DEPARTMENT OF HEALTI	H AND HUMAN	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES
	MEDIC	CARE/MEDICA	ID CERTIFIC	CATION A	ND TRANSMITTAL	ID: GWUN
	PART I	- TO BE COMP	PLETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 29463
. MEDICARE/MEDICAID PROVIDE     (L1) 245622	R NO.	3. NAME AND AI (L3) <b>MEADOWS</b>				4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 658925200	).	(L4) 25565 FAIR (L5) WYOMING		E	(L6) <b>55092</b>	3. Termination   4. CHOW     5. Validation   6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	<ol> <li>PROVIDER/SU</li> <li>01 Hospital</li> </ol>	JPPLIER CATEGO 05 HHA	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 05/24	<b>4/2017</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION	[	10.THE FACILITY	IS CERTIFIED AS	S:		
From (a):		X A. In Complia	ance With		And/Or Approved Waivers Of Th	ne Following Requirements:
To (b) :			Requirements ace Based On:		2. Technical Personnel 3. 24 Hour RN	<ul> <li>6. Scope of Services Limit</li> <li>7. Medical Director</li> </ul>
		1.	Acceptable POC		4. 7-Day RN (Rural SNI	—
12.Total Facility Beds	14 (L18)				5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	<b>14</b> (L17)		mpliance with Prog and/or Applied Wa		* Code: <b>A</b> *	(L12)
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
14						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Glenora Souther, HFI	E-NE II		09/19/2017	(L19)	Anne Peterson, Enforc	ement Specialist 09/20/2017 (L20)
1	PART II - TO BE	COMPLETED	BY HCFA R	EGIONAI	OFFICE OR SINGLE ST	· · · · · · · · · · · · · · · · · · ·
19. DETERMINATION OF ELIGIBILI	TY		MPLIANCE WITH GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to I	Participate				3. Both of the Above	
2. Facility is not Eligibl	e (L21)					
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Έ	<u>VOLUNTARY</u> <u>0</u>	INVOLUNTARY
12/23/2014					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	/E SANCTIONS			03-Risk of Involuntary Termination	<u>OTHER</u>
	A. Suspensior	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active
		<u>.</u>	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00010				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	30	. DETERMINATION	OF APPROVAL	ATE		
5 KO KLEEN I OF CMD-1557	32	05/23/2017	SI ILLING VAL D			
	(L32)	0 <i>0  40  4</i> 01		(L33)	DETERMINATION APPR	ROVAL



#### Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245622

September 19, 2017

Ms. Amy Koehnen, Administrator Meadows on Fairview 25565 Fairview Avenue Wyoming, MN 55092

Dear Ms. Koehnen:

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

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

Effective May 15, 2017 the above facility is recommended for:

14 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 14 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Retenson\_

Licensing and Certification Program Health Regulation Division Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697



#### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 19, 2017

Ms. Amy Koehnen, Administrator Meadows on Fairview 25565 Fairview Avenue Wyoming, MN 55092

RE: Project Number S5622002

Dear Ms. Koehnen:

On April 26, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 5, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 15, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 5, 2017, effective May 15, 2017 and therefore remedies outlined in our letter to you dated April 26, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Sincerely,

Anne Retension -

Licensing and Certification Program Health Regulation Division Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697



Electronically delivered

September 19, 2017

Ms. Amy Koehnen, Administrator Meadows on Fairview 25565 Fairview Avenue Wyoming, MN 55092

Re: Reinspection Results - Project Number S5622002

Dear Ms. Koehnen:

On May 24, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 24, 2017, with orders received by you on May 2, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Anne Retenson\_

Licensing and Certification Program Health Regulation Division Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

DEPARTMENT OF HEALTH AND HUMA	N SERVICES	CENTERS FOR MED	ICARE & MEDICAID SERVICES		
	<b>ARE/MEDICAID CERTIFICATION A</b>		ID: GWUN		
PART I -	TO BE COMPLETED BY THE STAT	TE SURVEY AGENCY	Facility ID: 29463		
1. MEDICARE/MEDICAID PROVIDER	3. NAME AND ADDRESS OF FACILITY (L3) <b>MEADOWS ON FAIRVIEW</b>		4. TYPE OF ACTION: $\underline{2}(L8)$		
NO.(L1) 245622	(L4) 25565 FAIRVIEW AVENUE		1. Initial 2. Recertification		
2. STATE VENDOR OR MEDICAID NO. (L2) 658925200	(L5) <b>WYOMING, MN</b>	(L6) <b>55092</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY <b>04/05/2017</b> (L34)	02 SNF/NF/Dual 06 PRTF 10 NF	14 CORF			
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	12/31		
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:				
From (a):	A. In Compliance With	And/Or Approved Waivers Of T			
To (b):	Program Requirements Compliance Based On:	2. Technical Personnel	6. Scope of Services Limit		
	-	3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds 14 (L18)	1. Acceptable POC	4. 7-Day RN (Rural SNF			
13.Total Certified Beds 14 (L17)	X B. Not in Compliance with Program	5. Life Safety Code	9. Beds/Room		
	Requirements and/or Applied Waivers:	bout D	(L12)		
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS			
18 SNF 18/19 SNF 19 SNF	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)		
14					
(L37) (L38) (L39)	(L42) (L43)				
16. STATE SURVEY AGENCY REMARKS (IF APPLICA	BLE SHOW LTC CANCELLATION DATE):				
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY A	APPROVAL Date:		
Magdalene Jares, HFE NE II	05/08/2017 (L19)	Kamala Fiske-Downing, E	Enforcement Specialist 05/22/2017 (L20)		
PART II - TO BE	COMPLETED BY HCFA REGIONAL	OFFICE OR SINGLE ST	TATE AGENCY		
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
1. Facility is Eligible to Participate	RIGHTS ACT:	<ol> <li>Ownership/Control</li> <li>Both of the Above :</li> </ol>	Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible		5. Bour of the Above .	·		
(L21)					
22. ORIGINAL DATE 23. LTC AGREEM	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION BEGINNING	G DATE ENDING DATE	VOLUNTARY 00	INVOLUNTARY		
12/23/2014		01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburser	ment 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE: 27. ALTERNATI	VE SANCTIONS	03-Risk of Involuntary Termination	<u>OTHER</u>		
A. Suspension	n of Admissions:	04-Other Reason for Withdrawal	07-Provider Status Change		
(L27) P. Paggind St.	(L44)		00-Active		
B. Rescind St	ispension Date:				
28. TERMINATION DATE: 29	(L45) . INTERMEDIARY/CARRIER NO.	30. REMARKS			
	00010				
(L28)	(L31)				
31. RO RECEIPT OF CMS-1539 32	. DETERMINATION OF APPROVAL DATE				
(L32)	(L33)	DETERMINATION APPR	OVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 26, 2017

Ms. Amy Koehnen, Administrator Meadows On Fairview 25565 Fairview Avenue Wyoming, MN 55092

RE: Project Number S5622002

Dear Ms. Koehnen:

On April 6, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

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

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

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

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

#### DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Metro C Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite #220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: Gloria.derfus@state.mn.us Phone: (651) 201-3792 Fax: (651) 215-9697

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 15, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

#### Original deficiencies not corrected

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

## Original deficiencies not corrected and new deficiencies found during the revisit

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

## Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 5, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 5, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

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

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

# Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM AP							
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY IPLETED
		245622	B. WING			04/	05/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	VS ON FAIRVIEW				5565 FAIRVIEW AVENUE YOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	00			
	signature is not req						
F 157	revisit of your facilit validate that substa regulations has bee your verification. 483.10(g)(14) NOT		F 1	57			5/14/17
SS=D	(INJURY/DECLINE (g)(14) Notification	· · · · · ·					
	consult with the res	mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is-					
		olving the resident which has the potential for requiring on;					
	mental, or psychoso deterioration in hea	ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or ns);					
	a need to discontinu treatment due to ac	treatment significantly (that is, ue an existing form of lverse consequences, or to orm of treatment); or					
	(D) A decision to tra	ansfer or discharge the					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						05/05/2017

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.

PRINTED: 05/08/2017

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 245622 B. WING 04/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAIRVIEW AVENUE **MEADOWS ON FAIRVIEW** WYOMING, MN 55092 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 157 Continued From page 1 F 157 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document Resident (R94) s physician orders were review, the facility failed to ensure the physician reviewed and were accurately followed as was notified for a change in a resident weights for of April 6, 2017. 1 of 1 resident (R94) reviewed for notification of Facility implemented weekly change. interdisciplinary meetings designed to Findings include: address each current resident and any changes to their care plan or the need to notify the resident s physician. These R94's diagnoses included muscle weakness, hyperkalemia, presence of cardiac pacemaker, weekly meetings began April 19, 2016. bradycardia, atrial fibrillation, arteriosclerotic heart disease of native coronary artery without angina Education of staff has been, and will be, pectoris, cardiomyopathy, acute kidney failure, provided to staff regarding Change of edema, chronic kidney disease, stage 3, Condition/Notification Policy and

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 29463

If continuation sheet Page 2 of 35

PRINTED: 05/08/2017

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COME	SURVEY
			A. BUILDING	·	00111	
		245622	B. WING		04/05/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAIRVIEW AVENUE		
MEADO\	WS ON FAIRVIEW					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 157	Continued From pa	age 2	F 157			
	<ul> <li>pulmonary hypertension, essential hypertension and acute on chronic systolic (congestive) heart failure (CHF) obtained from the electronic Medication Administration Record (EMAR) for April 2017.</li> <li>On 4/4/17, at 1:05 p.m. when approached and asked about all his medications, R94 stated the staff at the facility managed all that for him. When asked about anxiety R94 stated that had gotten better with the medications and he was getting stronger that before and the CHF was getting well managed at that time. At 1:30 p.m. R94 was observed sitting on a regular chair in his room looking at his cell phone. When approached and asked about edema in the lower extremities, R94 stated he had improved a whole lot and there was none around his legs and ankles however thought his toes were still swollen. When asked about being short of breath with activity, R94 stated the shortness of breath was much better now compared to before however still did experience some.</li> </ul>			procedures. This initial re-education be complete by May 14, 2017.	on will	
				DON/designee will do on-going au until 100% compliant for one quart		
				All re-training, and audit/review sch will be in place by May 14, 2017.	ledules	
	3/23/17, it was reve orders: -"Daily weights-call weight gain of 2 po in a week, every da heart failure]" -Carvedilol (anti-hy (mg) give 1 tablet b atrial fibrillation give -Furosemide (wate	r pill-diuretic) 40 mg give 1 he morning for heart failure				

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		AND HUMAN SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245622	B. WING	i		04/0	05/2017
NAME OF I	PROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW				25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	administration reco April 2017, weights -3/28/17: 170 pound -3/29/17: 173# (3# -3/30/17: 174# -3/31/17: 171.8# -4/1/17: 173.4# -4/2/17: 171.4# -4/2/17: 174.4 R94's medical reco medical doctor and notified of the weigh 4/3/17, as directed R94's dehydration 0 dated 3/30/17, indic daily for congestive both lower extremit encouraged resider and chair. CAA dire observe for change On 4/4/17, at 3:39 p verified the weight of and April 2017, revi notes and verified N RN-A stated she wo been notified becau order as resident has On 4/5/17, at 7:43 a weights nursing ass a daily weight and s put it in the comput know the weight.	e electronic treatment rd (ETAR) for March 2017 and had been obtained as follows: ds (#) gain from previous day) gain from previous day) rd lack documentation of the /or nurse practitioner being nt gains on 3/29/17, and by the physician order. Care Area Assessment (CAA) cated R94 received a diuretic heart failure, had edema to ies (BLE) and staff nt to elevate BLE when in bed ceted staff to continue to is and update MD as needed. D.m. registered nurse (RN)-A gain in the ETAR for March ewed the interdisciplinary MD had not been notified. build expect the MD to have use it was a specific physician	F	157			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · /	E SURVEY
		245622	B. WING		04/05/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		03/2017
MEADO	WS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 157 F 279 SS=D	notified regarding the the physician order On 4/5/17, a Physic requested however was not able to find The facility Change policy revised 12/16 attending physician immediately of resic condition/health stat comprehensive ass 483.20(d);483.21(b COMPREHENSIVE 483.20 (d) Use. A facility n assessments comp months in the resid results of the asses	ave expected the doctor to be ne weight gain as directed by cian's Order policy was the director of nursing stated it. of Condition/Notification 6, directed staff to notify the /nurse practitioner or on-call dents change in tus change based on a sessment. )(1) DEVELOP	F 15			5/14/17
	comprehensive per each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial n	t develop and implement a son-centered care plan for sistent with the resident rights P(c)(2) and §483.10(c)(3), that le objectives and timeframes a medical, nursing, and mental eeds that are identified in the sessment. The comprehensive				

If continuation sheet Page 5 of 35

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM A	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY
		245622	B. WING		04/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOW	WS ON FAIRVIEW			5565 FAIRVIEW AVENUE VYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa	ıge 5	F 279			
	or maintain the resi physical, mental, ar required under §48 (ii) Any services tha under §483.24, §48 provided due to the	at are to be furnished to attain ident's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not e resident's exercise of rights luding the right to refuse 83.10(c)(6).				
	rehabilitative servic provide as a result recommendations. findings of the PAS rationale in the resi	If a facility disagrees with the ARR, it must indicate its ident's medical record.				
	(iv)In consultation v resident's represen	with the resident and the ntative (s)-				
	(A) The resident's g desired outcomes.	goals for admission and				
	future discharge. Fa whether the resider community was ass	preference and potential for acilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate rpose.				
	plan, as appropriate requirements set for section. This REQUIREMEN by:	s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced				
	Based on observat	tion, interview and document		Resident (R35) Care Plan was upo	dated to	

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION		0938-039 SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _		COM	PLETED
		245622	B. WING _			04/0	)5/2017
NAME OF I	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW			25 W			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 279	Continued From pa	age 6	F 27	79			
	<ul> <li>(R35) who had an in plan developed rew in addition, the faci 2 of 2 residents (R3 ulcers.</li> <li>Findings include:</li> <li>On 4/3/17, at 2:08 use of an indwelling nurse (RN)-A state</li> </ul>	ailed to ensure 1 of 3 residents indwelling catheter had a care riewed for urinary catheter use. lity failed to develop a care for 39, R35) reviewed for pressure p.m. when asked was there g Foley catheter, registered d "Yes." When asked the atheter RN-A stated was ention.			reflect the existence of the Foley ca It was additionally updated to reflect removal of the catheter on April 16, Resident (R39) was no longer a res of the facility at the time of the surver review. Resident (R56) was no longer resident of the facility at the time of survey review. Education of staff has been, and with provided to staff regarding developed care plans with specific focus on car and skin assessments. This initial re-education will be complete by Ma	t the 2017. sident ey ger a the ill be, ment of atheters	
	in bed on her back approached and as when it had been p able to re-call how empty it for her. WI pain/discomfort R3 was able to use the	p.m. R35 was observed lying , lights out on room. When sked about the catheter and out in place resident was not ever, stated the staff always did hen asked if she had any 5 stated "no" she stated she e bathroom for her bowel atheter bag was hanging on e bed at the time.			<ul><li>2017.</li><li>DON/designee will conduct regular monitoring of care plans and care plaudits.</li><li>All re-training, monitoring and audit schedules will be in place by May 1 2017.</li></ul>	olans /review	
	catheter Care Area 11/27/16, indicated resulting in a right f hospitalization and transitional care un	tinence and indwelling Assessment (CAA) dated resident had a recent fall femur fracture, recent was admitted to the hit (TCU). The CAA indicated had been discontinued on					
	resident was not at daily living (ADLs) i	ted 12/28/16, indicated ble to complete activities of independently at the time. The R35 had left a fracture,					

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		AND HUMAN SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		245622	B. WING			04/	05/2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MEADO	<b>WS ON FAIRVIEW</b>				25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279	weakness and limit care plan directed s assist to help with p management." The resident had a Fole R35's Physician Or "Okay [Ok] to place Foley catheter for u R35's diagnoses in kidney disease, sta urine, weakness an from the quarterly M dated 2/25/17. In ac had an indwelling c assist of one for toi and required extens staff with transfers R35's Physician No were reviewed and rationale for the ong catheter. In addition the progress notes the family had indic a problem for R35 for recent hospital stay after R35 had a fall fracture. During fur and nurse practition Flomax (used to im benign prostatic hyp discontinued on 1/9 recommendation w of the retention. On 4/4/17, at 3:17 p	ed functional movement. The staff to provide "TOILETING: 1 bersonal hygiene and clothing care plan did not identify care plan did not identify y catheter. der dated 1/17/17, directed 14 French 5 ml [milliliter] irine retention." cluded heart failure, chronic ge 3 (moderate), retention of d difficulty in walking obtained Minimum Data Set (MDS) ddition, the MDS indicated R35 atheter, required extensive let use and personal hygiene sive physical assistance of two and did not ambulate. etes from 11/22/16 to 3/28/17, lacked documentation of going use of the indwelling n, it was revealed on some of the provider had documented ated urine retention had been following surgeries, with most r 12/24/16, through 12/28/16, and had sustained a right hip ther review of the physician her notes it was revealed prove urination in men with perplasia) had been	F 2	279			

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		AND HUMAN SERVICES			FORM	: 05/08/2017 APPROVED : 0938-0391
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245622	B. WING		04/	05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	address R35 had a embarrassed." RN- supposed to be in the through this care plands of the On 4/5/17, at 12:46 (DON) stated she we to be developed to a The facility Indwelling 10/16, directed the "2) Each resident we a comprehensive as care plan for the tree their catheter. Attent factors for infection indwelling catheter Maintain a closed c The facility Individue 12/13, directed "1. It department begins the immediate need care plan. The press functional dependent R39's Ebenezer init 1/17/17, indicated s impaired, was occa and bladder and red bed mobility, transfe plan dated 2/3/17, in skin integrity related back pain. A facility	Foley catheter "Am totally A acknowledged it was he care plan "I have gone an several times." p.m. the director of nursing vould have expected care plan address the catheter. ng Catheter policy revised following: <i>i</i> th a urinary catheter receives ssessment and individualized eatment or management of ntion is given to minimize risk . Continued need for the is assessed periodically.	F 279			

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		AND HUMAN SERVICES			FORM	: 05/08/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245622	B. WING		04/	05/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEADO	WS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	A facility Weekly Pa 1/25/17, indicated F identified redness to (the largest of the th the hip bone) and ro Meadows on Fairvio 1/27/17 indicated: back and buttock p blanchable, 3 small near intragluteal cle Ebenezer Skin Inter assessment dated "abrasion" number area, redness and p surrounding area re number 3, small and area redness and p include measureme bed or staging. An Documentation ass identified a skin issi healed, however the documentation of th While R39 initial as her sacrum and rec activities of daily livi ulcers was not deve acquired a pressure R56's 60 day Minim 12/30/16, indicated a related to cerebral sided weakness. Th an alteration in skin	ain and Bath Sheet, dated R39's skin was not intact and o the right and left iliac crests hree bones that merge to form edness to her groin. R39's ew Progress Note dated Patient complained of lower ain today. Buttocks area red, l open areas on right buttock eft. See skin charting. An grity Documentation 1/27/17, indicated new onset one: no drainage, surrounding pain. "Abrasion" number 2, edness and pain, "Abrasion" nount of exudate, surrounding pain. The assessment did not ents, assessment of the wound Ebenezer Skin Integrity sessment dated 2/2/17, ue on R39's left buttock had ere was no prior ne skin issue. sessment identified redness to quired assistance to complete ing, a care plan for pressure eloped until R39 had already	F 27	9		

Facility ID: 29463

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	05/08/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
	245622	B. WING			04/0	05/2017
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOWS ON FAIRVIEW				5565 FAIRVIEW AVENUE VYOMING, MN 55092		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
<ul> <li>the hip bone,) identi</li> <li>A review of a facility Documentation asse identified a stage II (partial-thickness loo dermis. The wound moist, and may also ruptured serum-fille measuring 0.5 centi remained in the faci evidence the facility assessments of her interview on 4/4/17, practical nurse (LPN was identified, staff LPN-B stated open documented weekly</li> <li>R56 admitted to the breakdown, there w nictitated a care pla acquired a pressure</li> <li>During an interview registered nurse (RI were completed on issue was found. RI was identified, staff assess weekly inclu weekly progress noi should receive a ski document on the W Sheet.</li> <li>During an interview RN-A stated she was</li> </ul>	d on the lower back part of ified on 1/12/17. Pressure Wound essment, dated 1/12/17, pressure injury ss of skin with exposed bed is viable, pink or red, o present as an intact or d blister) on R56's left buttock imeters (cm) x 0.3 cm. R56 ility until 1/24/16, there was no completed any additional pressure ulcer. During an at 3:19 p.m., licensed N)-B stated if a skin concern open a skin assessment. areas are measured and y by the nurse on duty.	F 2	279			

Facility ID: 29463

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245622 B. WING 04/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAIRVIEW AVENUE MEADOWS ON FAIRVIEW WYOMING, MN 55092 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 279 | Continued From page 11 F 279 up to date. She stated a care plan for skin should have been in place for both R39 and R56 on admission. During an interview on 4/5/17, at 1:00 p.m., the director of nursing stated she would expect staff to initiate a plan of care for activities of daily living, pain and skin on admit. F 280 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO F 280 5/14/17 PARTICIPATE PLANNING CARE-REVISE CP SS=D 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process. including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED
		& MEDICAID SERVICES				<u>MB NO. 0938-0391</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			/\. DO	11.10			
		245622	B. WING			04/	05/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	WS ON FAIRVIEW				25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	) BE	COMPLETION DATE
					DEFICIENCY)		
<b>-</b> 000		· -					
F 280	Continued From pa	•	F 2	280			
	planning process m	iust					
		lusion of the resident and/or					
	resident representa	itive.					
	(ii) Include an asse	ssment of the resident's					
	strengths and need						
	(iii) Incorporate the	resident's personal and					
		s in developing goals of care.					
	483.21						
	(b) Comprehensive	Care Plans					
	(2) A comprehensiv	ve care plan must be-					
	(i) Developed within the comprehensive	n 7 days after completion of assessment.					
	(ii) Prepared by an i includes but is not l	interdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	rse with responsibility for the					
	(C) A nurse aide wit resident.	th responsibility for the					
	(D) A member of fo	od and nutrition services staff.					
	the resident and the An explanation mus medical record if the and their resident re	racticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined the development of the					

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PRINTED: 05/08/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES         CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         245622         NAME OF PROVIDER OR SUPPLIER         MEADOWS ON FAIRVIEW         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES				PRINTED: 05/0 FORM APPE OMB NO. 0938 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAIRVIEW AVENUE WYOMING, MN 55092					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 280	resident's care plan (F) Other appropria disciplines as deter or as requested by (iii) Reviewed and r team after each ass comprehensive and assessments. This REQUIREMEN by: Based on interview facility failed to revis interventions for 1 of experienced a fall in Findings include: R15's Admission M 10/29/16, indicated required extensive a daily living. A care a 11/3/16, indicated a dated 10/22/16, did Fall Risk Tool dated at risk for falls. A review of R15's M Note dated 10/22/1 the facility on that d of 1 staff to complein using a walker and and was continent of Meadows on Fairvie 10/25/15, identified progress note indica floor in her bathroom	te staff or professionals in mined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced or and document review, the se the care plan to include fall of 2 residents (R15) who had	F 2	80	Resident (R15) was no longer a resider of the facility at the time of the survey review. Fall assessments and care plan data ha been reviewed or updated for current residents. Education of staff has been, and will be, provided to staff regarding revision of ca plans with specific focus on falls assessments, Policies and Procedures. This initial re-education will be complete by May 14, 2017. DON/designee will conduct regular monitoring of care plans and care plan audits particularly with relation to falls. All re-training, monitoring and audit/revie schedules will be in place by May 14, 2017.	are			

Facility ID: 29463

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		AND HUMAN SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245622	B. WING			04/05/2017	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	WS ON FAIRVIEW				5565 FAIRVIEW AVENUE VYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 F 281 SS=D	on her walker when have a 10 centimet upper arm. R15 sta her balance. During an interview registered nurse (R independent prior to participating in ther "usually" does a foll there was not one of "we missed it." RN- for developing the of care plan should ha During an interview director of nursing s to initiate a plan of of The facility Individu 12/13, directed "1. I department begins the immediate need care plan. The press functional depende While R15 admitted had an identified ris evidence of care pla prevention even aft 483.21(b)(3)(i) SEF PROFESSIONAL S (b)(3) Comprehens The services provid	a she fell. R15 was noted to er (CM) x 5 cm bruise on her atted she felt "wobbly" and lost on 4/5/16, at 10:50 a.m., RN)-A sated R15 had been o her fall and had been apy. She stated the facility low- up after a fall but stated done for R15. RN-A stated, A stated, she was responsible care plans and stated R15's ave identified falls. on 4/5/17, at 1:00 p.m., the stated she would expect staff care on admit. alized Care plan policy revised Upon admission, the nursing the care plan and addresses ds of the resident in the initial senting problem and significant ncies will be addressed" d to the facility for therapy and sk for falls, there was no anned interventions for fall ter R5 sustained a fall. RVICES PROVIDED MEET STANDARDS	F 2				5/14/17

Facility ID: 29463

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED	
		245622	B. WING		04/	05/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAIRVIEW AVENUE WYOMING, MN 55092		1 01/00/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 281	This REQUIREMEN by: Based on observat review, the facility facare plan was deve 1 of 2 residents (RS Findings include: R90's diagnoses into osteoarthritis right k diabetic polyneurop electronic medicatio (EMAR) for April 20 Orders revealed RS on 3/31/17. On 4/3/17, at 1:29 p asked do you have you been having dis heaviness, burning, neck, back and legs not time for the pair appointment with th During the interview the back of the nec able to turn her neo requested for a war On 4/4/17, at 8:24 a (LPN)-B went to roo when R90 stated sh neck. At that time a observed on the ba When surveyor told LPN-B stated she w to the skin. LPN-B i	A standards of quality. NT is not met as evidenced ion, interview and document ailed to ensure a temporary loped following admission for 00) reviewed for pain. cluded unilateral primary snee, chronic migraine and bathy obtained from the on administration record 17. In addition, the Physician 00 was admitted to the facility o.m. during interview when any discomfort now or have scomfort such as pain, or hurting with no relief, "My is sometimes they tell me it's in medications. I have an the pain clinic on Wednesday." w, R90 was observed rubbing k and indicated she was not ik due to the pain and	F 2	<ul> <li>Resident (R90) was no longer at the time of the survey review However, during the duration of survey (R90) is Care Plan was include interventions for pain.</li> <li>Pain assessments and care plathave been reviewed or updated current residents.</li> <li>Education of staff has been, ar provided to staff regarding reviet plans with specific focus on pathassessments, Policies and Pro This initial re-education will be by May 14, 2017.</li> <li>DON/designee will conduct regmonitoring of care plans and care p</li></ul>	n. f the updated to an data d for d will be, sion of care n cedures. complete ular are plan to pain. audit/review		

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		AND HUMAN SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245622	B. WING			04/	05/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO\	<b>WS ON FAIRVIEW</b>				5565 FAIRVIEW AVENUE /YOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 281	to room observed re- indicated to R90 sh and the breakfast tr observed get herse the bed, removed h a headache. LPN-E "some Tylenol [a mit to administer the m the concern of not k get to the appointm Maple Grove which LPN-B stated she w then asked R90 if s LPN-B attempted to (topical gel for pain) stated she would w On 4/5/17, at 9:22 a observed propelling dining room to her r pain, R90 stated sh cuff repairs, had a s neuropathy in her fe and had arthritis. R working with her reg who had referred he stated because of c with adjusting or inc R90 stated in the pa (narcotic) or Trama for break through p she was going to as that day at the appor surveyor her fingers observed swollen a about her fingers R which was "sometim	ge 16 At 8:40 a.m. LPN-B returned esident lying in bed and LPN-B e had all the morning meds ray was coming. R90 was if up and sat on the edge of her oxygen and stated she had 8 stated she would get her ild analgesic]" then continued edications. R90 brought up being sure if she was going to ents she had scheduled in included the pain clinic one. would follow up on it. LPN-B the wanted a heat pack. to apply the Diclofenac gel however, R90 declined ait until she had a shower. a.m. to 9:27 a.m. R90 was ther wheelchair from the room. When asked about her be had in the past two rotator spinal fusion, she had beet which was bad at times 90 stated she had been gular family practice doctor er to the pain clinic. R90 constipation there was issues creasing the pain medications. ast she had used Vicodin dol (analgesic pain reliever) ain and this really did help and sk the pain clinic doctor later bintment. As R90 spoke to s on both hands were and deformed. When asked 90 stated she had arthritis nes really bad and like to able to pick up a piece of	F 2	:81			

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		AND HUMAN SERVICES			FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		245622	B. WING		04/(	05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MEADO	WS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 281	and she had notice been changed since was going to discus doctor. R90 also sta was rated between the facility before th tolerable pain thres about the pain med the Fentanyl patch she thought was 25 R90's Physician Or the following pain m -Fentanyl Patch 72 patch transdermal e remove per schedu -Imitrex (migraine m needed for migraine not exceed 200 mg -Lidocaine Patch 59 topically one time a Am and Off HS and -Oxycodone hydroo mouth four times a hours. On 4/4/17, during re care plan which wa facility, it was revea scheduled pain med of pain the medical plan addressing he On 4/5/17, at 12:29 reviewed the initial was no pain care plusually on admit sh	the pain at time was so bad d her pain medications had e being at the facility and she as this with the pain clinic ated her pain most of the time a 7-10 since she admitted to be pain medications and her hold was 2-3. When asked lications, R90 stated she used (narcotic pain patch) which 6 microgram (mcg). ders dated 4/5/17, revealed hedications: Hour 25 mcg/HR Apply 1 every 48 hours for pain and le nedication) 50 mg by mouth as e may repeat after 2 hours. Do /24 hr. % Apply to painful areas day for Pain 1-3 patches. On d remove per schedule chloride 10 mg 1 tablet by day for pain give every 6 eview of the initial temporary s fours after admission to the led even though, R90 had dications and had complained record lack a temporary care	F 281			

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		AND HUMAN SERVICES			FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED
		245622	B. WING _		04/(	05/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	WS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281 F 314 SS=D	and add to it. When facility on 3/31/17, v stated "Yes. It shou On 4/5/17, at 12:44 stated she would ex- plan to be develope pain and skin care a care areas identified The facility Individua 12/13, directed "1. It department begins the immediate need care plan. The press functional dependen 483.25(b)(1) TREA PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers. comprehensive ass facility must ensure (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer professional standa healing, prevent infe from developing.	<ul> <li>asked if she had been at the when R90 admitted RN-A Id have been done."</li> <li>p.m. the director of nursing xpect the initial temporary care ed especially to addressing areas right away and other d with each resident.</li> <li>alized Care plan policy revised Upon admission, the nursing the care plan and addresses ds of the resident in the initial senting problem and significant ncies will be addressed"</li> <li>TMENT/SVCS TO RESSURE SORES</li> <li>Based on the sessment of a resident, the</li> </ul>	F 28			5/14/17

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245622 B. WING 04/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAIRVIEW AVENUE MEADOWS ON FAIRVIEW WYOMING, MN 55092 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 19 F 314 Based on interview and record review, the facility Resident (R39) was no longer a resident failed to accurately assess pressure ulcers for 2 of the facility at the time of survey review. Resident (R56) was no longer a resident of 2 resident (R39, R56) reviewed for pressure of the facility at the time of the survey ulcers. review. Findings include: Skin/Pressure Sore assessments and R39's initial Admit Assessment dated 1/17/17, care plan data have been reviewed or indicated R39 had "sacral redness." There were updated for current residents. no measurements, no indication of whether the area was blanchable, no staging, nor was there Education of staff has been, and will be, evidence of ongoing monitoring. provided to staff regarding revision of care plans with specific focus on skin, pressure A facility Braden and Skin Risk assessment dated sore documentation. Policies and 1/18/17, identified a history of pressure ulcers. Procedures. This initial re-education will be complete by May 14, 2017. R39's admission Minimum Data Set (MDS) dated 1/24/17, indicated she was moderately cognitively DON/designee will conduct regular impaired, was occasionally incontinent of bowel monitoring of care plans and care plan and bladder and required physical assistance for audits particularly with relation to bed mobility, transfers and toileting. skin/pressure sores. A facility Weekly Pain and Bath Sheet dated All re-training, monitoring and audit/review 1/25/17, indicated R39's skin was not intact and schedules will be in place by May 14, identified redness to the right and left iliac crests 2017. (the largest of the three bones that merge to form the hip bone) and redness to her groin. A Progress Note dated 1/27/17, included: "Patient complained of lower back and buttock pain today. Buttocks area red, blanchable, three small open areas on right buttock near intragluteal cleft. See skin charting." A Skin Integrity Documentation assessment dated 1/27/17, indicated: new onset "abrasion" number one: no drainage, surrounding area, redness and pain. "Abrasion" number 2, surrounding area redness and pain, "Abrasion" number 3, small

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PRINTED: 05/08/2017

		AND HUMAN SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245622	B. WING			04/(	05/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW				5565 FAIRVIEW AVENUE VYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	amount of exudate, and pain. The assess measurements, asso or staging. A Skin Integrity Doc 2/2/17, indicated and buttock had healed, documentation of w R39's care plan dat alteration in skin int mobility and back p Registered nurse (F having seen R39's on 1/17/17, but stat until the 25th of Jan R56's Progress Not the facility until 1/24 evidence the facility assessments of her R56's 60 day MDS was cognitively inta assistance with bed toileting, R56's care a need for physical vascular accident (C The care plan furthe alteration in skin int pressure injury, stag skin with exposed of viable, pink or red, n as an intact or ruptu the left tuberosity (c	surrounding area redness ssment did not include sessment of the wound beds cumentation assessment dated a area of skin on R39's left , however there was no prior /hat the skin issue had been. ted 2/3/17, identified a risk for egrity related to decreased ain. RN)-A stated she recalled skin, and stated it was noted ed nothing was done about it nuary.		314			

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		AND HUMAN SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245622	B. WING _			04/(	05/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEADOV	VS ON FAIRVIEW				5565 FAIRVIEW AVENUE /YOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	been identified on 1 A review of a Press assessment dated pressure ulcer on F 0.5 centimeters (cm During an interview licensed practical n concern was identifi assessment. LPN-E measured and docu nurse on duty. During an interview stated skin assess completed on admi issue was found. R was identified, staff assess weekly inclu weekly progress no every resident shou conducted each we documented on the Sheet. During an interview RN-A stated staff w skin check each we on the Weekly Pain	<ul> <li>I/12/17.</li> <li>aure Wound Documentation 1/12/17, identified a stage II R56's left buttock measuring n) x 0.3 cm.</li> <li>aon 4/4/17, at 3:19 p.m., urse (LPN)-B stated if a skin ied, staff would initiated a skin a further stated open areas are umented on weekly by the</li> <li>aon 4/5/17, at 9:15 a.m., RN-B ments were supposed to be ssion and any time a new skin N-B stated if a skin concern would monitor daily and uding measurements and otes. In addition, RN-B stated uld have a skin assessment</li> </ul>	F 3	14			
	initiate skin integrity R56's skin alteration and that it was "like description on the a education on skin is During an interview	v documentation. RN-A stated n was noted as an abrasion ely" due to a lack of a better assessment. RN-A stated ssues was likely needed.					

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED
		245622	B. WING _		04/05/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO\	WS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 314	body skin assessm alterations were no documented on uni descriptions with m blanching. A facility policy for s	ent on admit. She stated if any ted they should be	F 31	4		
F 315 SS=D	483.25(e)(1)-(3) NG RESTORE BLADD (e) Incontinence. (1) The facility mus continent of bladde receives services a continence unless	O CATHETER, PREVENT UTI,	F 31	5		5/14/17
		ith urinary incontinence, based omprehensive assessment, the that-				
	indwelling catheter	enters the facility without an is not catheterized unless the ondition demonstrates that necessary;				
	indwelling catheter is assessed for ren as possible unless	enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary				
	receives appropriat	is incontinent of bladder te treatment and services to t infections and to restore				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/08/2017 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245622	B. WING			04/05/2017			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
MEADOV	VS ON FAIRVIEW				5565 FAIRVIEW AVENUE VYOMING, MN 55092				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 315	on the resident's co facility must ensure incontinent of bowe treatment and servi bowel function as p This REQUIREMEN by: Based on observat review, the facility fa justification for the to was provided for 1 or reviewed for urinary Findings include: On 4/3/17, at 2:08 p use of an indwelling nurse (RN)-A stated reason for R35's ca related to urine rete On 4/4/17, at 2:52 p in bed on her back, approached and as when it had been pu able to re-call howe empty it for her. Wh pain/discomfort R33 was able to use the movements. The ca the right side of the R35's urinary incom	<ul> <li>Attent possible.</li> <li>Attent possible.</li> <li>Attent possible.</li> <li>Attent a resident who is a receives appropriate ces to restore as much normal ossible.</li> <li>AT is not met as evidenced</li> <li>Attent a resident who is a resident and document alled to ensure medical use of an indwelling catheter of 3 residents (R35) who were y catheters.</li> <li>Attent RN-A stated was there a folgy catheter, registered d "Yes." When asked the theter RN-A stated was ention.</li> <li>Attent RN-A stated was not ever, stated the staff always did to have a stated the staff always did the theter bag was hanging on bed at the time.</li> </ul>	F 3	315	Resident (R35) s catheter was ren on April 16, 2016 per physician orde (R35) s care plan has been update reflect the removal of the catheter. Review of medical justification for catheters for current residents will b complete. Education of staff has been, and wi provided to staff with specific focus regarding catheter placement, care review. This initial re-education will complete by May 14, 2017. DON/designee will conduct regular monitoring of catheters and care pla audits particularly with relation to catheters. All re-training, monitoring and audit schedules will be in place by May 1 2017.	er. ed to be II be, and be an			
	catheter Care Area 11/27/16, indicated	Assessment (CAA) dated resident had a recent fall emur fracture, recent							

		AND HUMAN SERVICES			FORM	05/08/2017 APPROVED 0938-0391
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		245622	B. WING		04/(	05/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
MEADOW	WS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	hospitalization and transitional care un the Foley catheter h 11/28/16. R35's care plan dat resident was not ab daily living (ADLs) i care plan indicated weakness and limit care plan directed s assist to help with p management." The resident had a Fole R35's Physician Or "Okay [Ok] to place Foley catheter for u R35's diagnoses in kidney disease - sta urine, weakness an from the quarterly M dated 2/25/17. In ac had an indwelling c assist of one for toi	was admitted to the it (TCU). The CAA indicated had been discontinued on ted 12/28/16, indicated ble to complete activities of ndependently at the time. The R35 had left a fracture, ed functional movement. The staff to provide "TOILETING: 1 bersonal hygiene and clothing e care plan did not identify ey catheter. der dated 1/17/17, directed a 14 French 5 ml [milliliter] wine retention." cluded heart failure, chronic age 3 (moderate), retention of nd difficulty in walking obtained Minimum Data Set (MDS) ddition, the MDS indicated R35 atheter, required extensive let use and personal hygiene	F 315	5		
	staff with transfers R35's Physician No were reviewed and rationale for the one catheter. In addition review of the Progre documented the fair retention had been surgeries, with most through 12/28/16, a	sive physical assistance of two and did not ambulate. otes from 11/22/16 to 3/28/17, lacked documentation of going use of the indwelling h, it was revealed through ess Notes, the provider had mily had indicated urine a problem for R35 following st recent hospital stay 12/24/16 after R35 had a fall and had p fracture. During further				

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245622 04/05/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 25565 FAIRVIEW AVENUE MEADOWS ON FAIRVIEW WYOMING, MN 55092 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 315 Continued From page 25 F 315 review of the physician and nurse practitioner (NP) notes it was revealed Flomax (used to improve urination in men with benign prostatic hyperplasia) had been discontinued on 1/9/17, however no recommendation was done to identify the cause of the retention. On 4/4/17, at 3:17 p.m. RN-A reviewed the interdisciplinary (IDT) notes stated R35 had been retaining urine and had large amount of post void residuals (PVR's) around 1/17/17, and the nurses were straight catheterizing R35 and this was when the catheter was inserted again. RN-A stated from 12/31/16, 1/1/17, 1/2/17, and 1/3/17, were dates the nurses had documented R35 was retaining urine and resident needed staff to straight catheterize her as she had PVR's great than 375 ml after the blood scans. When asked if any attempts had been done to discontinue the catheter RN-A stated "honestly I don't believe so." When asked what the diagnoses for the catheter was, RN-A stated "urine retention." When asked if had been referred to the urologist to rule out the cause of the retention and why R35 was not able to fully empty her bladder, RN-A stated "no." RN-A also stated around the time the catheter had been inserted other PVR's had been done and R35 showed large amounts of PVR's however not greater than 375 ml for the nurses to straight catheterize R35. RN-A did review multiple NP and doctor notes which indicated resident had urine retention however did not indicate the cause. RN-A reviewed R35's care plan and verified the care plan did not address R35 had a Foley catheter "Am totally embarrassed." RN-A acknowledged it was supposed to be in the care plan "I have gone through this care plan several times." RN-A also reviewed medical record and verified when R35 had been admitted to the

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PRINTED: 05/08/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	facility originally the discontinued on 11/ successful. RN-A sit the NP to attempt a On 4/5/17, at 12:46 (DON) stated she w have been done aft re-inserted to disco stated she would ha nurse practitioner to catheter use justific was brought up abo medical record white trials done to discor been sent to the urd the retention, DON up with the NP and documentation for to The facility Indwellin 10/16, directed the "1) Each resident is force specific condi clinical need for an insertion. Indwelling for residents with un obstruction, to assis sacral or perineal w immobilization or fo Obtain a urology co 2) Each resident wir a comprehensive a care plan for the tre their catheter. Attern factors for infection	catheter had been 28/16, and had been tated "Am going to suggest to trial." p.m. the director of nursing yould have expected a trial to er the catheter was ntinue the catheter. DON also ave expected the doctor or b have followed up with the ation for use. When concern but no documentation in the ch addressed any attempt ntinue catheter or if R35 had blogist to identify the cause of stated she would be following doctor to see if there was any his. ng Catheter policy revised following: assessed and a diagnosis tion necessitating for the indwelling catheter prior to g catheters will only be used inary retention, or bladder st in the healing of an open round, prolonged, strict r comfort at the end of life. nsult. th a urinary catheter receives seessment and individualized eatment or management of tion is given to minimize risk . Continued need for the is assessed periodically.	F	315			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	OMI PLE CONSTRUCTION	(3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	à	COMPLETED
		245622	B. WING		04/05/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MEADOV	VS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 315	Continued From pa	ige 27	F 315	5	
F 323 SS=D	catheter and remov	ss resident need for urinary /e catheter as appropriate" 1)-(3) FREE OF ACCIDENT VISION/DEVICES	F 323	3	5/14/17
	(d) Accidents. The facility must er	nsure that -			
		vironment remains as free rds as is possible; and			
		eceives adequate supervision rices to prevent accidents.			
	appropriate alterna bed rail. If a bed of must ensure correc	e facility must attempt to use tives prior to installing a side or r side rail is used, the facility tt installation, use, and d rails, including but not limited ments.			
	(1) Assess the resident from bed rails prior	dent for risk of entrapment to installation.			
		s and benefits of bed rails with dent representative and obtain prior to installation.			
	appropriate for the	bed's dimensions are resident's size and weight. NT is not met as evidenced			
	Based on interview facility failed to ass interventions relate	v and document review, the ess and implement d to falls for 1 of 2 resident		Resident (R15) was no longer a resident facility at the time of survey review	-
	(R15) reviewed for	accidents.		Fall assessments and post fall protoc have been reviewed and/or updated	

Facility ID: 29463

If continuation sheet Page 28 of 35

		AND HUMAN SERVICES				FORM	05/08/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245622	B. WING			04/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	VS ON FAIRVIEW			-	5565 FAIRVIEW AVENUE /YOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa Findings include:	ge 28	F 3	323	current residents.		
	R15's Admission M 10/29/16, indicated required extensive a daily living. A care a 11/3/16, indicated a dated 10/22/16, did Fall Risk Tool dated a low fall risk. R15's Summary Report, c use of Warfarin.(Wa used to prevent hea clots.) The Plan of a anti-coagulant mon A review of R15's M Note dated 10/22/1 the facility on that d of 1 staff to comple using a walker and and was continent of A Meadows on Fair 10/23/16, indicated 3 and independent A Meadows on Fair 10/25/15, identified progress note indic floor in her bathrood she did not hit her h on her walker when have a 10 centimet upper arm. R15 sta her balance.	Meadows on Fairview Progress 6, indicated R15 admitted to late. She required assistance te activities of daily living, was wheel chair for long distances of bowel and bladder. view Progress Note dated R15 was alert and oriented x with activities of daily living. rview Progress Note dated a fall in her bathroom. The ated R15 was found on the m facing the toilet. She stated head, but did hit her upper arm o she fell. R15 was noted to er (CM) x 5 cm bruise on her ted she felt "wobbly" and lost			Education of staff has been, and will provided to staff regarding falls polic and procedures and implementing post-fall interventions. This initial re-education will be complete by Ma 2017. DON/designee will conduct regular monitoring of falls and post-fall interventions. All re-training, monitoring and audit schedules will be in place by May 14 2017.	cies ay 14, /review	
		view progress note dated R15 was having increased					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245622	B. WING			04/	05/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW				5565 FAIRVIEW AVENUE VYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	with cares and assi A Meadows on Fair 10/30/116, indicated hospice. A meadows on Fair 11/2/16, indicated F During an interview registered nurse (R independent prior to participating in there "usually" does a foll there was not one of "we missed it." RN- was refusing to get RN-A further stated been on monitoring During an interview director of nursing s there should be an within 24 hours. Sh staff to assess the p the patient was on a be monitoring for bu While R15 admitted had an identified ris evidence of care pla prevention and whil anti-coagulating me evidence the facility effects, even after F there was no evider R15's risk for falls a	ge 29 kness and needed total assist stance with feeding. view Progress Note dated d R15 had signed on to view Progress Note dated R15 expired at the facility. on 4/5/16, at 10:50 a.m., N)-A sated R15 had been apy. She stated the facility low- up after a fall but stated done for R15. RN-A stated, A stated, after R15 fell she out of bed and go to therapy. R15 should "definitely" have for anti-coagulant use. on 4/5/17, at 1:04 p.m., the stated when a patient falls incident report and a follow up e stated she would expect patient for injury and stated if anti-coagulants, staff should ruising and bleeding.	F	323			

Facility ID: 29463

If continuation sheet Page 30 of 35

		AND HUMAN SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245622	B. WING			04/(	05/2017
NAME OF F	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	WS ON FAIRVIEW				5565 FAIRVIEW AVENUE VYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323		age 30 to no longer able to get out of	F3	323			
F 328 SS=E	received. 483.25(b)(2)(f)(g)(5	alls was requested but not 5)(h)(i)(j) TREATMENT/CARE EDS	F	328			5/14/17
		o ensure that residents receive nd care to maintain mobility th, the facility must:					
	with professional st	e and treatment, in accordance andards of practice, including ations from the resident's s) and					
	appointments with a	sist the resident in making a qualified person, and portation to and from such					
	The facility must en require colostomy, services, receive su professional standa	son-centered care plan, and					
	receives the approp to prevent comp including but not lim diarrhea, vomiting,	no is fed by enteral means priate treatment and services lications of enteral feeding nited to aspiration pneumonia, dehydration, metabolic nasal-pharyngeal ulcers.					
	(h) Parenteral Fluid	ls. Parenteral fluids must be					

Facility ID: 29463

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245622	B. WING _		04/(	05/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MEADOV	VS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 328	administered consis standards of practic physician orders, th person-centered ca goals and preference (i) Respiratory care and tracheal suction that a resident who including tracheosto suctioning, is provid professional standa comprehensive per residents' goals and this subpart. (j) Prostheses. The resident who has a and assistance, cor standards of practic person-centered ca and preferences, to prosthetic device. This REQUIREMEN by: Based on observat review, the facility fa administration of ins R92) who was obser an insulin pen. This residents who utilize reviewed during a m Findings include: R90 On 4/4/17, at 8:36 a (LPN)-B was obser	stent with professional e and in accordance with e comprehensive re plan, and the resident's ces. , including tracheostomy care ning. The facility must ensure needs respiratory care, omy care and tracheal led such care, consistent with	F 3	28 Resident (R90) was no longer a r at the facility at the time of survey Resident (R92) was no longer a re of the facility at the time of survey Proper Insulin administration has I reviewed with staff for current resi Education has been, and will be, p to staff regarding Insulin Administr policies and procedures. This initia re-education will be complete by N 2017.	review. esident review. been dents. provided ration al	

Facility ID: 29463

If continuation sheet Page 32 of 35

STATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			(X3) DAT	0938-039 E SURVEY
				G	001	
		245622	B. WING		04/	05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 328	from the top drawe wiped the rubber st then twisted the ne proceeded to prime Humalog. At 8:43 a was going to receiv per the sliding scale addition to 10 units lunch making a tota LPN-B was asked a dialing the dose, ar instructed to prime and that was what the stated the nurses requested for the p stated the pen did r LPN-B indicated sh different insulin type was asked what the Flexpen's however sure. At 9:09 a.m. I the medication stor package insert for I insulin which both o 2 units. During review of the 3/31/17, revealed F 10 units subcutane breakfast and lunch dinner and per slidi R92 On 4/5/17, at 7:55 a apply a pair of glow R92's Lantus FlexF	r. LPN-B then took the cap off, copper with an alcohol wipe edle onto the FlexPen tip then a the pen with one unit of Lm. LPN-B then indicated R90 re 2 units of Humalog insulin e for blood sugar of 133 in scheduled at breakfast and al of 12 units. At 8:46 a.m. about priming the pen prior to nd LPN-B stated she had been the pens with only one unit the consultant pharmacist to do. At 9:07 a.m. surveyor ackage insert and LPN-B not come with any. At that time the had R2 left to administer two es using Flexpen's. LPN-B e facility policy was for priming , LPN-B stated she was not LPN-B and surveyor went into age room and reviewed the R2's Lantus and Novolog directed to prime the pens with the Physician Order dated R90 had an order for Humalog ously two times a day with n; 15 units in the evening with ng scale for diabetes mellitus.	F 32	8 DON/designee will conduct regumonitoring of insulin administrat All re-training, monitoring and an schedules will be in place by Ma 2017.	ion. ıdit/review	

If continuation sheet Page 33 of 35

		AND HUMAN SERVICES				FORM	05/08/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	0	(X3) DATE	E SURVEY PLETED
		245622	B. WING _			04/0	05/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
MEADO	WS ON FAIRVIEW			25565 FAIRVIEW AVENUE WYOMING, MN 55092			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
F 328	needle on the tip the without priming the the surveyor walked cart and got to R92 was going to knock intervened. When a pen prior to dialing acknowledged she supposed to prime dialing the actual do cart dialed the pen pen with 2 units was scheduled 13 units. to R92's room and a of insulin this time. During review of the 3/24/17, revealed R Solostar solution pe subcutaneously in t bedtime diabetes m On 4/5/17, at 12:29 expectation for nurs registered nurse (R supposed to prime some education." On 4/5/17, at 12:40 stated she would ex Flexpens "Will do e facility policy was for with two units and v thought it was supp unit. DON further st another facility and confusion on the an	en dialed 13 units of Lantus pen. At 7:57 a.m. LPN-A and d away from the medication ''s room door and as LPN-A and enter room, surveyor asked if she had primed the the 13 units LPN-A had not and stated she was the pen with 2 units before ose. LPN-A returned to the back to zero them primed the sted it then dialed the . At 7:59 a.m. LPN-A returned administered the correct dose e Physician Order dated R92 had an order for Lantus en-injector 13 units the morning and 26 units at	F 32				

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		AND HUMAN SERVICES					FORM	05/08/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245622	B. WING				04/0	05/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MEADO	WS ON FAIRVIEW				5565 FAIRVIEW AVENUE VYOMING, MN 55092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 328	pen needle onto pe an air shot to prime	cted "Screw the appropriate n. Dial up 2 units and perform e needle and ensure that you ut of needle. This step can be	F	328				

Facility ID: 29463

		AND HUMAN SERV & MEDICAID SERV		F56	72002	FORM	04/12/2017 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1	PLE CONSTRUCTION G 01 - MEADOWS FAIRVIEW	(X3) DATE SU COMPLE	
		245622		B. WING		04/06	5/2017
	ROVIDER OR SUPPLIER <b>NS ON FAIRVIEW</b>		25565 F	RESS, CITY, S AIRVIEW NG, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY						
	Minnesota Departm Fire Marshal Divisio Meadows on Fairvio with the requiremen Medicare/Medicaid 483.70(a), Life Safe edition of National F	Survey was conduct nent of Public Safety, on. At the time of this ew was found in com nts for participation ir at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code ealth Care.	, State s survey ppliance n e 2012 ciation		14	5	
	living facility that wa converted to nursin construction type ha Type V(111)). It is p original building cor	ew is one wing of an as constructed in 200 g home in 2014. The as been determined roperly separated fro nstructed in 2004 by on, with 1.5 hour rate	04 and building to be om the 2 hour fire				
	facility has a fire all detection in the cor corridors that is mo department notifica have either heat de	sprinklered through arm system with smo ridors and spaces of nitored for automatic tion. Other hazardou tection or smoke de alarm system in acco State Fire Code.	oke pen to the c fire us areas tection				
	The facility has a ca census of 13 at the	apacity of 14 beds ar time of the survey.	nd had a				
	The requirement at is MET.	42 CFR, Subpart 48	35.623 (d)				
LABORATO	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESE	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 26, 2017

Ms. Amy Koehnen, Administrator Meadows On Fairview 25565 Fairview Avenue Wyoming, MN 55092

Re: State Nursing Home Licensing Orders - Project Number S5622002

Dear Ms. Koehnen:

The above facility was surveyed on April 3, 2017 through April 5, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the licensing orders cited herein are not corrected, a civil fine for each licensing order not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited licensing orders. Please remember that this provision is <u>only a suggestion</u> 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 licensing 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Meadows On Fairview April 26, 2017 Page 2

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 Gloria Derfus at:

Gloria Derfus, Unit Supervisor Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite #220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: Gloria.derfus@state.mn.us Phone: (651) 201-3792 Fax: (651) 215-9697

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Sincerely,

# Mark meath

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

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		29463	B. WING		04/0	5/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW		RVIEW AVE 6, MN 55092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet <http: td="" www.health.<=""><td>participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are</td><td></td><td></td><td></td><td></td></http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 05/05/17

STATE FORM

If continuation sheet 1 of 32

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		29463	B. WING		04/	04/05/2017		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
IEADO	WS ON FAIRVIEW		AIRVIEW AVEN IG, MN 55092	IUE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE		
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm On 4/3/17, through Department's staff, the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag m column entitled " II statute/rule out of co "Summary Statement and replaces the "T correction order. Th findings which are in after the statement evidence by." Follo are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA	<ul> <li>Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading le date your orders will be electronically submitting to the nent of Health.</li> <li>4/5/17, surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed the orders using ag numbers have been sota state statutes/rules for</li> <li>number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column fo Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and</li> </ul>		DEFICIENC				

	IT OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	or connection	IDENTITION NOMBEN.	A. BUILDING: _			
		29463	B. WING		04/	05/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO\	WS ON FAIRVIEW		G, MN 55092	IUE		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 265	MN Rule 4658.0085 Resident Health Sta	5 Notification of Chg in atus	2 265			5/14/17
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, ar attending physician development of the	st develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening l complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision t resident from the nu	o transfer or discharge the ursing home; or				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/05/2017	
		29463	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	<b>WS ON FAIRVIEW</b>	25565 F#	AIRVIEW AVE	NUE		
		WYOMIN	IG, MN 5509	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 265	Continued From pa	age 3	2 265			
	E. expected ar	nd unexpected resident deaths				
	This MN Requirem	ent is not met as evidenced				
	by: Based on observat review, the facility f was notified for a c	ion, interview and document failed to ensure the physician hange in a resident weights for 4) reviewed for notification of		Corrected.		
	Findings include:					
	hyperkalemia, pres bradycardia, atrial disease of native c pectoris, cardiomyc edema, chronic kic pulmonary hyperte and acute on chror failure (CHF) obtain	icluded muscle weakness, sence of cardiac pacemaker, fibrillation, arteriosclerotic hear oronary artery without angina opathy, acute kidney failure, lney disease, stage 3, nsion, essential hypertension nic systolic (congestive) heart ned from the electronic stration Record (EMAR) for	t			
	asked about all his staff at the facility r asked about anxiet better with the med stronger that before managed at that tir observed sitting on looking at his cell p asked about edem stated he had impr none around his ley his toes were still s	p.m. when approached and medications, R94 stated the nanaged all that for him. When y R94 stated that had gotten lications and he was getting e and the CHF was getting wel ne. At 1:30 p.m. R94 was a regular chair in his room whone. When approached and a in the lower extremities, R94 oved a whole lot and there was gs and ankles however though wollen. When asked about th with activity, R94 stated the	1			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29463	B. WING		04/	05/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADOV	VS ON FAIRVIEW		IRVIEW AVEN G, MN 55092	IUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 4	2 265			
	compared to before some.	e however still did experience				
	3/23/17, it was reve orders: -"Daily weights-call weight gain of 2 po in a week, every da heart failure]" -Carvedilol (anti-hy (mg) give 1 tablet b atrial fibrillation give -Furosemide (wate tablet by mouth in 1 -Ramipril (anti-hype capsule by mouth in 1 -Ramipril (2017, weights -3/28/17: 170 poun -3/29/17: 173# (3# -3/30/17: 174# -3/31/17: 171.8# -4/1/17: 173.4# -4/2/17: 171.4# -4/3/17: 174# R94's medical reco medical doctor and notified of the weig 4/3/17, as directed R94's dehydration	er pill-diuretic) 40 mg give 1 the morning for heart failure ertensive) 10 mg give 1 in the morning for hypertension e electronic treatment ord (ETAR) for March 2017 and a had been obtained as follows: ids (#) gain from previous day) erd lack documentation of the for nurse practitioner being ht gains on 3/29/17, and by the physician order. Care Area Assessment (CAA)				
	daily for congestive both lower extremit encouraged reside	cated R94 received a diuretic e heart failure, had edema to ties (BLE) and staff nt to elevate BLE when in bed ected staff to continue to				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29463	B. WING		04/	05/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	WS ON FAIRVIEW		G, MN 55092	IUE		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C			(X5) COMPLET DATE
2 265	Continued From pa	ige 5	2 265			
	observe for change	es and update MD as needed.				
	verified the weight and April 2017, revi notes and verified N RN-A stated she we	o.m. registered nurse (RN)-A gain in the ETAR for March lewed the interdisciplinary MD had not been notified. ould expect the MD to have use it was a specific physician ad CHF.				
	weights nursing ass a daily weight and s	a.m. when asked about sistant (NA)-A stated R94 was she had weighed him and had er and would let the nurse				
	stated she would have	o.m. the director of nursing ave expected the doctor to be he weight gain as directed by				
		cian's Order policy was the director of nursing stated l it.				
	policy revised 12/16 attending physician immediately of resid	itus change based on a				
	The Director of Nur develop policies an resident's represen changes in conditio treatments. The DC all appropriate staff	THOD OF CORRECTION: rsing (DON) or designee could d procedures to ensure each tative is promptly notified of all on and/or changes in DN or designee could educate on the policies/procedures, ure ongoing compliance.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/05/2017	
		29463	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW		RVIEW AVE G, MN 5509			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPL	
2 265	Continued From pa	ige 6	2 265			
	TIME PERIOD FOR (21) Days.	R CORRECTION: Twenty One				
2 555	MN Rule 4658.040 Plan of Care; Deve	5 Subp. 1 Comprehensive lopment	2 555		5/14/1	
	must develop a cor each resident within completion of the c assessment as def comprehensive pla by an interdisciplina attending physician responsibility for the appropriate staff in the resident's need practicable, with the	A nursing home nprehensive plan of care for n seven days after the omprehensive resident ined in part 4658.0400. The n of care must be developed ary team that includes the , a registered nurse with e resident, and other disciplines as determined by s, and, to the extent e participation of the resident, guardian or chosen				
	by: Based on observati review, the facility f (R35) who had an i plan developed rev In addition, the faci	ent is not met as evidenced ion, interview and document ailed to ensure 1 of 3 residents ndwelling catheter had a care iewed for urinary catheter use. lity failed to develop a care for 39, R35) reviewed for pressure		Corrected		
	use of an indwelling nurse (RN)-A state	o.m. when asked was there g Foley catheter, registered d "Yes." When asked the atheter RN-A stated was				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		29463	B. WING		04/	05/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
MEADOV	<b>WS ON FAIRVIEW</b>		AIRVIEW AVEN	IUE		
			IG, MN 55092	PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	age 7	2 555			
	related to urine rete	ention.				
	in bed on her back, approached and as when it had been p able to re-call howe empty it for her. WI pain/discomfort R3 was able to use the movements. The ca the right side of the R35's urinary incon catheter Care Area 11/27/16, indicated resulting in a right f hospitalization and transitional care un	p.m. R35 was observed lying , lights out on room. When sked about the catheter and out in place resident was not ever, stated the staff always did hen asked if she had any 5 stated "no" she stated she e bathroom for her bowel atheter bag was hanging on e bed at the time. Assessment (CAA) dated resident had a recent fall femur fracture, recent was admitted to the hit (TCU). The CAA indicated had been discontinued on	Ł			
	resident was not all daily living (ADLs) if care plan indicated weakness and limit care plan directed s assist to help with p management." The resident had a Fole	ted 12/28/16, indicated ble to complete activities of independently at the time. The R35 had left a fracture, ted functional movement. The staff to provide "TOILETING: 1 bersonal hygiene and clothing e care plan did not identify ey catheter. rder dated 1/17/17, directed				
	"Okay [Ok] to place Foley catheter for u	e 14 French 5 ml [milliliter] urine retention."				
	kidney disease, sta urine, weakness ar	cluded heart failure, chronic uge 3 (moderate), retention of nd difficulty in walking obtained Minimum Data Set (MDS)				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		29463	B. WING		04/	05/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MEADO	WS ON FAIRVIEW		RVIEW AVEN G, MN 55092			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From pa	age 8	2 555			
	had an indwelling of assist of one for to and required exten staff with transfers R35's Physician No were reviewed and rationale for the on catheter. In addition the progress notes the family had indic a problem for R35 recent hospital stay after R35 had a fall fracture. During fur and nurse practition Flomax (used to im benign prostatic hy discontinued on 1/8	ddition, the MDS indicated R35 catheter, required extensive ilet use and personal hygiene sive physical assistance of two and did not ambulate. otes from 11/22/16 to 3/28/17, I lacked documentation of going use of the indwelling n, it was revealed on some of the provider had documented cated urine retention had been following surgeries, with most y 12/24/16, through 12/28/16, I and had sustained a right hip ther review of the physician ner notes it was revealed uprove urination in men with perplasia) had been 9/17, however no vas done to identify the cause				
	care plan and verif address R35 had a embarrassed." RN	p.m. RN-A reviewed R35's ied the care plan did not a Foley catheter "Am totally -A acknowledged it was the care plan "I have gone lan several times."				
	(DON) stated she v	S p.m. the director of nursing would have expected care plan address the catheter.				
	10/16, directed the "2) Each resident v a comprehensive a care plan for the tro	ing Catheter policy revised following: with a urinary catheter receives assessment and individualized eatment or management of ntion is given to minimize risk				

	ta Department of He					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO\	WS ON FAIRVIEW		AIRVIEW AVEN IG, MN 55092	UE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET
2 555	Continued From pa	age 9	2 555			
		n. Continued need for the is assessed periodically. catheter system"				
	12/13, directed "1. department begins the immediate nee care plan. The pres	alized Care plan policy revised Upon admission, the nursing the care plan and addresses ds of the resident in the initial senting problem and significant encies will be addressed"				
		tial Admit Assessment dated R39 had "sacral redness."				
	1/24/17, indicated s impaired, was occa and bladder and re bed mobility, transf plan dated 2/3/17, skin integrity relate back pain. A facility	linimum Data Set (MDS) dated she was moderately cognitively asionally incontinent of bowel equired physical assistance for fers and toileting. R39's care identified a risk for alteration in d to decreased mobility and v Braden and Skin Risk 1/18/18, identified a history of	/			
	1/25/17, indicated l identified redness t (the largest of the t the hip bone) and r Meadows on Fairvi 1/27/17 indicated: back and buttock p blanchable, 3 smal near intragluteal clo	ain and Bath Sheet, dated R39's skin was not intact and to the right and left iliac crests hree bones that merge to form redness to her groin. R39's iew Progress Note dated Patient complained of lower pain today. Buttocks area red, I open areas on right buttock eft. See skin charting. An				
	assessment dated	egrity Documentation 1/27/17, indicated new onset one: no drainage, surrounding				

STATEMEN	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		29463	B. WING		04/	05/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	WS ON FAIRVIEW	25565 FA	IRVIEW AVEN	IUE		
MEADO		WYOMIN	G, MN 55092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 555	Continued From pa	age 10	2 555			
	surrounding area re number 3, small an area redness and p include measureme bed or staging. An Documentation ass identified a skin iss healed, however th documentation of th While R39 initial as her sacrum and red activities of daily liv	he skin issue. sessment identified redness to quired assistance to complete ing, a care plan for pressure eloped until R39 had already				
	12/30/16, indicated required extensive transfers and toileti 11/5/16, indicated a related to cerebral sided weakness. T an alteration in skir pressure injury, sta	num Data Set (MDS) dated I she was cognitively intact and assistance with bed mobility, ing, R56's care plan dated a need for physical assistance vascular attack (CVA) with left he care plan further indicated n integrity and indicated a new ige II, left tuberosity (one of two nd on the lower back part of tified on 1/12/17.				
	identified a stage II (partial-thickness lo dermis. The wound moist, and may als ruptured serum-fille measuring 0.5 cent remained in the fac evidence the facility	sessment, dated 1/12/17,				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		29463	B. WING		04/	05/2017
AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	·	
IEADO\	WS ON FAIRVIEW		G, MN 55092	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 555	interview on 4/4/17 practical nurse (LP was identified, staf LPN-B stated oper documented week R56 admitted to th breakdown, there week acquired a care pla acquired a pressur During an interview registered nurse (F were completed or issue was found. F was identified, staf assess weekly incl weekly progress not should receive a sl document on the V Sheet. During an interview RN-A stated she we initial plan of care a up to date. She staf have been in place admission. During an interview director of nursing to initiate a plan of living, pain and ski SUGGESTED MET	<ul> <li><sup>7</sup>, at 3:19 p.m., licensed</li> <li><sup>7</sup>/<sub>2</sub>, at 3:19 p.m., licensed</li> <li><sup>7</sup>/<sub>2</sub>, P)-B stated if a skin concern f open a skin assessment.</li> <li><sup>6</sup>/<sub>1</sub> a reas are measured and ly by the nurse on duty.</li> <li><sup>6</sup>/<sub>2</sub> facility with risk for skin was no evidence the facility an until R56 had already</li> <li><sup>7</sup>/<sub>2</sub> e ulcer.</li> <li><sup>7</sup>/<sub>2</sub> v on 4/5/17, at 9:15 a.m., RN)-B stated skin assessments a dmission and if a new skin RN-B stated if a skin concern f would monitor daily and uding measurements and otes. She stated every resident kin assessment each week and Veekly Pain and Bath Day</li> <li><sup>7</sup>/<sub>2</sub> v on 4/5/17, at 10:34 a.m., ras responsible for starting the and the nurses should keep it ated a care plan for skin should a for both R39 and R56 on</li> <li><sup>8</sup>/<sub>2</sub> v on 4/5/17, at 1:00 p.m., the stated she would expect staff care for activities of daily n on admit.</li> </ul>				
	admission. During an interview director of nursing to initiate a plan of living, pain and ski SUGGESTED ME The Director of Nu develop a system to developed to reflect	v on 4/5/17, at 1:00 p.m., the stated she would expect staff care for activities of daily n on admit.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				·		
		29463	B. WING		04/05/2017	
IAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
IEADOV	<b>WS ON FAIRVIEW</b>		NRVIEW AVE	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 555	Continued From pa	age 12	2 555			
	ensure ongoing co	mpliance.				
	TIME PERIOD FOI (21) Days	R CORRECTION: Twenty One	9			
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			5/14/17
	care must be review interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility d other appropriate staff in mined by the resident's needs practicable, with the resident, the resident's legal a representative at least a seven days of the revision of resident assessment required subpart 3, item B.				
	by: Based on interview facility failed to revi	ent is not met as evidenced and document review, the se the care plan to include fall of 2 residents (R15) who had n the facility.		Corrected		
	Findings include:					
	10/29/16, indicated required extensive daily living. A care a 11/3/16, indicated a dated 10/22/16, dic	linimum Data Set (MDS) dated she was cognitively intact and assistance with all activities of area assessment (CAA) dated a risk for falls. R15's care plan I not identify falls. An Ebenezer d 10/23/16, indicated R15 was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29463	B. WING		04/	05/2017
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
IEADO\	WS ON FAIRVIEW		RVIEW AVEN G, MN 55092	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
2 570	Continued From pa	age 13	2 570			
	Note dated 10/22/1 the facility on that of of 1 staff to complet using a walker and and was continent Meadows on Fairv 10/25/15, identified progress note indic floor in her bathroot she did not hit her on her walker when have a 10 centime	Meadows on Fairview Progress 16, indicated R15 admitted to date. She required assistance ete activities of daily living, was I wheel chair for long distances of bowel and bladder. A iew Progress Note dated d a fall in her bathroom. The cated R15 was found on the om facing the toilet. She stated head, but did hit her upper arm n she fell. R15 was noted to ter (CM) x 5 cm bruise on her ated she felt "wobbly" and lost				
	registered nurse (F independent prior t participating in the "usually" does a fo there was not one "we missed it." RN	v on 4/5/16, at 10:50 a.m., RN)-A sated R15 had been to her fall and had been rapy. She stated the facility llow- up after a fall but stated done for R15. RN-A stated, -A stated, she was responsible care plans and stated R15's ave identified falls.				
		v on 4/5/17, at 1:00 p.m., the stated she would expect staff care on admit.				
	12/13, directed "1. department begins the immediate nee care plan. The pre- functional depende While R15 admitte had an identified ris	ualized Care plan policy revised Upon admission, the nursing the care plan and addresses ds of the resident in the initial senting problem and significant encies will be addressed" d to the facility for therapy and sk for falls, there was no lanned interventions for fall				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		29463	B. WING		04/	05/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW		NRVIEW AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	ige 14	2 570			
	prevention even aft	er R5 sustained a fall.				
	The Director of Nur develop a system to revised in a timely r residents current ca designee could edu	THOD OF CORRECTION: rsing (DON) or designee could o ensure care plans are manner and reflect each are needs. The DON or ucate all appropriate staff on ponitor to ensure ongoing				
2 830	(21) Days	R CORRECTION: Twenty One	2 830			5/14/17
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
	by: Based on interview facility failed to ass	d to falls for 1 of 2 resident		Corrected		

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29463		B. WING		05/2017
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			00/2011
MEADOV	WS ON FAIRVIEW		AIRVIEW AVEN IG, MN 55092	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa Findings include:		2 830			
	10/29/16, indicated required extensive daily living. A care 11/3/16, indicated a dated 10/22/16, did Fall Risk Tool date a low fall risk. R15 Summary Report, use of Warfarin.(W used to prevent he	Ainimum Data Set (MDS) dated a she was cognitively intact and assistance with all activities of area assessment (CAA) dated a risk for falls. R15's care plan d not identify falls. An Ebenezed d 10/23/16, indicated R15 was 's Meadows on Fairview Order dated 10/22/16, identified the 'arfarin is an anticoagulant art attacks, strokes, and blood Care did not address hitoring.	r			
	Note dated 10/22/1 the facility on that o of 1 staff to complet using a walker and	Meadows on Fairview Progress 16, indicated R15 admitted to date. She required assistance ate activities of daily living, was wheel chair for long distances of bowel and bladder.				
	10/23/16, indicated	rview Progress Note dated I R15 was alert and oriented x with activities of daily living.				
	10/25/15, identified progress note indic floor in her bathroo she did not hit her on her walker when have a 10 centime	irview Progress Note dated I a fall in her bathroom. The cated R15 was found on the om facing the toilet. She stated head, but did hit her upper arm n she fell. R15 was noted to ter (CM) x 5 cm bruise on her ated she felt "wobbly" and lost				
	10/26/16, indicated	rview progress note dated I R15 was having increased kness and needed total assist				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED		
		29463	B. WING		04/05/2017			
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE				
MEADO	WS ON FAIRVIEW		G, MN 55092					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE A           REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED T		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 16	2 830					
	with cares and assi	istance with feeding.						
	A Meadows on Fairview Progress Note dated 10/30/116, indicated R15 had signed on to hospice.							
	A meadows on Fairview Progress Note dated 11/2/16, indicated R15 expired at the facility.							
	registered nurse (F independent prior to participating in ther "usually" does a fol there was not one o "we missed it." RN- was refusing to get RN-A further stated	on 4/5/16, at 10:50 a.m., RN)-A sated R15 had been o her fall and had been rapy. She stated the facility low- up after a fall but stated done for R15. RN-A stated, -A stated, after R15 fell she out of bed and go to therapy. R15 should "definitely" have g for anti-coagulant use.						
	director of nursing s there should be an within 24 hours. Sh staff to assess the the patient was on	on 4/5/17, at 1:04 p.m., the stated when a patient falls incident report and a follow up the stated she would expect patient for injury and stated if anti-coagulants, staff should ruising and bleeding.						
	had an identified ris evidence of care pl prevention and whi anti-coagulating me evidence the facility effects, even after 1 there was no evide R15's risk for falls a	d to the facility for therapy and sk for falls, there was no anned interventions for fall le she was receiving edications, there was no y was monitoring for side R5 sustained a fall. Further, nce the facility re-assessed after she sustained a fall on ugh she declined from an						
anagata D		to no longer able to get out of						

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		29463	B. WING		04/	05/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO\	WS ON FAIRVIEW		AIRVIEW AVEN IG, MN 55092	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	A facility policy for t received.	alls was requested but not				
	Director of Nursing polices and proced monitoring falls. The designee could edu procedures. The D designee could dev ensue residents real TIME PERIOD FOR	THOD OF CORRECTION: The or her designee could develop ures regarding assessing and he Director of Nursing or her ucate staff on the policies and irector of Nursing or her velop a monitoring system to ceive the appropriate care. R CORRECTION: Twenty One	ס			
2 900	(21) Days MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			5/14/17
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the nursing care plan which				
	without pressure s pressure sores unle condition demonstr	to enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	This MN Requirem by:	ent is not met as evidenced				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		29463	B. WING		04/05/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MEADO\	WS ON FAIRVIEW		IRVIEW AVE G, MN 5509	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 18	2 900			
	failed to accurately	and record review, the facility assess pressure ulcers for 2 R56) reviewed for pressure		Corrected		
	Findings include:					
	indicated R39 had no measurements,	Assessment dated 1/17/17, "sacral redness." There were no indication of whether the le, no staging, nor was there g monitoring.				
		nd Skin Risk assessment dated a history of pressure ulcers.				
	1/24/17, indicated s impaired, was occa	inimum Data Set (MDS) dated she was moderately cognitively asionally incontinent of bowel quired physical assistance for ers and toileting.				
	1/25/17, indicated F identified redness t (the largest of the t	ain and Bath Sheet dated R39's skin was not intact and to the right and left iliac crests hree bones that merge to form edness to her groin.				
	complained of lowe Buttocks area red,	ated 1/27/17, included: "Patient er back and buttock pain today. blanchable, three small open ock near intragluteal cleft. See				
	1/27/17, indicated: one: no drainage, s pain. "Abrasion" nu redness and pain, '	cumentation assessment dated new onset "abrasion" number surrounding area, redness and imber 2, surrounding area 'Abrasion" number 3, small , surrounding area redness				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		29463	B. WING		04/05/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
	WS ON FAIRVIEW		IRVIEW AVENU G, MN 55092	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	and pain. The asse measurements, ass or staging. A Skin Integrity Doc 2/2/17, indicated ar buttock had healed documentation of w R39's care plan dat alteration in skin int mobility and back p Registered nurse (If having seen R39's on 1/17/17, but stat until the 25th of Jan R56's Progress Not the facility until 1/24 evidence the facility assessments of he R56's 60 day MDS was cognitively inta assistance with bec toileting, R56's care a need for physical vascular accident (IThe care plan furth alteration in skin int pressure injury, sta skin with exposed of viable, pink or red, as an intact or rupto the left tuberosity (or	essment did not include sessment of the wound beds cumentation assessment dated n area of skin on R39's left , however there was no prior what the skin issue had been. ted 2/3/17, identified a risk for tegrity related to decreased pain. RN)-A stated she recalled skin, and stated it was noted ted nothing was done about it nuary. tes indicated R56 remained in 4/16, and there was no y had completed any additional		DEFICIENC		

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29463	B. WING			05/0017
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		04/	05/2017
MEADO	WS ON FAIRVIEW	WYOMIN	IG, MN 55092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 20	2 900			
	A review of a Pressure Wound Documentation assessment dated 1/12/17, identified a stage II pressure ulcer on R56's left buttock measuring 0.5 centimeters (cm) x 0.3 cm.					
	licensed practical n concern was identif assessment. LPN-I	on 4/4/17, at 3:19 p.m., ourse (LPN)-B stated if a skin fied, staff would initiated a skin B further stated open areas are umented on weekly by the				
	stated skin assess completed on admi issue was found. R was identified, staff assess weekly inclu weekly progress no every resident shou conducted each we	on 4/5/17, at 9:15 a.m., RN-B ments were supposed to be ssion and any time a new skin N-B stated if a skin concern would monitor daily and uding measurements and otes. In addition, RN-B stated uld have a skin assessment eek which would be Weekly Pain and Bath Day				
	RN-A stated staff w skin check each we on the Weekly Pair stated if a skin con- initiate skin integrity R56's skin alteratio and that it was "like description on the a	y on 4/5/17, at 10:34 a.m., yere supposed to complete a eek on bath day and document n and Bath Day sheet. She cern was identified, staff would y documentation. RN-A stated n was noted as an abrasion ely" due to a lack of a better assessment. RN-A stated ssues was likely needed.				
	director of nursing		,			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO\	WS ON FAIRVIEW		G, MN 55092	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETI DATE
2 900	Continued From pa	ge 21	2 900			
	descriptions with m blanching.	easurements and any				
		skin assessment and requested but not received.				
	The Director of Nur develop policies an residents have a co the risk for develop individualized interv implemented. The designee could edu the polices and pro ulcers. The Directo could develop a mo residents are asses	HOD OF CORRECTION: sing or her designee could d procedure to ensure omprehensive assessment of bing pressure ulcers so that ventions could be Director of Nursing or her acate all appropriate staff on cedures related to pressure r of Nursing or her designee onitoring system to ensure assed and receive interventions lopment of pressure ulcers.				
	TIME PERIOD FOR (21) Days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.0528 Incontinence	5 Subp. 5 A.B Rehab -	2 910			5/14/17
	have a continuous management to rec unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident w receives appropriat	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home og catheter is not catheterized s clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to t infections and to restore as				

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED	
		29463	B. WING		04/	04/05/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	1		
MEADO	<b>WS ON FAIRVIEW</b>		IRVIEW AVE G, MN 5509				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 910	Continued From pa	age 22	2 910				
	much normal bladc	ler function as possible.					
	by: Based on observat review, the facility f justification for the	ent is not met as evidenced ion, interview and document failed to ensure medical use of an indwelling catheter of 3 residents (R35) who were y catheters.		Corrected			
	Findings include:						
	use of an indwelling nurse (RN)-A state	p.m. when asked was there g Foley catheter, registered d "Yes." When asked the atheter RN-A stated was ention.					
	in bed on her back approached and as when it had been p able to re-call how empty it for her. Wh pain/discomfort R3 was able to use the	p.m. R35 was observed lying , lights out on room. When sked about the catheter and out in place resident was not ever, stated the staff always dic hen asked if she had any 5 stated "no" she stated she e bathroom for her bowel atheter bag was hanging on e bed at the time.					
	catheter Care Area 11/27/16, indicated resulting in a right f hospitalization and transitional care un	atinence and indwelling Assessment (CAA) dated resident had a recent fall femur fracture, recent was admitted to the had been discontinued on					

STATEMEN	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		29463	B. WING		04/	04/05/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
MEADO	WS ON FAIRVIEW		G, MN 55092	UE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 23	2 910				
	resident was not al daily living (ADLs) i care plan indicated weakness and limit care plan directed assist to help with p management." The resident had a Fole R35's Physician Or	ted 12/28/16, indicated ole to complete activities of ndependently at the time. The R35 had left a fracture, red functional movement. The staff to provide "TOILETING: 1 bersonal hygiene and clothing e care plan did not identify ey catheter. der dated 1/17/17, directed e 14 French 5 ml [milliliter]					
	Foley catheter for u R35's diagnoses in kidney disease - sta urine, weakness ar from the quarterly N dated 2/25/17. In a had an indwelling c assist of one for toi and required exten		5				
	were reviewed and rationale for the on catheter. In addition review of the Progr documented the fa retention had been surgeries, with most through 12/28/16, a sustained a right hi review of the physic (NP) notes it was re improve urination in hyperplasia) had be	otes from 11/22/16 to 3/28/17, lacked documentation of going use of the indwelling n, it was revealed through ess Notes, the provider had mily had indicated urine a problem for R35 following st recent hospital stay 12/24/16 after R35 had a fall and had p fracture. During further cian and nurse practitioner evealed Flomax (used to n men with benign prostatic een discontinued on 1/9/17, mendation was done to identify					

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	29463	B. WING	B. WING		05/2017
OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
S ON FAIRVIEW			IUE		
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 24	2 910			
he cause of the re	tention.				
nterdisciplinary (ID etaining urine and esiduals (PVR's) a vere straight catheter stated from 12/31/- vere dates the nur- etaining urine and straight catheterize han 375 ml after th any attempts had b catheter RN-A stated When asked what was, RN-A stated " had been referred to cause of the retent o fully empty her b RN-A also stated a had been inserted and R35 showed la however not greated straight catheterize NP and doctor noted urine retention how cause. RN-A review verified the care pla foley catheter "Am acknowledged it wa olan "I have gone t imes." RN-A also r verified when R35 acility originally the	T) notes stated R35 had been had large amount of post void around 1/17/17, and the nurses eterizing R35 and this was was inserted again. RN-A 16, 1/1/17, 1/2/17, and 1/3/17, ses had documented R35 was resident needed staff to a her as she had PVR's great he blood scans. When asked if been done to discontinue the ed "honestly I don't believe so." the diagnoses for the catheter urine retention." When asked it blodder, RN-A stated "no." round the time the catheter other PVR's had been done arge amounts of PVR's er than 375 ml for the nurses to e R35. RN-A did review multiple es which indicated resident had vever did not indicate the wed R35's care plan and an did not address R35 had a n totally embarrassed." RN-A as supposed to be in the care hrough this care plan several reviewed medical record and had been admitted to the e catheter had been	f			
	OVIDER OR SUPPLIER SON FAIRVIEW SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From pathe cause of the re On 4/4/17, at 3:17 Interdisciplinary (ID etaining urine and esiduals (PVR's) a vere straight catheter that of from 12/31/ vere dates the nur etaining urine and esiduals (PVR's) a vere straight catheter that 375 ml after th any attempts had b catheter RN-A state When asked what vas, RN-A stated " had been referred cause of the retent o fully empty her b RN-A also stated a had been inserted and R35 showed la however not greated traight catheterized and R35 showed la how and doctor noted and R35 showed la how and the care pla foley catheter "Arr acknowledged it wa cause. RN-A also i reified when R35 acility originally the	IDENTIFICATION NUMBER:         29463         OVIDER OR SUPPLIER       STREET AI         SON FAIRVIEW       25565 FA         WYOMIN       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 24       he cause of the retention.         Dn 4/4/17, at 3:17 p.m. RN-A reviewed the netaining urine and had large amount of post void esiduals (PVR's) around 1/17/17, and the nurses were straight catheterizing R35 and this was when the catheter was inserted again. RN-A stated from 12/31/16, 1/1/17, 1/2/17, and 1/3/17, were dates the nurses had documented R35 was etaining urine and resident needed staff to straight catheterize her as she had PVR's great han 375 ml after the blood scans. When asked if any attempts had been done to discontinue the vas, RN-A stated "urine retention." When asked if any attempts had been done to discontinue the aubeen referred to the urologist to rule out the ause of the retention and why R35 was not able o fully empty her bladder, RN-A stated "no." RN-A also stated around the time the catheter and been inserted other PVR's had been done and R35 showed large amounts of PVR's nowever not greater than 375 ml for the nurses to straight catheterize R35. RN-A did review multiple VP and doctor notes which indicated resident had urine retention however did not indicate the cause. RN-A reviewed R35's care plan and rerified the care plan did not address R35 had a Toley catheter "Am totally embarrassed." RN-A acknowledged it was supposed to be in the care plan "I have gone through this care plan several imes." RN-A also reviewed medical record and rerified when R35 had been admitted to the acility originally the catheter had been	OF DEFICIENCIES FORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING: 29463         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST 25565 FAIRVIEW AVEN WYOMING, MN 55092         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST 25565 FAIRVIEW AVEN WYOMING, MN 55092         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 24       2 910         he cause of the retention.       PREFIX TAG         Dn 4/4/17, at 3:17 p.m. RN-A reviewed the nterdisciplinary (IDT) notes stated R35 had been etaining urine and had large amount of post void esiduals (PVR's) around 1/17/17, and the nurses were straight catheterizing R35 and this was when the catheter was inserted again. RN-A tated from 12/31/16, 1/1/17, 1/2/17, and 1/3/17, vere dates the nurses had documented R35 was etaining urine and resident needed staff to traight catheterize her as she had PVR's great han 375 ml after the blood scans. When asked if inny attempts had been done to discontinue the atheter RN-A stated "honestly I don't believe so." When asked what the diagnoses for the catheter was, RN-A also endore to PVR's was not able o fully empty her bladder, RN-A stated "no." RN-A also stated around the time the catheter had been inserted other PVR's had been done ind R35 showed large amounts of PVR's however not greater than 375 ml for the nurses to traight catheterize R35. RN-A did review multiple JP and doctor notes which indicated resident had wrine retention however did not indicate the ause. RN-A reviewed R35's care plan and rerified when R35 had been admitted to the acility originally the catheter had been	OF DEFICIENCIES F CORRECTION       (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:         29463       B. WING         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2IP CODE         S ON FAIRVIEW       25565 FAIRVIEW AVENUE WYOMING, MN 55092         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 24       2 910         he cause of the retention.       Dr 4/4/17, at 3:17 p.m. RN-A reviewed the netradisciplinary (IDT) notes stated R35 had been etaining urine and had large amount of post void esiduals (PVR's) around 1/17/17, and the nurses were straight catheterizing R35 and this was when the catheter was inserted again. RN-A tated from 12/31/16, 1/1/17, 1/2/17, and 1/3/17, were dates the nurses had documented R35 was etaining urine and resident needde staff to straight catheterize her as she had PVR's great han 375 ml after the blood scans. When asked if nad been referred to the urologist to rule out the sause of the retention and why R35 was not able o fully empty her bladder, RN-A stated "no." NN-A also stated around the time the catheter wad been inserted other PVR's had been done ind R35 showed large amounts of PVR's iowever not greater than 375 ml for the nurses to itraight catheterize R35. RN-A direview multiple JP and doctor notes which indicated resident had rine retention however did not address R35 had a Foley catheter "Am totally embarrassed." RN-A ause. RN-A also reviewed medical record and rerified when R35 had been admitted to the	OP DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLAT       (X2) MULTIPLE CONSTRUCTION       (X3) DATA         PROVIDER OR SUPPLIER       29463       B. WING       04/         OVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       2000         SON FAIRVIEW       25565 FAIRVIEW AVENUE       WYOMING, NM 55092       PROVIDER'S PLAN OF CORRECTION         SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION DEFICIENCY MAY ENDER PROCEDED BY FULL       PREEX       CROSS-REFERENCED TO THE APPROPRIATE         Continued From page 24       2 910       PROVIDER'S PLAN OF CORRECTIVE ATTON DEFICIENCY       DEFICIENCY WAS THE PROCEDED BY FULL       PREEX         REGULATORY OR LSC IDENTIFYING INFORMATION,       PREEX       TAG       CROSS-REFERENCED TO THE APPROPRIATE         Deficiency MUST BE PROCEDED BY FULL       PREEX       TAG       CROSS-REFERENCED TO THE APPROPRIATE         Deficiency MUST BE PROCEDED BY FULL       PREEX       TAG       CROSS-REFERENCED TO THE APPROPRIATE         Deficiency MUST BE PROCEDED BY FULL       PREEX       TAG       CROSS-REFERENCED TO THE APPROPRIATE         Deficiency MUST BE PROCEDED BY FULL       PREEX       TAG       CROSS-REFERENCED TO THE APPROPRIATE         Deficiency MUST BE ADDRESS (TYN, TATE, ZIP CODE       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY         Continue The anate of the

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		29463	B. WING		04/	04/05/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	<u>.</u>		
MEADOW	VS ON FAIRVIEW		RVIEW AVEN G, MN 55092	IUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	ge 25	2 910				
	have been done aft re-inserted to disco stated she would have nurse practitioner to catheter use justific was brought up about medical record white trials done to disco been sent to the ure the retention, DON up with the NP and documentation for the						
	10/16, directed the "1) Each resident is force specific condi- clinical need for an insertion. Indwelling for residents with u obstruction, to assis sacral or perineal w	assessed and a diagnosis ition necessitating for the indwelling catheter prior to g catheters will only be used rinary retention, or bladder st in the healing of an open yound, prolonged, strict or comfort at the end of life.					
	a comprehensive a care plan for the tre their catheter. Atter factors for infection	th a urinary catheter receives ssessment and individualized eatment or management of ntion is given to minimize risk . Continued need for the is assessed periodically. eatheter system.					
		ss resident need for urinary /e catheter as appropriate"					
	The director of nurs	HOD OF CORRECTION: sing (DON) or designee could procedures regarding					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		29463	B. WING		04/0	)5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MEADOV	WS ON FAIRVIEW		IRVIEW AVE G, MN 5509			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETI DATE
2 910	Continued From pa	ge 26	2 910			
		ndwelling urinary catheters, perform audits to ensure their				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21580	MN Rule 4658.1328 Medications; Requi	5 Subp. 7 Administration of rements	21580			5/14/17
	administration of m complete procedure record, transferring medication from the	tration requirements. The edications must include the e of checking the resident's individual doses of the e resident's prescription ibuting the medication to the				
	by: Based on observati review, the facility fa administration of ins R92) who was obse an insulin pen. This residents who utilize	ent is not met as evidenced on, interview and document ailed to ensure appropriate sulin for 2 of 3 residents (R90, erved to receive insulin from had the potential to affect 4 ed insulin pens in the facility medication observation.		Corrected		
	Findings include:					
	(LPN)-B was obsert Flexpen (used to co from the top drawer wiped the rubber st then twisted the new	a.m. licensed practical nurse ved retrieve a Humalog Kwik ontrol blood sugar) for R90 r. LPN-B then took the cap off, opper with an alcohol wipe edle onto the FlexPen tip then the pen with one unit of				

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		29463	B. WING		04/	05/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
MEADO	WS ON FAIRVIEW		G, MN 55092	IUE		
(X4) ID	SUMMABY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET
21580	Continued From pa	ge 27	21580			
	Humalog. At 8:43 a.m. LPN-B then indicated R90 was going to receive 2 units of Humalog insulin per the sliding scale for blood sugar of 133 in addition to 10 units scheduled at breakfast and lunch making a total of 12 units. At 8:46 a.m. LPN-B was asked about priming the pen prior to dialing the dose, and LPN-B stated she had been instructed to prime the pens with only one unit and that was what the consultant pharmacist wanted the nurses to do. At 9:07 a.m. surveyor requested for the package insert and LPN-B stated the pen did not come with any. At that time LPN-B indicated she had R2 left to administer two different insulin types using Flexpen's. LPN-B was asked what the facility policy was for priming Flexpen's however, LPN-B and surveyor went into the medication storage room and reviewed the package insert for R2's Lantus and Novolog insulin which both directed to prime the pens with 2 units.					
	3/31/17, revealed F 10 units subcutane breakfast and lunch	e Physician Order dated 890 had an order for Humalog ously two times a day with n; 15 units in the evening with ng scale for diabetes mellitus.				
	apply a pair of glow R92's Lantus FlexF medication cart. LP stopper tip with an needle on the tip th without priming the the surveyor walked cart and got to R92	a.m. LPN-A was observed es then was observed retrieve Pen from the top drawer of the N-A then cleaned the rubber alcohol wipe then screwed the en dialed 13 units of Lantus pen. At 7:57 a.m. LPN-A and d away from the medication 's room door and as LPN-A and enter room, surveyor				

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 	
		29463				
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO	WS ON FAIRVIEW		AIRVIEW AVEN IG, MN 55092	IUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21580	•	-	21580			
	intervened. When asked if she had primed the pen prior to dialing the 13 units LPN-A acknowledged she had not and stated she was supposed to prime the pen with 2 units before dialing the actual dose. LPN-A returned to the cart dialed the pen back to zero them primed the pen with 2 units wasted it then dialed the scheduled 13 units. At 7:59 a.m. LPN-A returned to R92's room and administered the correct dose of insulin this time.					
	3/24/17, revealed F Solostar solution p	e Physician Order dated R92 had an order for Lantus en-injector 13 units the morning and 26 units at nellitus type 2.				
	expectation for nur registered nurse (F	9 p.m. when asked about her ses priming the Flexpens, RN)-A stated "they are with 2 units. Will have to do				
	stated she would e Flexpens "Will do e facility policy was fe with two units and thought it was supp unit. DON further s another facility and	) p.m. the director of nursing xpect the nurses to prime the education." DON indicated the or nurses to prime the pens was not sure why the LPN-B posed to be primed with one tated the LPN-B did work at was not sure about the mount to prime with.				
	revised 10/13, direct pen needle onto pe an air shot to prime	n Subcutaneous-Insulin policy cted "Screw the appropriate en. Dial up 2 units and perform e needle and ensure that you ut of needle. This step can be in is observed"				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29463			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 04/05/2017	
		B. WING				
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MEADO	WS ON FAIRVIEW		AIRVIEW AVE IG, MN 5509			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21580	Continued From pa	ige 29	21580			
	The director of nurs in-service all emplo medication adminis and proven standar administer medicat errors. The director could conduct spot compliance.	THOD OF CORRECTION: sing and/or pharmacist could byees responsible for stration to follow facility policies rds of practice to safely ions to residents and prevent of nursing and/or pharmacist audits to determine staff				
21710	(21) days. MN Rule 4658.141		21710			5/14/17
	Subp. 7. Hot water supplied to sinks ar maintained within a	r temperature. Hot water nd bathing fixtures must be a temperature range of 105 t to115 degrees Fahrenheit at				
	by: Based on observati failed to maintain s	ent is not met as evidenced ion and interveiw, the facility afe water temperatures for in o were occupied by residents		Corrected		
	Findings include:					
		vations on 4/3/17, twelve of oms were identified as having mpratures.				
	administrator on 4/3	ompleted with the facility 3/17, at 7:06 p.m., and ing water temperatures:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29463			CONSTRUCTION		E SURVEY PLETED	
		29463	B. WING		04/05/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MEADO\	WS ON FAIRVIEW		AIRVIEW AVEN IG, MN 55092	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21710	Continued From pa	age 30	21710			
	temperature of 116	n sink revealed a water degrees, the bathroom sink rature of 126.1 degrees.				
	temperature of 118	n sink revealed a water 3.4 degrees, the bathroom sink rature of 124 degrees.				
	Room three's kitchen sink revealed a water temperature of degrees, the bathroom sink had a water temperature of 126 degrees.		1			
	temperature of 126	n sink revealed a water degrees, the bathroom sink rature of 126 degrees.				
	temperature of 124	n sink revealed a water I.9 degrees, the bathroom sink rature of 127.8 degrees.				
	temperature of 123	nen sink revealed a water degrees degrees, the a water temperature of 125				
	temperature of 122	en sink revealed a water degrees, the bathroom sink rature of 125 degrees.				
	temperature of 122	en sink revealed a water 2.7 degrees, the bathroom sink rature of 125 degrees.				
	temperature of 122	n sink revealed a water 2.2 degrees, the bathroom sink rature of 125 degrees.				
	temperature of 125	hen sink revealed a water 5.6 degrees, the bathroom sink rature of 125.5 degrees.				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         29463			CONSTRUCTION		E SURVEY PLETED	
		29463	B. WING		04/	05/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	• • •	
MEADO	WS ON FAIRVIEW		AIRVIEW AVEN IG, MN 55092	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21710	Continued From pa	age 31	21710			
	temperature of 123 had a water tempe	chen sink revealed a water degrees, the bathroom sink rature of 124.9 degrees.				
	Room fouteen's kitchen sink revealed a water temperature of 123.9 degrees, the bathroom sink had a water temperature of 124.9 degrees.					
	of checking the war administrator state	p.m. when asked the process ter temperatures, the d she did not know the process e director had a log for that she				
	following the water facility was going to nursing home side forward a temperat	p.m. the administrator stated temperature concern the o install a mixing valve for the of the building and moving ure log was going to be ly monitor the water				
	The administrator of system for monitoring resident rooms at work of the administrator of the	THOD FOR CORRECTION: or designee could set up a ing water temperatures in varying times during the day. or designee could then audit to eratures are being monitored ole ranges.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				