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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GWUN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29463

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245622**

2.STATE VENDOR OR MEDICAID NO.
(L2) **658925200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOWS ON FAIRVIEW**
(L4) **25565 FAIRVIEW AVENUE**
(L5) **WYOMING, MN** (L6) **55092**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/24/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **14** (L18)

13.Total Certified Beds **14** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	14			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE-NE II 09/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 09/20/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/23/2014
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00010
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/23/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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 Peterson

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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 Peterson

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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: 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 Peterson

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GWUN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29463

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245622**

2. STATE VENDOR OR MEDICAID NO. (L2) **658925200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOWS ON FAIRVIEW**
(L4) **25565 FAIRVIEW AVENUE**
(L5) **WYOMING, MN** (L6) **55092**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/05/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **14** (L18)

13.Total Certified Beds **14** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	14			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 05/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/23/2014
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00010
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 157		5/14/17

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

Electronically Signed | 05/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 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 review, the facility failed to ensure the physician was notified for a change in a resident weights for 1 of 1 resident (R94) reviewed for notification of change. Findings include: R94's diagnoses included muscle weakness, hyperkalemia, presence of cardiac pacemaker, bradycardia, atrial fibrillation, arteriosclerotic heart disease of native coronary artery without angina pectoris, cardiomyopathy, acute kidney failure, edema, chronic kidney disease, stage 3,	F 157	Resident (R94)□s physician orders were reviewed and were accurately followed as of April 6, 2017. Facility implemented weekly interdisciplinary meetings designed to address each current resident and any changes to their care plan or the need to notify the resident□s physician. These weekly meetings began April 19, 2016. Education of staff has been, and will be, provided to staff regarding Change of Condition/Notification Policy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 pulmonary hypertension, essential hypertension and acute on chronic systolic (congestive) heart failure (CHF) obtained from the electronic Medication Administration Record (EMAR) for April 2017. 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. During review of the Physician Orders dated 3/23/17, it was revealed R94 had the following orders: -"Daily weights-call MD [medical doctor] with weight gain of 2 pounds in 24 hours or 5 pounds in a week, every day shift for CHF [congestive heart failure]" -Carvedilol (anti-hypertensive) 3.125 milligram (mg) give 1 tablet by mouth two times a day for atrial fibrillation give with meals -Furosemide (water pill-diuretic) 40 mg give 1 tablet by mouth in the morning for heart failure -Ramipril (anti-hypertensive) 10 mg give 1 capsule by mouth in the morning for hypertension	F 157	procedures. This initial re-education will be complete by May 14, 2017. DON/designee will do on-going audits until 100% compliant for one quarter. All re-training, and audit/review schedules will be in place by May 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 During review of the electronic treatment administration record (ETAR) for March 2017 and April 2017, weights had been obtained as follows: -3/28/17: 170 pounds (#) -3/29/17: 173# (3# gain from previous day) -3/30/17: 174# -3/31/17: 171.8# -4/1/17: 173.4# -4/2/17: 171.4# -4/3/17: 174# (2.6# gain from previous day) -4/4/17: 174# R94's medical record lack documentation of the medical doctor and/or nurse practitioner being notified of the weight gains on 3/29/17, and 4/3/17, as directed by the physician order. R94's dehydration Care Area Assessment (CAA) dated 3/30/17, indicated R94 received a diuretic daily for congestive heart failure, had edema to both lower extremities (BLE) and staff encouraged resident to elevate BLE when in bed and chair. CAA directed staff to continue to observe for changes and update MD as needed. On 4/4/17, at 3:39 p.m. registered nurse (RN)-A verified the weight gain in the ETAR for March and April 2017, reviewed the interdisciplinary notes and verified MD had not been notified. RN-A stated she would expect the MD to have been notified because it was a specific physician order as resident had CHF. On 4/5/17, at 7:43 a.m. when asked about weights nursing assistant (NA)-A stated R94 was a daily weight and she had weighed him and had put it in the computer and would let the nurse know the weight. On 4/5/17, at 1:51 p.m. the director of nursing	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4 stated she would have expected the doctor to be notified regarding the weight gain as directed by the physician order. On 4/5/17, a Physician's Order policy was requested however the director of nursing stated was not able to find it. The facility Change of Condition/Notification policy revised 12/16, directed staff to notify the attending physician/nurse practitioner or on-call immediately of residents change in condition/health status change based on a comprehensive assessment.	F 157		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279		5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 279	Resident (R35) Care Plan was updated to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 6 review, the facility failed to ensure 1 of 3 residents (R35) who had an indwelling catheter had a care plan developed reviewed for urinary catheter use. In addition, the facility failed to develop a care for 2 of 2 residents (R39, R35) reviewed for pressure ulcers. Findings include: On 4/3/17, at 2:08 p.m. when asked was there use of an indwelling Foley catheter, registered nurse (RN)-A stated "Yes." When asked the reason for R35's catheter RN-A stated was related to urine retention. On 4/4/17, at 2:52 p.m. R35 was observed lying in bed on her back, lights out on room. When approached and asked about the catheter and when it had been put in place resident was not able to re-call however, stated the staff always did empty it for her. When asked if she had any pain/discomfort R35 stated "no" she stated she was able to use the bathroom for her bowel movements. The catheter bag was hanging on the right side of the bed at the time. R35's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 11/27/16, indicated resident had a recent fall resulting in a right femur fracture, recent hospitalization and was admitted to the transitional care unit (TCU). The CAA indicated the Foley catheter had been discontinued on 11/28/16. R35's care plan dated 12/28/16, indicated resident was not able to complete activities of daily living (ADLs) independently at the time. The care plan indicated R35 had left a fracture,	F 279	reflect the existence of the Foley catheter. It was additionally updated to reflect the removal of the catheter on April 16, 2017. Resident (R39) was no longer a resident of the facility at the time of the survey review. Resident (R56) was no longer a resident of the facility at the time of the survey review. Education of staff has been, and will be, provided to staff regarding development of care plans with specific focus on catheters and skin assessments. This initial re-education will be complete by May 14, 2017. DON/designee will conduct regular monitoring of care plans and care plans audits. All re-training, monitoring and audit/review schedules will be in place by May 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 7	F 279		

weakness and limited functional movement. The care plan directed staff to provide "TOILETING: 1 assist to help with personal hygiene and clothing management." The care plan did not identify resident had a Foley catheter.

R35's Physician Order dated 1/17/17, directed "Okay [Ok] to place 14 French 5 ml [milliliter] Foley catheter for urine retention."

R35's diagnoses included heart failure, chronic kidney disease, stage 3 (moderate), retention of urine, weakness and difficulty in walking obtained from the quarterly Minimum Data Set (MDS) dated 2/25/17. In addition, the MDS indicated R35 had an indwelling catheter, required extensive assist of one for toilet use and personal hygiene and required extensive physical assistance of two staff with transfers and did not ambulate.

R35's Physician Notes from 11/22/16 to 3/28/17, were reviewed and lacked documentation of rationale for the ongoing use of the indwelling catheter. In addition, it was revealed on some of the progress notes the provider had documented the family had indicated urine retention had been a problem for R35 following surgeries, with most recent hospital stay 12/24/16, through 12/28/16, after R35 had a fall and had sustained a right hip fracture. During further review of the physician and nurse practitioner 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 R35's care plan and verified the care plan did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 8	F 279		

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."

On 4/5/17, at 12:46 p.m. the director of nursing (DON) stated she would have expected care plan to be developed to address the catheter.

The facility Indwelling Catheter policy revised 10/16, directed the following:
"2) Each resident with a urinary catheter receives a comprehensive assessment and individualized care plan for the treatment or management of their catheter. Attention is given to minimize risk factors for infection. Continued need for the indwelling catheter is assessed periodically. Maintain a closed catheter system..."

The facility Individualized Care plan policy revised 12/13, directed "1. Upon admission, the nursing department begins the care plan and addresses the immediate needs of the resident in the initial care plan. The presenting problem and significant functional dependencies will be addressed..."
R39's Ebenezer initial Admit Assessment dated 1/17/17, indicated R39 had "sacral redness."

R39's admission Minimum Data Set (MDS) dated 1/24/17, indicated she was moderately cognitively impaired, was occasionally incontinent of bowel and bladder and required physical assistance for bed mobility, transfers and toileting. R39's care plan dated 2/3/17, identified a risk for alteration in skin integrity related to decreased mobility and back pain. A facility Braden and Skin Risk assessment dated 1/18/18, identified a history of pressure ulcers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9	F 279		

A facility Weekly Pain and Bath Sheet, dated 1/25/17, indicated R39's skin was not intact and identified redness to the right and left iliac crests (the largest of the three bones that merge to form the hip bone) and redness to her groin. R39's Meadows on Fairview Progress Note dated 1/27/17 indicated: Patient complained of lower back and buttock pain today. Buttocks area red, blanchable, 3 small open areas on right buttock near intragluteal cleft. See skin charting. An Ebenezer 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 amount of exudate, surrounding area redness and pain. The assessment did not include measurements, assessment of the wound bed or staging. An Ebenezer Skin Integrity Documentation assessment dated 2/2/17, identified a skin issue on R39's left buttock had healed, however there was no prior documentation of the skin issue.

While R39 initial assessment identified redness to her sacrum and required assistance to complete activities of daily living, a care plan for pressure ulcers was not developed until R39 had already acquired a pressure ulcer.

R56's 60 day Minimum Data Set (MDS) dated 12/30/16, indicated she was cognitively intact and required extensive assistance with bed mobility, transfers and toileting, R56's care plan dated 11/5/16, indicated a need for physical assistance related to cerebral vascular attack (CVA) with left sided weakness. The care plan further indicated an alteration in skin integrity and indicated a new pressure injury, stage II, left tuberosity (one of two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10	F 279		

bony swellings found on the lower back part of the hip bone,) identified on 1/12/17.

A review of a facility Pressure Wound Documentation assessment, dated 1/12/17, identified a stage II pressure injury (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) on R56's left buttock measuring 0.5 centimeters (cm) x 0.3 cm. R56 remained in the facility until 1/24/16, there was no evidence the facility completed any additional assessments of her pressure ulcer. During an interview on 4/4/17, at 3:19 p.m., licensed practical nurse (LPN)-B stated if a skin concern was identified, staff open a skin assessment. LPN-B stated open areas are measured and documented weekly by the nurse on duty.

R56 admitted to the facility with risk for skin breakdown, there was no evidence the facility nictitated a care plan until R56 had already acquired a pressure ulcer.

During an interview on 4/5/17, at 9:15 a.m., registered nurse (RN)-B stated skin assessments were completed on admission and if a new skin issue was found. RN-B stated if a skin concern was identified, staff would monitor daily and assess weekly including measurements and weekly progress notes. She stated every resident should receive a skin assessment each week and document on the Weekly Pain and Bath Day Sheet.

During an interview on 4/5/17, at 10:34 a.m., RN-A stated she was responsible for starting the initial plan of care and the nurses should keep it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 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 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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	F 280		5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 13 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include fall interventions for 1 of 2 residents (R15) who had experienced a fall in the facility. Findings include: R15's Admission Minimum Data Set (MDS) dated 10/29/16, indicated she was cognitively intact and required extensive assistance with all activities of daily living. A care area assessment (CAA) dated 11/3/16, indicated a risk for falls. R15's care plan dated 10/22/16, did not identify falls. An Ebenezer Fall Risk Tool dated 10/23/16, indicated R15 was at risk for falls. A review of R15's Meadows on Fairview Progress Note dated 10/22/16, indicated R15 admitted to the facility on that date. She required assistance of 1 staff to complete activities of daily living, was using a walker and wheel chair for long distances and was continent of bowel and bladder. A Meadows on Fairview Progress Note dated 10/25/15, identified a fall in her bathroom. The progress note indicated R15 was found on the floor in her bathroom facing the toilet. She stated she did not hit her head, but did hit her upper arm	F 280	Resident (R15) was no longer a resident of the facility at the time of the survey review. Fall assessments and care plan data have been reviewed or updated for current residents. Education of staff has been, and will be, provided to staff regarding revision of care 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/review schedules will be in place by May 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 14 on her walker when she fell. R15 was noted to have a 10 centimeter (CM) x 5 cm bruise on her upper arm. R15 stated she felt "wobbly" and lost her balance. During an interview on 4/5/16, at 10:50 a.m., registered nurse (RN)-A sated R15 had been independent prior to her fall and had been participating in therapy. She stated the facility "usually" does a follow- up after a fall but stated there was not one done for R15. RN-A stated, "we missed it." RN-A stated, she was responsible for developing the care plans and stated R15's care plan should have identified falls. 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 on admit. The facility Individualized Care plan policy revised 12/13, directed "1. Upon admission, the nursing department begins the care plan and addresses the immediate needs of the resident in the initial care plan. The presenting problem and significant functional dependencies will be addressed..." While R15 admitted to the facility for therapy and had an identified risk for falls, there was no evidence of care planned interventions for fall prevention even after R5 sustained a fall.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 281		5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE WYOMING, MN 55092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 15 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a temporary care plan was developed following admission for 1 of 2 residents (R90) reviewed for pain. Findings include: R90's diagnoses included unilateral primary osteoarthritis right knee, chronic migraine and diabetic polyneuropathy obtained from the electronic medication administration record (EMAR) for April 2017. In addition, the Physician Orders revealed R90 was admitted to the facility on 3/31/17. On 4/3/17, at 1:29 p.m. during interview when asked do you have any discomfort now or have you been having discomfort such as pain, heaviness, burning, or hurting with no relief, "My neck, back and legs sometimes they tell me it's not time for the pain medications. I have an appointment with the pain clinic on Wednesday." During the interview, R90 was observed rubbing the back of the neck and indicated she was not able to turn her neck due to the pain and requested for a warm pack. On 4/4/17, at 8:24 a.m. licensed practical nurse (LPN)-B went to room to check the blood sugar when R90 stated she was in a lot of pain on her neck. At that time a white adhesive patch was observed on the back of the neck area peeled off. When surveyor told the LPN-B about the patch, LPN-B stated she would get skin prep to adhere it to the skin. LPN-B indicated to R90 she had just received Oxycodone and would be getting the	F 281	Resident (R90) was no longer a resident at the time of the survey review. However, during the duration of the survey (R90)□s Care Plan was updated to include interventions for pain. Pain assessments and care plan data have been reviewed or updated for current residents. Education of staff has been, and will be, provided to staff regarding revision of care plans with specific focus on pain 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 pain. All re-training, monitoring and audit/review schedules will be in place by May 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 16	F 281		

next dose at noon. At 8:40 a.m. LPN-B returned to room observed resident lying in bed and LPN-B indicated to R90 she had all the morning meds and the breakfast tray was coming. R90 was observed get herself up and sat on the edge of the bed, removed her oxygen and stated she had a headache. LPN-B stated she would get her "some Tylenol [a mild analgesic]" then continued to administer the medications. R90 brought up the concern of not being sure if she was going to get to the appointments she had scheduled in Maple Grove which included the pain clinic one. LPN-B stated she would follow up on it. LPN-B then asked R90 if she wanted a heat pack. LPN-B attempted to apply the Diclofenac gel (topical gel for pain) however, R90 declined stated she would wait until she had a shower.

On 4/5/17, at 9:22 a.m. to 9:27 a.m. R90 was observed propelling her wheelchair from the dining room to her room. When asked about her pain, R90 stated she had in the past two rotator cuff repairs, had a spinal fusion, she had neuropathy in her feet which was bad at times and had arthritis. R90 stated she had been working with her regular family practice doctor who had referred her to the pain clinic. R90 stated because of constipation there was issues with adjusting or increasing the pain medications. R90 stated in the past she had used Vicodin (narcotic) or Tramadol (analgesic pain reliever) for break through pain and this really did help and she was going to ask the pain clinic doctor later that day at the appointment. As R90 spoke to surveyor her fingers on both hands were observed swollen and deformed. When asked about her fingers R90 stated she had arthritis which was "sometimes really bad and like yesterday I was not able to pick up a piece of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 17	F 281		

bacon." R90 stated the pain at time was so bad and she had noticed her pain medications had been changed since being at the facility and she was going to discuss this with the pain clinic doctor. R90 also stated her pain most of the time was rated between a 7-10 since she admitted to the facility before the pain medications and her tolerable pain threshold was 2-3. When asked about the pain medications, R90 stated she used the Fentanyl patch (narcotic pain patch) which she thought was 25 microgram (mcg).

R90's Physician Orders dated 4/5/17, revealed the following pain medications:
-Fentanyl Patch 72 Hour 25 mcg/HR Apply 1 patch transdermal every 48 hours for pain and remove per schedule
-Imitrex (migraine medication) 50 mg by mouth as needed for migraine may repeat after 2 hours. Do not exceed 200 mg/24 hr.
-Lidocaine Patch 5% Apply to painful areas topically one time a day for Pain 1-3 patches. On Am and Off HS and remove per schedule
-Oxycodone hydrochloride 10 mg 1 tablet by mouth four times a day for pain give every 6 hours.

On 4/4/17, during review of the initial temporary care plan which was fours after admission to the facility, it was revealed even though, R90 had scheduled pain medications and had complained of pain the medical record lack a temporary care plan addressing her pain.

On 4/5/17, at 12:29 p.m. registered nurse (RN)-A reviewed the initial care plan and verified there was no pain care plan initiated. RN-A stated usually on admit she would be the one who would initiate the care plan then other staff would go in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 18 and add to it. When asked if she had been at the facility on 3/31/17, when R90 admitted RN-A stated "Yes. It should have been done." On 4/5/17, at 12:44 p.m. the director of nursing stated she would expect the initial temporary care plan to be developed especially to addressing pain and skin care areas right away and other care areas identified with each resident. The facility Individualized Care plan policy revised 12/13, directed "1. Upon admission, the nursing department begins the care plan and addresses the immediate needs of the resident in the initial care plan. The presenting problem and significant functional dependencies will be addressed..."	F 281		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 314		5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 Based on interview and record review, the facility failed to accurately assess pressure ulcers for 2 of 2 resident (R39, R56) reviewed for pressure ulcers. Findings include: R39's initial Admit Assessment dated 1/17/17, indicated R39 had "sacral redness." There were no measurements, no indication of whether the area was blanchable, no staging, nor was there evidence of ongoing monitoring. A facility Braden and Skin Risk assessment dated 1/18/17, identified a history of pressure ulcers. R39's admission Minimum Data Set (MDS) dated 1/24/17, indicated she was moderately cognitively impaired, was occasionally incontinent of bowel and bladder and required physical assistance for bed mobility, transfers and toileting. A facility Weekly Pain and Bath Sheet dated 1/25/17, indicated R39's skin was not intact and identified redness to the right and left iliac crests (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	F 314	Resident (R39) was no longer a resident of the facility at the time of survey review. Resident (R56) was no longer a resident of the facility at the time of the survey review. Skin/Pressure Sore assessments and care plan data have been reviewed or updated for current residents. Education of staff has been, and will be, provided to staff regarding revision of care plans with specific focus on skin, pressure sore documentation, 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 skin/pressure sores. All re-training, monitoring and audit/review schedules will be in place by May 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 20	F 314		

amount of exudate, surrounding area redness and pain. The assessment did not include measurements, assessment of the wound beds or staging.

A Skin Integrity Documentation assessment dated 2/2/17, indicated an area of skin on R39's left buttock had healed, however there was no prior documentation of what the skin issue had been.

R39's care plan dated 2/3/17, identified a risk for alteration in skin integrity related to decreased mobility and back pain.

Registered nurse (RN)-A stated she recalled having seen R39's skin, and stated it was noted on 1/17/17, but stated nothing was done about it until the 25th of January.

R56's Progress Notes indicated R56 remained in the facility until 1/24/16, and there was no evidence the facility had completed any additional assessments of her pressure ulcer.

R56's 60 day MDS dated 12/30/16, indicated she was cognitively intact and required extensive assistance with bed mobility, transfers and toileting, R56's care plan dated 11/5/16, indicated a need for physical assistance related to cerebral vascular accident (CVA) with left sided weakness. The care plan further indicated R56 had an alteration in skin integrity and indicated a new pressure injury, stage II (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister), on the left tuberosity (one of two bony swellings found on the lower back part of the hip bone) had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE WYOMING, MN 55092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 21 been identified on 1/12/17. 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. During an interview on 4/4/17, at 3:19 p.m., licensed practical nurse (LPN)-B stated if a skin concern was identified, staff would initiated a skin assessment. LPN-B further stated open areas are measured and documented on weekly by the nurse on duty. During an interview on 4/5/17, at 9:15 a.m., RN-B stated skin assessments were supposed to be completed on admission and any time a new skin issue was found. RN-B stated if a skin concern was identified, staff would monitor daily and assess weekly including measurements and weekly progress notes. In addition, RN-B stated every resident should have a skin assessment conducted each week which would be documented on the Weekly Pain and Bath Day Sheet. During an interview on 4/5/17, at 10:34 a.m., RN-A stated staff were supposed to complete a skin check each week on bath day and document on the Weekly Pain and Bath Day sheet. She stated if a skin concern was identified, staff would initiate skin integrity documentation. RN-A stated R56's skin alteration was noted as an abrasion and that it was "likely" due to a lack of a better description on the assessment. RN-A stated education on skin issues was likely needed. During an interview on 4/5/17, at 1:00 p.m., the director of nursing stated nurses complete a full	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 22 body skin assessment on admit. She stated if any alterations were noted they should be documented on until healed, including descriptions with measurements and any blanching. A facility policy for skin assessment and documentation was requested but not received.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 315		5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE WYOMING, MN 55092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 23 continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medical justification for the use of an indwelling catheter was provided for 1 of 3 residents (R35) who were reviewed for urinary catheters. Findings include: On 4/3/17, at 2:08 p.m. when asked was there use of an indwelling Foley catheter, registered nurse (RN)-A stated "Yes." When asked the reason for R35's catheter RN-A stated was related to urine retention. On 4/4/17, at 2:52 p.m. R35 was observed lying in bed on her back, lights out on room. When approached and asked about the catheter and when it had been put in place resident was not able to re-call however, stated the staff always did empty it for her. When asked if she had any pain/discomfort R35 stated "no" she stated she was able to use the bathroom for her bowel movements. The catheter bag was hanging on the right side of the bed at the time. R35's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 11/27/16, indicated resident had a recent fall resulting in a right femur fracture, recent	F 315	Resident (R35)□s catheter was removed on April 16, 2016 per physician order. (R35)□s care plan has been updated to reflect the removal of the catheter. Review of medical justification for catheters for current residents will be complete. Education of staff has been, and will be, provided to staff with specific focus regarding catheter placement, care and review. This initial re-education will be complete by May 14, 2017. DON/designee will conduct regular monitoring of catheters and care plan audits particularly with relation to catheters. All re-training, monitoring and audit/review schedules will be in place by May 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 24	F 315		

hospitalization and was admitted to the transitional care unit (TCU). The CAA indicated the Foley catheter had been discontinued on 11/28/16.

R35's care plan dated 12/28/16, indicated resident was not able to complete activities of daily living (ADLs) independently at the time. The care plan indicated R35 had left a fracture, weakness and limited functional movement. The care plan directed staff to provide "TOILETING: 1 assist to help with personal hygiene and clothing management." The care plan did not identify resident had a Foley catheter.

R35's Physician Order dated 1/17/17, directed "Okay [Ok] to place 14 French 5 ml [milliliter] Foley catheter for urine retention."

R35's diagnoses included heart failure, chronic kidney disease - stage 3 (moderate), retention of urine, weakness and difficulty in walking obtained from the quarterly Minimum Data Set (MDS) dated 2/25/17. In addition, the MDS indicated R35 had an indwelling catheter, required extensive assist of one for toilet use and personal hygiene and required extensive physical assistance of two staff with transfers and did not ambulate.

R35's Physician Notes from 11/22/16 to 3/28/17, were reviewed and lacked documentation of rationale for the ongoing use of the indwelling catheter. In addition, it was revealed through review of the Progress Notes, the provider had documented the family had indicated urine retention had been a problem for R35 following surgeries, with most recent hospital stay 12/24/16 through 12/28/16, after R35 had a fall and had sustained a right hip fracture. During further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE WYOMING, MN 55092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 26	F 315		

facility originally the catheter had been discontinued on 11/28/16, and had been successful. RN-A stated "Am going to suggest to the NP to attempt a trial."

On 4/5/17, at 12:46 p.m. the director of nursing (DON) stated she would have expected a trial to have been done after the catheter was re-inserted to discontinue the catheter. DON also stated she would have expected the doctor or nurse practitioner to have followed up with the catheter use justification for use. When concern was brought up about no documentation in the medical record which addressed any attempt trials done to discontinue catheter or if R35 had been sent to the urologist to identify the cause of the retention, DON stated she would be following up with the NP and doctor to see if there was any documentation for this.

The facility Indwelling Catheter policy revised 10/16, directed the following:
"1) Each resident is assessed and a diagnosis force specific condition necessitating for the clinical need for an indwelling catheter prior to insertion. Indwelling catheters will only be used for residents with urinary retention, or bladder obstruction, to assist in the healing of an open sacral or perineal wound, prolonged, strict immobilization or for comfort at the end of life. Obtain a urology consult.

2) Each resident with a urinary catheter receives a comprehensive assessment and individualized care plan for the treatment or management of their catheter. Attention is given to minimize risk factors for infection. Continued need for the indwelling catheter is assessed periodically. Maintain a closed catheter system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 27 3) Continually assess resident need for urinary catheter and remove catheter as appropriate..."	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess and implement interventions related to falls for 1 of 2 resident (R15) reviewed for accidents.	F 323	Resident (R15) was no longer a resident of facility at the time of survey review. Fall assessments and post fall protocol have been reviewed and/or updated for	5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28 Findings include: R15's Admission Minimum Data Set (MDS) dated 10/29/16, indicated she was cognitively intact and required extensive assistance with all activities of daily living. A care area assessment (CAA) dated 11/3/16, indicated a risk for falls. R15's care plan dated 10/22/16, did not identify falls. An Ebenezer Fall Risk Tool dated 10/23/16, indicated R15 was a low fall risk. R15's Meadows on Fairview Order Summary Report, dated 10/22/16, identified the use of Warfarin.(Warfarin is an anticoagulant used to prevent heart attacks, strokes, and blood clots.) The Plan of Care did not address anti-coagulant monitoring. A review of R15's Meadows on Fairview Progress Note dated 10/22/16, indicated R15 admitted to the facility on that date. She required assistance of 1 staff to complete activities of daily living, was using a walker and wheel chair for long distances and was continent of bowel and bladder. A Meadows on Fairview Progress Note dated 10/23/16, indicated R15 was alert and oriented x 3 and independent with activities of daily living. A Meadows on Fairview Progress Note dated 10/25/15, identified a fall in her bathroom. The progress note indicated R15 was found on the floor in her bathroom facing the toilet. She stated she did not hit her head, but did hit her upper arm on her walker when she fell. R15 was noted to have a 10 centimeter (CM) x 5 cm bruise on her upper arm. R15 stated she felt "wobbly" and lost her balance. A Meadows on Fairview progress note dated 10/26/16, indicated R15 was having increased	F 323	current residents. Education of staff has been, and will be, provided to staff regarding falls policies and procedures and implementing post-fall interventions. This initial re-education will be complete by May 14, 2017. DON/designee will conduct regular monitoring of falls and post-fall interventions. All re-training, monitoring and audit/review schedules will be in place by May 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 29	F 323		

confusion and weakness and needed total assist with cares and assistance 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.

During an interview on 4/5/16, at 10:50 a.m., registered nurse (RN)-A sated R15 had been independent prior to her fall and had been participating in therapy. She stated the facility "usually" does a follow- up after a fall but stated there was not one done for R15. RN-A stated, "we missed it." RN-A stated, after R15 fell she was refusing to get out of bed and go to therapy. RN-A further stated R15 should "definitely" have been on monitoring for anti-coagulant use.

During an interview on 4/5/17, at 1:04 p.m., the director of nursing stated when a patient falls there should be an incident report and a follow up within 24 hours. She stated she would expect staff to assess the patient for injury and stated if the patient was on anti-coagulants, staff should be monitoring for bruising and bleeding.

While R15 admitted to the facility for therapy and had an identified risk for falls, there was no evidence of care planned interventions for fall prevention and while she was receiving anti-coagulating medications, there was no evidence the facility was monitoring for side effects, even after R5 sustained a fall. Further, there was no evidence the facility re-assessed R15's risk for falls after she sustained a fall on 10/26/16, even though she declined from an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 30 independent status to no longer able to get out of bed. A facility policy for falls was requested but not received.	F 323		
F 328 SS=E	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be	F 328		5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 31 administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate administration of insulin for 2 of 3 residents (R90, R92) who was observed to receive insulin from an insulin pen. This had the potential to affect 4 residents who utilized insulin pens in the facility reviewed during a medication observation. Findings include: R90 On 4/4/17, at 8:36 a.m. licensed practical nurse (LPN)-B was observed retrieve a Humalog Kwik Flexpen (used to control blood sugar) for R90	F 328	Resident (R90) was no longer a resident at the facility at the time of survey review. Resident (R92) was no longer a resident of the facility at the time of survey review. Proper Insulin administration has been reviewed with staff for current residents. Education has been, and will be, provided to staff regarding Insulin Administration policies and procedures. This initial re-education will be complete by May 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 32 from the top drawer. LPN-B then took the cap off, wiped the rubber stopper with an alcohol wipe then twisted the needle onto the FlexPen tip then proceeded to prime the pen with one unit of 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 stated she was not sure. At 9:09 a.m. 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. During review of the Physician Order dated 3/31/17, revealed R90 had an order for Humalog 10 units subcutaneously two times a day with breakfast and lunch; 15 units in the evening with dinner and per sliding scale for diabetes mellitus. R92 On 4/5/17, at 7:55 a.m. LPN-A was observed apply a pair of gloves then was observed retrieve R92's Lantus FlexPen from the top drawer of the medication cart. LPN-A then cleaned the rubber stopper tip with an alcohol wipe then screwed the	F 328	DON/designee will conduct regular monitoring of insulin administration. All re-training, monitoring and audit/review schedules will be in place by May 14, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 33	F 328		

needle on the tip then dialed 13 units of Lantus without priming the pen. At 7:57 a.m. LPN-A and the surveyor walked away from the medication cart and got to R92's room door and as LPN-A was going to knock and enter room, surveyor 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.

During review of the Physician Order dated 3/24/17, revealed R92 had an order for Lantus Solostar solution pen-injector 13 units subcutaneously in the morning and 26 units at bedtime diabetes mellitus type 2.

On 4/5/17, at 12:29 p.m. when asked about her expectation for nurses priming the Flexpens, registered nurse (RN)-A stated "they are supposed to prime with 2 units. Will have to do some education."

On 4/5/17, at 12:40 p.m. the director of nursing stated she would expect the nurses to prime the Flexpens "Will do education." DON indicated the facility policy was for nurses to prime the pens with two units and was not sure why the LPN-B thought it was supposed to be primed with one unit. DON further stated the LPN-B did work at another facility and was not sure about the confusion on the amount to prime with.

The facility Injection Subcutaneous-Insulin policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE WYOMING, MN 55092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 34 revised 10/13, directed "Screw the appropriate pen needle onto pen. Dial up 2 units and perform an air shot to prime needle and ensure that you see insulin come out of needle. This step can be repeated until insulin is observed..."	F 328		

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

F5622002

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING **01 - MEADOWS FAIRVIEW** B. WING _____	**04/06/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	**25565 FAIRVIEW AVENUE WYOMING, MN 55092**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Meadows on Fairview was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Meadows on Fairview is one wing of an assisted living facility that was constructed in 2004 and converted to nursing home in 2014. The building construction type has been determined to be Type V(111)). It is properly separated from the original building constructed in 2004 by 2 hour fire resistive construction, with 1.5 hour rated doors. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 14 beds and had a census of 13 at the time of the survey. The requirement at 42 CFR, Subpart 485.623 (d) is MET.	K 000		

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

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

MDH
Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/3/17, through 4/5/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician was notified for a change in a resident weights for 1 of 1 resident (R94) reviewed for notification of change. Findings include: R94's diagnoses included muscle weakness, hyperkalemia, presence of cardiac pacemaker, bradycardia, atrial fibrillation, arteriosclerotic heart disease of native coronary artery without angina pectoris, cardiomyopathy, acute kidney failure, edema, chronic kidney disease, stage 3, pulmonary hypertension, essential hypertension and acute on chronic systolic (congestive) heart failure (CHF) obtained from the electronic Medication Administration Record (EMAR) for April 2017. 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	2 265	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4 compared to before however still did experience some. During review of the Physician Orders dated 3/23/17, it was revealed R94 had the following orders: -"Daily weights-call MD [medical doctor] with weight gain of 2 pounds in 24 hours or 5 pounds in a week, every day shift for CHF [congestive heart failure]" -Carvedilol (anti-hypertensive) 3.125 milligram (mg) give 1 tablet by mouth two times a day for atrial fibrillation give with meals -Furosemide (water pill-diuretic) 40 mg give 1 tablet by mouth in the morning for heart failure -Ramipril (anti-hypertensive) 10 mg give 1 capsule by mouth in the morning for hypertension During review of the electronic treatment administration record (ETAR) for March 2017 and April 2017, weights had been obtained as follows: -3/28/17: 170 pounds (#) -3/29/17: 173# (3# gain from previous day) -3/30/17: 174# -3/31/17: 171.8# -4/1/17: 173.4# -4/2/17: 171.4# -4/3/17: 174# (2.6# gain from previous day) -4/4/17: 174# R94's medical record lack documentation of the medical doctor and/or nurse practitioner being notified of the weight gains on 3/29/17, and 4/3/17, as directed by the physician order. R94's dehydration Care Area Assessment (CAA) dated 3/30/17, indicated R94 received a diuretic daily for congestive heart failure, had edema to both lower extremities (BLE) and staff encouraged resident to elevate BLE when in bed and chair. CAA directed staff to continue to	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 5 observe for changes and update MD as needed. On 4/4/17, at 3:39 p.m. registered nurse (RN)-A verified the weight gain in the ETAR for March and April 2017, reviewed the interdisciplinary notes and verified MD had not been notified. RN-A stated she would expect the MD to have been notified because it was a specific physician order as resident had CHF. On 4/5/17, at 7:43 a.m. when asked about weights nursing assistant (NA)-A stated R94 was a daily weight and she had weighed him and had put it in the computer and would let the nurse know the weight. On 4/5/17, at 1:51 p.m. the director of nursing stated she would have expected the doctor to be notified regarding the weight gain as directed by the physician order. On 4/5/17, a Physician's Order policy was requested however the director of nursing stated was not able to find it. The facility Change of Condition/Notification policy revised 12/16, directed staff to notify the attending physician/nurse practitioner or on-call immediately of residents change in condition/health status change based on a comprehensive assessment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop policies and procedures to ensure each resident's representative is promptly notified of all changes in condition and/or changes in treatments. The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance.	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 265		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R35) who had an indwelling catheter had a care plan developed reviewed for urinary catheter use. In addition, the facility failed to develop a care for 2 of 2 residents (R39, R35) reviewed for pressure ulcers. Findings include: On 4/3/17, at 2:08 p.m. when asked was there use of an indwelling Foley catheter, registered nurse (RN)-A stated "Yes." When asked the reason for R35's catheter RN-A stated was	2 555	Corrected	5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 7 related to urine retention. On 4/4/17, at 2:52 p.m. R35 was observed lying in bed on her back, lights out on room. When approached and asked about the catheter and when it had been put in place resident was not able to re-call however, stated the staff always did empty it for her. When asked if she had any pain/discomfort R35 stated "no" she stated she was able to use the bathroom for her bowel movements. The catheter bag was hanging on the right side of the bed at the time. R35's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 11/27/16, indicated resident had a recent fall resulting in a right femur fracture, recent hospitalization and was admitted to the transitional care unit (TCU). The CAA indicated the Foley catheter had been discontinued on 11/28/16. R35's care plan dated 12/28/16, indicated resident was not able to complete activities of daily living (ADLs) independently at the time. The care plan indicated R35 had left a fracture, weakness and limited functional movement. The care plan directed staff to provide "TOILETING: 1 assist to help with personal hygiene and clothing management." The care plan did not identify resident had a Foley catheter. R35's Physician Order dated 1/17/17, directed "Okay [Ok] to place 14 French 5 ml [milliliter] Foley catheter for urine retention." R35's diagnoses included heart failure, chronic kidney disease, stage 3 (moderate), retention of urine, weakness and difficulty in walking obtained from the quarterly Minimum Data Set (MDS)	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 8 dated 2/25/17. In addition, the MDS indicated R35 had an indwelling catheter, required extensive assist of one for toilet use and personal hygiene and required extensive physical assistance of two staff with transfers and did not ambulate. R35's Physician Notes from 11/22/16 to 3/28/17, were reviewed and lacked documentation of rationale for the ongoing use of the indwelling catheter. In addition, it was revealed on some of the progress notes the provider had documented the family had indicated urine retention had been a problem for R35 following surgeries, with most recent hospital stay 12/24/16, through 12/28/16, after R35 had a fall and had sustained a right hip fracture. During further review of the physician and nurse practitioner 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 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." On 4/5/17, at 12:46 p.m. the director of nursing (DON) stated she would have expected care plan to be developed to address the catheter. The facility Indwelling Catheter policy revised 10/16, directed the following: "2) Each resident with a urinary catheter receives a comprehensive assessment and individualized care plan for the treatment or management of their catheter. Attention is given to minimize risk	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 9 factors for infection. Continued need for the indwelling catheter is assessed periodically. Maintain a closed catheter system..." The facility Individualized Care plan policy revised 12/13, directed "1. Upon admission, the nursing department begins the care plan and addresses the immediate needs of the resident in the initial care plan. The presenting problem and significant functional dependencies will be addressed..." R39's Ebenezer initial Admit Assessment dated 1/17/17, indicated R39 had "sacral redness." R39's admission Minimum Data Set (MDS) dated 1/24/17, indicated she was moderately cognitively impaired, was occasionally incontinent of bowel and bladder and required physical assistance for bed mobility, transfers and toileting. R39's care plan dated 2/3/17, identified a risk for alteration in skin integrity related to decreased mobility and back pain. A facility Braden and Skin Risk assessment dated 1/18/18, identified a history of pressure ulcers. A facility Weekly Pain and Bath Sheet, dated 1/25/17, indicated R39's skin was not intact and identified redness to the right and left iliac crests (the largest of the three bones that merge to form the hip bone) and redness to her groin. R39's Meadows on Fairview Progress Note dated 1/27/17 indicated: Patient complained of lower back and buttock pain today. Buttocks area red, blanchable, 3 small open areas on right buttock near intragluteal cleft. See skin charting. An Ebenezer Skin Integrity Documentation assessment dated 1/27/17, indicated new onset "abrasion" number one: no drainage, surrounding	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 10	2 555		

area, redness and pain. "Abrasion" number 2, surrounding area redness and pain, "Abrasion" number 3, small amount of exudate, surrounding area redness and pain. The assessment did not include measurements, assessment of the wound bed or staging. An Ebenezer Skin Integrity Documentation assessment dated 2/2/17, identified a skin issue on R39's left buttock had healed, however there was no prior documentation of the skin issue.

While R39 initial assessment identified redness to her sacrum and required assistance to complete activities of daily living, a care plan for pressure ulcers was not developed until R39 had already acquired a pressure ulcer.

R56's 60 day Minimum Data Set (MDS) dated 12/30/16, indicated she was cognitively intact and required extensive assistance with bed mobility, transfers and toileting, R56's care plan dated 11/5/16, indicated a need for physical assistance related to cerebral vascular attack (CVA) with left sided weakness. The care plan further indicated an alteration in skin integrity and indicated a new pressure injury, stage II, left tuberosity (one of two bony swellings found on the lower back part of the hip bone,) identified on 1/12/17.

A review of a facility Pressure Wound Documentation assessment, dated 1/12/17, identified a stage II pressure injury (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) on R56's left buttock measuring 0.5 centimeters (cm) x 0.3 cm. R56 remained in the facility until 1/24/16, there was no evidence the facility completed any additional assessments of her pressure ulcer. During an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 11 interview on 4/4/17, at 3:19 p.m., licensed practical nurse (LPN)-B stated if a skin concern was identified, staff open a skin assessment. LPN-B stated open areas are measured and documented weekly by the nurse on duty. R56 admitted to the facility with risk for skin breakdown, there was no evidence the facility nictitated a care plan until R56 had already acquired a pressure ulcer. During an interview on 4/5/17, at 9:15 a.m., registered nurse (RN)-B stated skin assessments were completed on admission and if a new skin issue was found. RN-B stated if a skin concern was identified, staff would monitor daily and assess weekly including measurements and weekly progress notes. She stated every resident should receive a skin assessment each week and document on the Weekly Pain and Bath Day Sheet. During an interview on 4/5/17, at 10:34 a.m., RN-A stated she was responsible for starting the initial plan of care and the nurses should keep it 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. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure a care plan is developed to reflect each residents' current care needs. The DON or designee could educate all appropriate staff on the system, and monitor to	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 12 ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 555		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include fall interventions for 1 of 2 residents (R15) who had experienced a fall in the facility. Findings include: R15's Admission Minimum Data Set (MDS) dated 10/29/16, indicated she was cognitively intact and required extensive assistance with all activities of daily living. A care area assessment (CAA) dated 11/3/16, indicated a risk for falls. R15's care plan dated 10/22/16, did not identify falls. An Ebenezer Fall Risk Tool dated 10/23/16, indicated R15 was at risk for falls.	2 570	Corrected	5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 13 A review of R15's Meadows on Fairview Progress Note dated 10/22/16, indicated R15 admitted to the facility on that date. She required assistance of 1 staff to complete activities of daily living, was using a walker and wheel chair for long distances and was continent of bowel and bladder. A Meadows on Fairview Progress Note dated 10/25/15, identified a fall in her bathroom. The progress note indicated R15 was found on the floor in her bathroom facing the toilet. She stated she did not hit her head, but did hit her upper arm on her walker when she fell. R15 was noted to have a 10 centimeter (CM) x 5 cm bruise on her upper arm. R15 stated she felt "wobbly" and lost her balance. During an interview on 4/5/16, at 10:50 a.m., registered nurse (RN)-A sated R15 had been independent prior to her fall and had been participating in therapy. She stated the facility "usually" does a follow- up after a fall but stated there was not one done for R15. RN-A stated, "we missed it." RN-A stated, she was responsible for developing the care plans and stated R15's care plan should have identified falls. 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 on admit. The facility Individualized Care plan policy revised 12/13, directed "1. Upon admission, the nursing department begins the care plan and addresses the immediate needs of the resident in the initial care plan. The presenting problem and significant functional dependencies will be addressed..." While R15 admitted to the facility for therapy and had an identified risk for falls, there was no evidence of care planned interventions for fall	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 14 prevention even after R5 sustained a fall. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure care plans are revised in a timely manner and reflect each residents current care needs. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assess and implement interventions related to falls for 1 of 2 resident (R15) reviewed for accidents.	2 830	Corrected	5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15 Findings include: R15's Admission Minimum Data Set (MDS) dated 10/29/16, indicated she was cognitively intact and required extensive assistance with all activities of daily living. A care area assessment (CAA) dated 11/3/16, indicated a risk for falls. R15's care plan dated 10/22/16, did not identify falls. An Ebenezer Fall Risk Tool dated 10/23/16, indicated R15 was a low fall risk. R15's Meadows on Fairview Order Summary Report, dated 10/22/16, identified the use of Warfarin.(Warfarin is an anticoagulant used to prevent heart attacks, strokes, and blood clots.) The Plan of Care did not address anti-coagulant monitoring. A review of R15's Meadows on Fairview Progress Note dated 10/22/16, indicated R15 admitted to the facility on that date. She required assistance of 1 staff to complete activities of daily living, was using a walker and wheel chair for long distances and was continent of bowel and bladder. A Meadows on Fairview Progress Note dated 10/23/16, indicated R15 was alert and oriented x 3 and independent with activities of daily living. A Meadows on Fairview Progress Note dated 10/25/15, identified a fall in her bathroom. The progress note indicated R15 was found on the floor in her bathroom facing the toilet. She stated she did not hit her head, but did hit her upper arm on her walker when she fell. R15 was noted to have a 10 centimeter (CM) x 5 cm bruise on her upper arm. R15 stated she felt "wobbly" and lost her balance. A Meadows on Fairview progress note dated 10/26/16, indicated R15 was having increased confusion and weakness and needed total assist	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16 with cares and assistance 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. During an interview on 4/5/16, at 10:50 a.m., registered nurse (RN)-A sated R15 had been independent prior to her fall and had been participating in therapy. She stated the facility "usually" does a follow- up after a fall but stated there was not one done for R15. RN-A stated, "we missed it." RN-A stated, after R15 fell she was refusing to get out of bed and go to therapy. RN-A further stated R15 should "definitely" have been on monitoring for anti-coagulant use. During an interview on 4/5/17, at 1:04 p.m., the director of nursing stated when a patient falls there should be an incident report and a follow up within 24 hours. She stated she would expect staff to assess the patient for injury and stated if the patient was on anti-coagulants, staff should be monitoring for bruising and bleeding. While R15 admitted to the facility for therapy and had an identified risk for falls, there was no evidence of care planned interventions for fall prevention and while she was receiving anti-coagulating medications, there was no evidence the facility was monitoring for side effects, even after R5 sustained a fall. Further, there was no evidence the facility re-assessed R15's risk for falls after she sustained a fall on 10/26/16, even though she declined from an independent status to no longer able to get out of bed.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 A facility policy for falls was requested but not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring falls. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	2 900		5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 18 Based on interview and record review, the facility failed to accurately assess pressure ulcers for 2 of 2 resident (R39, R56) reviewed for pressure ulcers. Findings include: R39's initial Admit Assessment dated 1/17/17, indicated R39 had "sacral redness." There were no measurements, no indication of whether the area was blanchable, no staging, nor was there evidence of ongoing monitoring. A facility Braden and Skin Risk assessment dated 1/18/17, identified a history of pressure ulcers. R39's admission Minimum Data Set (MDS) dated 1/24/17, indicated she was moderately cognitively impaired, was occasionally incontinent of bowel and bladder and required physical assistance for bed mobility, transfers and toileting. A facility Weekly Pain and Bath Sheet dated 1/25/17, indicated R39's skin was not intact and identified redness to the right and left iliac crests (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 amount of exudate, surrounding area redness	2 900	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 19 and pain. The assessment did not include measurements, assessment of the wound beds or staging. A Skin Integrity Documentation assessment dated 2/2/17, indicated an area of skin on R39's left buttock had healed, however there was no prior documentation of what the skin issue had been. R39's care plan dated 2/3/17, identified a risk for alteration in skin integrity related to decreased mobility and back pain. Registered nurse (RN)-A stated she recalled having seen R39's skin, and stated it was noted on 1/17/17, but stated nothing was done about it until the 25th of January. R56's Progress Notes indicated R56 remained in the facility until 1/24/16, and there was no evidence the facility had completed any additional assessments of her pressure ulcer. R56's 60 day MDS dated 12/30/16, indicated she was cognitively intact and required extensive assistance with bed mobility, transfers and toileting, R56's care plan dated 11/5/16, indicated a need for physical assistance related to cerebral vascular accident (CVA) with left sided weakness. The care plan further indicated R56 had an alteration in skin integrity and indicated a new pressure injury, stage II (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister), on the left tuberosity (one of two bony swellings found on the lower back part of the hip bone) had been identified on 1/12/17.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 20 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. During an interview on 4/4/17, at 3:19 p.m., licensed practical nurse (LPN)-B stated if a skin concern was identified, staff would initiated a skin assessment. LPN-B further stated open areas are measured and documented on weekly by the nurse on duty. During an interview on 4/5/17, at 9:15 a.m., RN-B stated skin assessments were supposed to be completed on admission and any time a new skin issue was found. RN-B stated if a skin concern was identified, staff would monitor daily and assess weekly including measurements and weekly progress notes. In addition, RN-B stated every resident should have a skin assessment conducted each week which would be documented on the Weekly Pain and Bath Day Sheet. During an interview on 4/5/17, at 10:34 a.m., RN-A stated staff were supposed to complete a skin check each week on bath day and document on the Weekly Pain and Bath Day sheet. She stated if a skin concern was identified, staff would initiate skin integrity documentation. RN-A stated R56's skin alteration was noted as an abrasion and that it was "likely" due to a lack of a better description on the assessment. RN-A stated education on skin issues was likely needed. During an interview on 4/5/17, at 1:00 p.m., the director of nursing stated nurses complete a full body skin assessment on admit. She stated if any alterations were noted they should be documented on until healed, including	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 21 descriptions with measurements and any blanching. A facility policy for skin assessment and documentation was requested but not received. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop policies and procedure to ensure residents have a comprehensive assessment of the risk for developing pressure ulcers so that individualized interventions could be implemented. The Director of Nursing or her designee could educate all appropriate staff on the polices and procedures related to pressure ulcers. The Director of Nursing or her designee could develop a monitoring system to ensure residents are assessed and receive interventions to prevent the development of pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as	2 910		5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 22 much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medical justification for the use of an indwelling catheter was provided for 1 of 3 residents (R35) who were reviewed for urinary catheters. Findings include: On 4/3/17, at 2:08 p.m. when asked was there use of an indwelling Foley catheter, registered nurse (RN)-A stated "Yes." When asked the reason for R35's catheter RN-A stated was related to urine retention. On 4/4/17, at 2:52 p.m. R35 was observed lying in bed on her back, lights out on room. When approached and asked about the catheter and when it had been put in place resident was not able to re-call however, stated the staff always did empty it for her. When asked if she had any pain/discomfort R35 stated "no" she stated she was able to use the bathroom for her bowel movements. The catheter bag was hanging on the right side of the bed at the time. R35's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 11/27/16, indicated resident had a recent fall resulting in a right femur fracture, recent hospitalization and was admitted to the transitional care unit (TCU). The CAA indicated the Foley catheter had been discontinued on 11/28/16.	2 910	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 23 R35's care plan dated 12/28/16, indicated resident was not able to complete activities of daily living (ADLs) independently at the time. The care plan indicated R35 had left a fracture, weakness and limited functional movement. The care plan directed staff to provide "TOILETING: 1 assist to help with personal hygiene and clothing management." The care plan did not identify resident had a Foley catheter. R35's Physician Order dated 1/17/17, directed "Okay [Ok] to place 14 French 5 ml [milliliter] Foley catheter for urine retention." R35's diagnoses included heart failure, chronic kidney disease - stage 3 (moderate), retention of urine, weakness and difficulty in walking obtained from the quarterly Minimum Data Set (MDS) dated 2/25/17. In addition, the MDS indicated R35 had an indwelling catheter, required extensive assist of one for toilet use and personal hygiene and required extensive physical assistance of two staff with transfers and did not ambulate. R35's Physician Notes from 11/22/16 to 3/28/17, were reviewed and lacked documentation of rationale for the ongoing use of the indwelling catheter. In addition, it was revealed through review of the Progress Notes, the provider had documented the family had indicated urine retention had been a problem for R35 following surgeries, with most recent hospital stay 12/24/16 through 12/28/16, after R35 had a fall and had sustained a right hip fracture. During further 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	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 24 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 facility originally the catheter had been discontinued on 11/28/16, and had been successful. RN-A stated "Am going to suggest to the NP to attempt a trial." On 4/5/17, at 12:46 p.m. the director of nursing	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 25 (DON) stated she would have expected a trial to have been done after the catheter was re-inserted to discontinue the catheter. DON also stated she would have expected the doctor or nurse practitioner to have followed up with the catheter use justification for use. When concern was brought up about no documentation in the medical record which addressed any attempt trials done to discontinue catheter or if R35 had been sent to the urologist to identify the cause of the retention, DON stated she would be following up with the NP and doctor to see if there was any documentation for this. The facility Indwelling Catheter policy revised 10/16, directed the following: "1) Each resident is assessed and a diagnosis force specific condition necessitating for the clinical need for an indwelling catheter prior to insertion. Indwelling catheters will only be used for residents with urinary retention, or bladder obstruction, to assist in the healing of an open sacral or perineal wound, prolonged, strict immobilization or for comfort at the end of life. Obtain a urology consult. 2) Each resident with a urinary catheter receives a comprehensive assessment and individualized care plan for the treatment or management of their catheter. Attention is given to minimize risk factors for infection. Continued need for the indwelling catheter is assessed periodically. Maintain a closed catheter system. 3) Continually assess resident need for urinary catheter and remove catheter as appropriate..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures regarding	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 26 appropriate use of indwelling urinary catheters, educate staff, and perform audits to ensure their appropriate. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21580	MN Rule 4658.1325 Subp. 7 Administration of Medications; Requirements Subp. 7. Administration requirements. The administration of medications must include the complete procedure of checking the resident's record, transferring individual doses of the medication from the resident's prescription container, and distributing the medication to the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate administration of insulin for 2 of 3 residents (R90, R92) who was observed to receive insulin from an insulin pen. This had the potential to affect 4 residents who utilized insulin pens in the facility reviewed during a medication observation. Findings include: R90 On 4/4/17, at 8:36 a.m. licensed practical nurse (LPN)-B was observed retrieve a Humalog Kwik Flexpen (used to control blood sugar) for R90 from the top drawer. LPN-B then took the cap off, wiped the rubber stopper with an alcohol wipe then twisted the needle onto the FlexPen tip then proceeded to prime the pen with one unit of	21580	Corrected	5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21580	Continued From page 27 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 stated she was not sure. At 9:09 a.m. 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. During review of the Physician Order dated 3/31/17, revealed R90 had an order for Humalog 10 units subcutaneously two times a day with breakfast and lunch; 15 units in the evening with dinner and per sliding scale for diabetes mellitus. R92 On 4/5/17, at 7:55 a.m. LPN-A was observed apply a pair of gloves then was observed retrieve R92's Lantus FlexPen from the top drawer of the medication cart. LPN-A then cleaned the rubber stopper tip with an alcohol wipe then screwed the needle on the tip then dialed 13 units of Lantus without priming the pen. At 7:57 a.m. LPN-A and the surveyor walked away from the medication cart and got to R92's room door and as LPN-A was going to knock and enter room, surveyor	21580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21580	Continued From page 28 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. During review of the Physician Order dated 3/24/17, revealed R92 had an order for Lantus Solostar solution pen-injector 13 units subcutaneously in the morning and 26 units at bedtime diabetes mellitus type 2. On 4/5/17, at 12:29 p.m. when asked about her expectation for nurses priming the Flexpens, registered nurse (RN)-A stated "they are supposed to prime with 2 units. Will have to do some education." On 4/5/17, at 12:40 p.m. the director of nursing stated she would expect the nurses to prime the Flexpens "Will do education." DON indicated the facility policy was for nurses to prime the pens with two units and was not sure why the LPN-B thought it was supposed to be primed with one unit. DON further stated the LPN-B did work at another facility and was not sure about the confusion on the amount to prime with. The facility Injection Subcutaneous-Insulin policy revised 10/13, directed "Screw the appropriate pen needle onto pen. Dial up 2 units and perform an air shot to prime needle and ensure that you see insulin come out of needle. This step can be repeated until insulin is observed..."	21580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21580	Continued From page 29 SUGGESTED METHOD OF CORRECTION: The director of nursing and/or pharmacist could in-service all employees responsible for medication administration to follow facility policies and proven standards of practice to safely administer medications to residents and prevent errors. The director of nursing and/or pharmacist could conduct spot audits to determine staff compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21580		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation and interveiw, the facility failed to maintain safe water temperatures for in 12 of 14 rooms who were occupied by residents in the sample. Findings include: During initial observations on 4/3/17, twelve of twelve residents rooms were identified as having unsafe hot water tempratures. A faciity tour was completed with the facility administrator on 4/3/17, at 7:06 p.m., and revealed the following water temperatures:	21710	Corrected	5/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21710	Continued From page 30 Room one's kitchen sink revealed a water temperature of 116 degrees, the bathroom sink had a water temperature of 126.1 degrees. Room two's kitchen sink revealed a water temperature of 118.4 degrees, the bathroom sink had a water temperature of 124 degrees. Room three's kitchen sink revealed a water temperature of degrees, the bathroom sink had a water temperature of 126 degrees. Room four's kitchen sink revealed a water temperature of 126 degrees, the bathroom sink had a water temperature of 126 degrees. Room five's kitchen sink revealed a water temperature of 124.9 degrees, the bathroom sink had a water temperature of 127.8 degrees. Room seven's kitchen sink revealed a water temperature of 123 degrees degrees, the bathroom sink had a water temperature of 125 degrees. Room eight's kitchen sink revealed a water temperature of 122 degrees, the bathroom sink had a water temperature of 125 degrees. Room nine's kitchen sink revealed a water temperature of 122.7 degrees, the bathroom sink had a water temperature of 125 degrees. Room ten's kitchen sink revealed a water temperature of 122.2 degrees, the bathroom sink had a water temperature of 125 degrees. Room twelve's kitchen sink revealed a water temperature of 125.6 degrees, the bathroom sink had a water temperature of 125.5 degrees.	21710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29463	A. BUILDING: _____ B. WING _____	04/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21710	Continued From page 31 Room thirteen's kitchen sink revealed a water temperature of 123 degrees, the bathroom sink had a water temperature 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. On 4/3/17, at 6:32 p.m. when asked the process of checking the water temperatures, the administrator stated she did not know the process as the maintenance director had a log for that she thought. On 4/4/17, at 4:00 p.m. the administrator stated following the water temperature concern the facility was going to install a mixing valve for the nursing home side of the building and moving forward a temperature log was going to be completed to closely monitor the water temperatures. SUGGESTED METHOD FOR CORRECTION: The administrator or designee could set up a system for monitoring water temperatures in resident rooms at varying times during the day. The administrator or designee could then audit to ensure water temperatures are being monitored and are in acceptable ranges. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710		