxycycline 100 milligrams by mouth twice daily for 10 days. R5's wound culture dated 8/19/24, identified methicillin-resistant staphylococcus aureus (MRSA). The CDC's Appendix A: Type and Duration dated 8/26/24, identified Multidrug-resistant organisms (MDROs), infection or colonization e.g., MRSA (an infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections)) required contact and	21375		

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21375	Continued From page 21 standard precautions. MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. During an observation on 8/25/24 at 6:54 p.m., R5 was sitting in her wheelchair in her room with a lap blanket covering to her waist. R5 was hollering out, "come here." Signage on R5's room door identified R5 was on contact precautions and required a gown and gloves on entry. There was a 3-drawer plastic cart containing gowns, gloves, and masks next to her door. Nursing assistant (NA)-A entered R5's room without putting on a gown or gloves and was standing next to R5 with her wheelchair and blanket brushing against NA-A clothing. NA-A reassured R5 and stated it was still early to go to bed. R5 agreed and NA-A offered a drink of water. NA-A picked up an ice water glass from R5's overbed table and gave R5 a drink. NA-A placed the glass back on R5's overbed table and exited the room where NA-A then used hand sanitizer. During an interview on 8/25/24 at 7:41 p.m., NA-E stated R5 just started needing contact precautions due to "that labia thing." Staff needed to wear a gown and gloves whenever staff were going to be in direct contact with R5. "Like cares or whenever you're going to touch her." If staff were just dropping off linens and were not going to touch anything in R5's room, staff probably wouldn't need the gown or gloves but would need to either wash their hands or use hand sanitizer. If giving a drink of water, yes, staff needed to wear a gown or gloves to not get anything on their	21375		

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21375	Continued From page 22 own clothes. During an interview on 8/25/24 at 7:43 p.m., NA-A stated a gown, and gloves was only needed if providing cares for R5. Otherwise, the gown and gloves were not needed. During an observation on 8/26/24 at 2:52 p.m., NA-F and NA-B entered R5's room after donning a gown, gloves, and mask. - At 2:53 p.m., NA-G rolled R5 to the right and removed R5's soiled brief. R5 had feces on her skin and NA-G proceeded to clean R5's skin with a disposable wipe. There was a circled area approximately 1 inch in diameter on R5's left infragluteal fold. The area was scabbed and without any covering. - At 2:54 p.m., NA-G stated she was going to put "salve" on R5's bottom. NA-G removed her gloves and applied new gloves but did not wash her hands. NA-G obtained a tube of zinc oxide ointment and placed a small amount in her left gloved hand. NA-A smeared the ointment between R5's buttocks and folds then removed her left glove. NA-A did not wash her hands nor applied new gloves and proceeded to apply and fasten a clean brief to R5, pull up R5's pants and position R5 in bed. - At 2:56 p.m., NA-G gave R5 a drink of water. NA-B removed the gown and gloves and exited R5's room. In the hallway, NA-B used hand sanitizer. - At 2:58 p.m., NA-G removed her gloves, used hand sanitizer, then removed her gown. During an interview on 8/26/24 at 3:06 p.m., NA-B and NA-G stated they hadn't been doing contact precautions for R5 for "maybe a week." NA-G stated they did not know why R5 needed precautions other than R5 had a boil her on	21375		

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21375	Continued From page 23 bottom. NA-G and NA-B stated they did not know R5 had an infection nor what kind of infection it was. NA-G stated she did not wash her hands after removing the glove soiled with feces and worked with R5 without applying clean gloves. NA-B and NA-G reviewed the contact precautions sign and NA-G then stated, "No one explained." During an interview on 8/26/24 at 3:09 p.m., licensed practical nurse (LPN)-A stated she would have to look up charting to know why R5 was on contact precautions. R5 had had multiple wounds in the past and R5 was being given an antibiotic for a "boil" in R5's groin and another "boil" on the back of R5's leg. Staff were applying warm packs to the areas, but there was no dressing covering. LPN-A stated she did not know if the areas were cultured or if the wounds were identified with a specific organism. Staff were directed to gown, gloves and mask when working with R5, so staff didn't take any "germs out of the room with you". Staff were expected to wash their hands whenever going from clean to soiled to clean again. Staff were also expected to put on gloves whenever they were touching R5. Additionally, LPN-A stated she would tell staff to wash their hands with soap and water but to also use hand sanitizer afterward "just to be safe". LPN-A stated "they routinely say a culture was done, the person was started on an antibiotic and here you go. They don't tell us much other than that." During an interview on 8/27/24 at 10:53 a.m., registered nurse (RN)-A stated R5 had one area on the left groin that tested positive for MRSA. The wound was in progress of resolving. R5 was on contact precautions and staff were directed to "gown up" whenever entering R5 room. Staff should gown and glove even while providing a drink of water. Staff were expected to wash their	21375		

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21375	Continued From page 24 hands or use hand sanitizer. Staff have had training on contact precautions during meetings, it was passed on during report and there should be information in the communication book. During an interview on 8/27/24 at 11:13 a.m., the assistant director of nursing (ADON) stated she was aware R5 tested positive for MRSA and R5 had been placed on contact precautions to prevent the spread of infection. Staff received education why R5 was on contact precautions and what PPE to wear especially during cares. The ADON stated the staff were expected to follow guidelines regarding all the types of precautions and it was the same for all who walked into R5's room. The facility Infection Prevention and Control Program Policy and Procedure revised 5/12/23, identified hand hygiene was a primary means of preventing the transmission of infection. Hand hygiene was to be performed after removing gloves and after contact with a resident's mucuous membranes and bodily fluids and excretions. The policy and procedure also identified Transmission-Based Precautions were used for residents who were known to be or suspected of being infected or colonized with infectious agents, including pathogens that required addtional control measures to prevent transmission. Contact precautions included the following staff direction: - Contact precautions are intended to prevent transmission of nosocomial infections that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE. - Contact Precautions are often used in addition to Standard Precautions: - Acute infection with Methicillin-Resistant	21375		

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21375	Continued From page 25 Staphylococcus Aureus (MRSA) or Vancomycin-Resistant Enterococcus (VRE). - Includes a gown and gloves upon entering (i.e., before making contact with the resident or resident's environment). - Prior to leaving the resident's room, the PPE is removed and hand hygiene is performed. - High Contact Care Activity Consists of: - Dressing - Bathing/Showering - Transferring - Providing Hygiene - Changing briefs or assisting with toileting - Wound care: any skin opening requiring a dressing SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review facility policies and practices for initiating and discontinueing contact precautions along with hand hygiene. Then train staff and perform audits to ensure contact precautions are being followed and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		

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	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/26/2024. At the time of this survey, Fair Meadow Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/13/2024

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 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:Inspected as one building: Fair Meadow Nursing Home is a 1-story building, without a basement, and constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1972 the south wing was added to	K 000		

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K 000	Continued From page 2 the original building and was determined to be of Type II (111) construction. The south wing is separated with at least a 2 hour fire barrier from an apartment building. The facility is divided into 4 separate smoke zones by 30 minute fire barriers. The facility has a fire alarm system with smoke detection throughout the corridor system and in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" with automatic fire department notification. The building is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems with quick response heads. Hazardous areas have automatic fire detection that is on the fire alarm system. The facility has a capacity of 95 beds and had a census of 80 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation	K 346	Fire Out of Service Policy's contact	10/3/24

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K 346	Continued From page 3 and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/26/2024, between 8:00am and 12:00pm, it was revealed by a review of available documentation that the facility could not provide a copy of an Out of Service Policy indicating that the facility would be unable to contact the State Fire Marshals Office (Authority having jurisdiction) as evident as the missing document is missing names and phone numbers in the existing policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	names and phone numbers for the local fire department, the local code official, the state/federal official, the facility's insurance agent/carrier, the alarm monitoring company and the facility's administrator and director of nursing were update in the existing Fire Out of Service manual. The Maintenance Director was educated, by the administrator, that the Fire Out of Service Policy must be current, with new contact names and phone numbers updated when there is a change. Annually the Maintenance Director will review the Fire Out of Service Policy for up-to-date contact information. In the event of an emergency or when the fire alarm system is out of service for more than 4 hours in a 24-hour period the State Fire Marshall must be contacted. Fire Out of Service Policy will be audited the administrator or designee for up-to-date contact information 1 time a week for 4 weeks. Audits will be reviewed for compliance or the need to continue audits, and will be reviewed at QA&A.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		10/3/24

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K 353	Continued From page 4 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/26/2024, between 8:00am and 12:00pm, it was revealed by a review of available documentation the facility failed to perform the five (5) year sprinkler system testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	At the time of the facility□s Life Safety survey the 5 Year Internal Inspection of the facility□s fire sprinkler system completed by Johnson Controls was not available. Johnson Controls 5 Year Internal Inspection was completed on 7/05/2022 and found in the facility's Fire Safety Binder. Fire Safety Binder will audited for organized locations and placement of fire documents within binder by maintenance director and administrator.	

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K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 10 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 19.3.5.1, 9.7.5, and NFPA 25 2017 edition, Installation, Test and Maintenance of Water Based System, section 15.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/26/2024, between 8:00am and 12:00pm, it was revealed by a review of available documentation that the facility could not provide a copy of an Out of Service Policy indicating that the facility would be unable to contact the State Fire Marshals Office (Authority having jurisdiction) as	K 354	Sprinkler Out of Service Policy's contact names and phone numbers for the local fire department, the local code official, the state/federal official, the facility□s insurance agent/carrier, the alarm monitoring company and the facility□s administrator and director of nursing were updated in the existing Sprinkler Out of Service Policy. The Maintenance Director was educated, by the administrator, that the Sprinkler Out of Service Policy must be current and updated with new contact names and phone numbers when there is a change. Annually the Maintenance Director will review the Sprinkler Out of Service Policy for up-to-date contact information.	10/3/24

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K 354	Continued From page 6 evident as the missing document is missing names and phone numbers in the existing policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	In the event of an emergency or when the fire alarm system is out of service for more than 10 hours in a 24-hour period the State Fire Marshall must be contacted. Sprinkler Out of Service Policy will be audited the administrator or designee for up-to-date contact information 1 time a week for 4 weeks. Audits will be reviewed for compliance or the need to continue the audits, and reviewed at QA&A.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K 363		10/3/24

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K 363	Continued From page 7 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1) On 08/26/2024, between 8:00am and 12:00pm, it was revealed by observation that the resident room door (RM23) and utility room (131) do not latch. 2) On 08/26/2024, between 8:00am and 12:00pm, it was revealed by observation that the egress corridor doors are equipped with roller latches. Roller latches are prohibited by CMS regulation. An interview with the Maintenance Director verified	K 363	Maintenance staff adjusted the door hinges on resident room 23,so the door latches. Maintenance staff adjusted the door hinges on utility room 131, so the door latches. Egress corridor doors equipped with roller latches will be upgraded to Von Duprin 99 fire rated exit devices with passage lever trim on the opposite side of door installed. Exit devices 9927-f-LBR-26D-4 and lever trim W996L-06-R/V-BE US26D LH/RH. Fargo Glass & Paint, Fargo, ND, will install the Von Duprin 99 fire rated exit devices with passage lever trim. 10/1,2,3/2024 is the scheduled date for the installation of the new exit devices and	

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K 363	Continued From page 8 this deficient finding at the time of discovery.	K 363	passage lever trim. An audit will be completed by the administrator or designee to ensure all doors latch properly. Random door audits will be 1 time weekly for 3 weeks to ensure door latching compliance. Audits will be reviewed for compliance or the need to continue and reviewed at QA&A.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility.	K 372	To facility is to ensure there are no penetrations running from one smoke compartment to another smoke compartment. Penetration above the doors by the boiler room 154 was filled in with fire rated	10/3/24

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K 372	Continued From page 9 Findings include: On 08/26/2024, between 8:00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors by the boiler room (rm 154) An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	caulking by maintenance department. Education provided by the administrator to the maintenance director and assistant that after a contractor completes a project involving penetration of a smoke barrier compartment, maintenance needs to check those areas to ensure the contractor filled in penetration with fire rated caulking. If contractor failed to fill in the penetration, maintenance would then fill in the penetration with fire rated caulking. Audit of the smoke barrier area above boiler room 154 to ensure compliance will be completed by the administrator or designee. Audit will be reviewed for compliance and reviewed at QA&A.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and	K 712	Facility fire drills will be completed at	10/3/24

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K 712	Continued From page 10 staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 08/26/2024, between 8:00am and 12:00pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift 02/19/2024 at 1449, 05/23/2024 at 1504, 08/18/23 at 1538 and 11/17/2023 at 1539. 2. On 08/26/2024, between 8:00am and 12:00pm, it was revealed by a review of available documentation that fire drills were not completed: First Shift, third quarter missing drill time. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	varying times under varying conditions, quarterly on each shift. Fire drills on each shift will not start at or near the same time each quarter. Administrator will complete education with maintenance director and maintenance assistant that 1-hour or 2-hour difference in time to start fire drills held on the same shift for subsequent quarters is an acceptable variance. Fire drills will be completed on each shift, quarterly at varying times and conditions. Fire drills between 9:00pm and 6:00am will be a simulated coded announcement instead of audible alarms. Administrator will complete education with maintenance director and maintenance assistant on the CFR:NFPA 101 requirements. Fair Meadows fire drills are to be done quarterly on each shift, with varying times under varying conditions. Fire drill audits will be completed by the administrator or designee to ensure fire drill requirements are met. Audits will be completed for 2 months for compliance or the need to continue audits and reviewed at QA&A.	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101	K 912		8/26/24

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FAIR MEADOW NURSING HOME	**300 GARFIELD AVENUE SOUTHEAST** **FERTILE, MN 56540**

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K 912	Continued From page 11 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the electrical system per NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, and NFPA 70 (2011 edition), National Electrical Code, section 406.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/26/2024, between 8:00am and 12:00pm, it was revealed by observation that there was a missing cover on an electrical junction box in the ceiling near the South Wing exit ramp. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 912	Missing cover on the electrical junction box in the ceiling near the South Wing exit ramp was replaced with a cover. The new cover was put over the electrical junction box the same day it was discovered missing, 8/26/24.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that	K 920		10/3/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	**300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540**

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K 920	Continued From page 12 have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/26/2024, between 8:00am and 12:00pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) Multi-plug adapter on East Wall of kitchen	K 920	To meet the requirements of the CFR: NFPA 101 requirements for power cords and extensions staff maintenance replaced the multi-plug adapter on the east wall of the kitchen with a new fixed wired outlet receptacle. The multi-plug adapter in the employee breakroom was verified by Hubbell manufacturer as being an approved UL hospital grade receptacle. The power strip in the infection control office was removed. The extension cords in the physical activity room were removed and outlet receptacles were fixed wired in the wall.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2024**

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K 920	Continued From page 13 2) Multi-plug adapter in employee break room 3) Power-strip in infection control office 4) Extension cords in Physical Activities room An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	Education completed by the administrator with the maintenance staff that power strips and multi-plug adapters and/extension cords are not to be used as a substitute for fixed wiring of a structure outlet. Maintenance staff to audit facility rooms to identify if there are other like areas with power strips, multi-plug adapters or extension cords in use. Random power strip, extension cord or multi-plug audits will be completed by administrator or designee 1 time an month for the next 2 months for compliance or need to continue audits and reviewed at QA&A.	