DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L32H PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00460 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) FAIR MEADOW NURSING HOME (L1)245545 1. Initial 2. Recertification (L4) BOX 8 300 GARFIELD AVENUE SOUTHEAST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 56540 804740500 (L2)(L5) FERTILE, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (1.9)05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 06/11/2014 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 16 HOSPICE 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN ___7. Medical Director 12. Total Facility Beds 1. Acceptable POC 4. 7-Day RN (Rural SNF) 8. Patient Room Size (L18)50 5. Life Safety Code __ 9. Beds/Room Not in Compliance with Program 50 (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12)* Code: A 15. FACILITY MEETS 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)50 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date: Anne Kleppe, Enforcement Specialist Iana Bromenshenkel, HFE NE II 06/17/2014 06/17/2014 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 21. 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) _X 1. Facility is Eligible to Participate 3. Both of the Above: 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23 LTC AGREEMENT 24 LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 02/01/1991 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (1.24)(L25) 03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS OTHER 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (1.44)(1.27)B. Rescind Suspension Date: (1.45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31)32. DETERMINATION OF APPROVAL DATE 31. RO RECEIPT OF CMS-1539

(L33)

DETERMINATION APPROVAL

05/27/2014

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

C&T REMARKS - CMS 1539 FORM

CCN: 24-5545

STATE AGENCY REMARKS

On 06/11/14, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the 04/10/14 survey, effective 05/10/14. Refer to the CMS 2567B for both health.

Effective 05/10/14, the facility is certified for 50 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5545

Electronically Delivered: June 17, 2014

Mr. Barry Robertson, Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, Minnesota 56540

Dear Mr. Robertson,

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 10, 2014, the above facility is certified for:

50 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Dire Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4124 Fax: (651) 215-9697

Email: anne.kleppe@state.mn.us



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 17, 2014

Mr. Barry Robertson, Administrator Fair Meadow Nursing Home Box 8300 Garfield Avenue Southeast Fertile, Minnesota 56540

RE: Project Number S5545023

Dear Mr. Robertson:

On April 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 10, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 11, 2014, the Minnesota Departments of Health and Public Safety 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 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 10, 2014, effective May 10, 2014 and therefore remedies outlined in our letter to you dated April 24, 2014, 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.

Sincerely,

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Division of Compliance Manitoring

Division of Compliance Monitoring Minnesota Department of Health

Email: <u>anne.kleppe@state.mn.us</u> Telephone: (651) 201-4124

Fax: (651) 215-9697

Dre Klegge

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245545	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/11/2014	
Name of Facility		Street Address, City, State, Zip Code		
FAIR MEADOW NURSING HOME		BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE. MN 56540		

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
		Correction			Correction					Correction
ID Prefix	F0241	Completed 05/10/2014	ID Prefix	F0279	Completed 05/10/2014		ID Prefix	F0282		Completed 05/10/2014
	483.15(a)		Reg. #	483.20(d), 483.20(k)(1)	-			483.20(k)(3)(ii		_
LSC			LSC				LSC	-		_
		Correction			Correction					Correction
ID Prefix	F0318	Completed 05/10/2014	ID Prefix	F0323	Completed 05/10/2014		ID Prefix	F0356		Completed 05/10/2014
	483.25(e)(2)			483.25(h)				483.30(e)		
			LSC		-					- -
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		05/10/2014	ID Prefix		-					_
Reg. #	483.65		Reg. #		-		Reg. #			_
										_
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #		-					_
					-		LSC			- -
		Correction			Correction					Correction
		Completed			Completed					Completed
					-					_
Reg. # LSC			Reg. # LSC		-		Reg. # LSC			_
					·	-				=:
Reviewed B		iewed By	Date:	Signature of Su	rveyor:		_	2001	Date:	1201.1
State Agen		B/AK riewed By	06/17/20 Date:		novor:		32	2981	06/11 Date:	/2014
CMS RO	By Rev	ieweu by	Date:	Signature of Su	veyor:				Date:	
Followup t	Followup to Survey Completed on:			Check for any Unco	rrected Defi	cienci	es. Was a	Summary of	1	
	4/10/201	4		Uncorrected Defi	ciencies (CN	18-256	67) Sent to	the Facility?	YES	NO

	State Form: Revisit Report							
(Y1)	Provider / Supplier / CLIA / Identification Number 00460	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/11/2014				
Nam	e of Facility		Street Address, City, State, Zip Code					
FA	IR MEADOW NURSING HOME		BOX 8 300 GARFIELD AVENUE FERTILE, MN 56540	SOUTHEAST				

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y	5) Date	(Y4)	Item		(Y5)	Date
ID Prefix	C	Correction Completed 5/10/2014	ID Prefix	20565	Correction Completed 05/10/2014		ID Prefix	20895		Correction Completed 05/10/2014
Reg. # LSC	MN Rule 4658.0405 Subp). ;	Reg. # LSC	MN Rule 4658.0405 S	Subp.		Reg. # LSC	MN Rule 4658	3.0525 S	ubp.
ID Prefix Reg. # LSC	C	Correction Completed 5/10/2014	1.00	21805 MN St. Statute 144.6	Correction Completed 05/10/2014 51 Sul		Reg. #			
Reg. #		Correction Completed	Reg. #		Correction Completed					
ID Prefix Reg. # LSC		Correction Completed	Reg. #							
ID Prefix Reg. # LSC	C	Correction Completed	ID Prefix Reg. # LSC							
Reviewed E State Agend Reviewed E	LB/AK		Date: 06/17/20 Date:	Signature of S	•		3298	81	Date: 06/11 Date:	1/2014
CMS RO Followup to Survey Completed on: 4/10/2014 STATE FORM: REVISIT REPORT (5/99)				Check for any Unc Uncorrected De	corrected Defi ficiencies (CI	iciencie MS-2567	es. Was a 7) Sent to	Summary of the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 17, 2014

Mr. Barry Robertson, Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, Minnesota 56540

Re: Reinspection Results - Project Number S5545023

Dear Mr. Robertson:

On June 11, 2014 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 April 10, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 Kleppe, Enforcement Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124

Fax: (651) 215-9697

Dire Klegge

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L32H PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00460 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) FAIR MEADOW NURSING HOME (L1)245545 1. Initial 2. Recertification (L4) BOX 8 300 GARFIELD AVENUE SOUTHEAST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 56540 804740500 (L2)(L5) FERTILE, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 8. Full Survey After Complaint (1.9)05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 04/10/2014 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 16 HOSPICE 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN ___7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) 8. Patient Room Size **50** (L18) _1. Acceptable POC 5. Life Safety Code ___ 9. Beds/Room X B. Not in Compliance with Program 50 (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: **R*** (L12)* Code: 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)50 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date: Mark Weath, Enforcement Specialist Deb Vincent, HFE NEII 05/02/2014 05/27/2014 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 21. 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) Facility is Eligible to Participate 3. Both of the Above: 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23 LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 02/01/1991 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (1.24)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS OTHER 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (1.44)(1.27)B. Rescind Suspension Date: (1.45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5545

On April 10, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remdies would be imposed. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 24, 2014

Mr. Barry Robertson, Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, MN 56540

RE: Project Number S5545023

Dear Mr. Robertson:

On April 10, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor Bemidji Survey Team Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104 Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 20, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 20, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 10, 2014 (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 10, 2014 (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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division Minnesota Department of Public Safety pat.sheehan@state.mn.us

Telephone: (651) 201-7205

Fax: (651) 215-0541

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 Division of Compliance Monitoring Minnesota Department of Health mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

5545s14epoc.rtf

PRINTED: 05/02/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245545	B. WING		04/10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS .	F 000		
	as your allegation of Department's acceptoriolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required a first page of the CMS-2567 nic submission of the POC will cion of compliance.			
F 241 SS=E	on-site revisit of you validate that substa regulations has bee your verification. 483.15(a) DIGNITY	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with	F 24	1	5/10/14
	manner and in an e	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observatifailed to ensure an experience was ma R13, R43, R15, R3 activity room during Findings include: On 4/7/14, at 5:30 pevening meal in the R28, R13, R43 and their meals. R43 are	ion and interview, the facility enhanced and dignified dining intained for 6 of 6 (R31, R28,) residents who dined in the 2 of 3 meal observations. o.m. during observation of the activity dining room, R31, R15 were observed eating at R15 were observed seated ainst bedside tables,		The facility will ensure a dignified dining service for its residents. Residents R3, R13, R15, R28, R31 and R43 will be served their meals on dishware without tray. All residents will be served their meals on dishware without a tray. A dining policy addressing the subject has been written and implemented. License nursing staff were inserviced on this requirement on 04/15/14. Nursing assistants were educated as well on the rationale for their responsibility on providing dignity for the residents during	a Seed
ABORATOR'	Z DIRECTOR'S OR PROVID	PER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

05/02/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245545	B. WING			04/	10/2014	
	PROVIDER OR SUPPLIER ADOW NURSING HO				SS, CITY, STATE, ZIP CODE RFIELD AVENUE SOUTHE I 56540	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECT I CORRECTIVE ACTION SHOU REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 241	observed seated a table and assisted observed seated a staff member, seat to eat. All resident tray with their food throughout the me room were observed dishware without a common of the common of th	ng. R13 and R28 were cross from each other at a by two aides to eat. R31 was t a separate table with one ted next to him, assisting him is were served their meal on a remaining on the tray al. Residents in the main dining ed to be served their meal on	F 2	their dining Aides were well becau time meals Room. Da week nurs dishware f consuming needed. F conducted one month Results wi	g experience. OTR and a last also updated on this use they are present did a last are served in the Actually audits were conducted as a last a	issue as uring the civity cted for 1 moving dents s were be ekly for nonths.		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245545	B. WING		04/	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 241	served residents in meal. AA-B confir trays. She stated to for the trays but a didn't do that all the At 8:55 a.m. NA-B activity room were don't know why we worked at the facility always been that who be served on transupposed to put the it was done in the room 4/10/14, at 11:1	y assistant (AA)-B stated she the activity room for the noon med the meals were served on ney sometimes took the dishes she was not sure why they time. confirmed the meals in the served on trays. She stated "I do that." She stated she had ty for 1 1/2 years and "it's ay." (DS) was interviewed on n. and stated meals were not ys. She stated staff were endishes on the table, just like nain dining room. 5 a.m. director of nursing	F 2	41		
F 279 SS=D	served their meals residents who recedining area should manner as the resithe main dining room. A dining policy was provided. 483.20(d), 483.20(l) COMPREHENSIVE A facility must use to develop, review comprehensive pla	requested but none was (A)(1) DEVELOP E CARE PLANS The results of the assessment and revise the resident's	F 2	79		5/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245545	B. WING			04/-	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		во	REET ADDRESS, CITY, STATE, ZIP CODE DX 8 300 GARFIELD AVENUE SOUTHEAST RTILE, MN 56540	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	objectives and time medical, nursing, a needs that are ider assessment. The care plan mus to be furnished to a highest practicable psychosocial well-b §483.25; and any significant of the resident §483.10, including under §483.10, including under §483.10(b)(4) This REQUIREME by: Based on interview facility failed to enswere addressed or residents (R28) revisited from the resident of the residen	ent that includes measurable etables to meet a resident's and mental and psychosocial atified in the comprehensive of the describe the services that are attain or maintain the resident's physical, mental, and being as required under derivices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment of the right to refuse treatment of the care plan for 1 of 2 derived for accidents. Note that would otherwise services that are also services that are service	F 2		R28's side rail assessment was completed and it determined that s rails should be removed because F does not purposefully use them. T bilateral half side rails were remove R28's low bed. All other in house residents using side rails have bee assessed and care plans reflect the appropriate use. A side rail assess will be performed for every resident admission. If it is determined by the comprehensive assessment that si will be used, then side rail assessment will be completed annually or with a significant change in condition for a residents using side rails. Care plate to conducted accordingly. Side rail has been added to the checklist of reviewed at care conferences. Lice nursing staff were inserviced on the	R28 he ed from n eir ment t on e de rails nents a all ans will il use items ensed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245545	B. WING			04/-	10/2014	
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		В	TREET ADDRESS, CITY, STATE, ZIP CODE OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282 SS=D	problems, incontine weakness, and a hi did not address the on the bed. On 4/10/14, at 8:20 rails were not address. A policy related to in care plan was required. 483.20(k)(3)(ii) SEPPERSONS/PER CA	a.m. RN-A verified the side essed on R28s care plan. htterventions documented on a ested and none was provided. RVICES BY QUALIFIED	F 2		on 4-15-14. Primary RNs will audit compliance at the time of each resi care conference. Results will be repto QAA committee.	dents	5/10/14	
	by: Based on interview facility failed to ensiprogram was imple care plan for 1 of 1 reviewed for ROM s Findings include: R1's quarterly Minimal 2/19/14, indicated Finderentia, cerebral muscle coordination impairment. The Minimal Parket Par	num Data Set (MDS) dated R1 was diagnosed with palsy (CP) with impaired n and had severe cognitive DS also indicated R1 had both lower extremities (LE),			The facility will ensure that the ROI program will be implemented as dir by the care plan. R1's care plan wi updated to reflect ROM exercises to provide a more realistic goal since resident R1 often exercises his right refuse. Other residents receiving not rehab programs are reviewed quart nursing rehab RN and at care confectively primary RN and care plans updated accordingly. A legend will be developed achieve accurate and consistent chain our rehab nursing department. The length of nursing rehab shifts will be extended as necessary to achieve or rehab goals. Nursing rehab staff to	ected II be to t to ursing terly by terence ted toped to terting the enursing		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245545	B. WING			04/ ⁻	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		В	TREET ADDRESS, CITY, STATE, ZIP CODE OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	R1's current care p R1 received active t-band to the left up pound weight for th to the right finger at limitations. Passive knees and ankles. R1's contractures w Review of R1's unti documentation form March 2014, reveal -October 2013: Out R1 refused 17 time 11 times, a line was "5" was documente narrative document -November 2103: O ROM, R1 refused s documented 18 tim one time, and there documentation. The documentation on t -December 2013: O ROM, R1 refused f documented 16 tim with no documentat documentation on t -January 2014: The identified ROM prod documented. The r There was no narra back of the formFebruary 2014:, O for ROM, R1 refused documented one tir On 2/21/14, the refused	lan printed 4/10/14, indicated ROM exercises with a blue per extremity (UE) and a four e left shoulder. Passive ROM and wrist extension within pain ROM to both legs, hips, The care plan also indicated would be measured quarterly. Ited nursing rehab as from October 2013, through	F 2	282	inserviced and the above updates. Results will be reported to QAA committee. Rehab RN to monitor compliance.		

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245545	B. WING _		04/	10/2014
_	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	did not have time to -March 2014: Out of ROM, R1 refused for documented nine ti with no documental RA-A documented time one aide." On 4/9/14, at 12:10 therapist (OT) state OT and physical the had difficulty with or could not lift a cup of stated a nursing reference R1 on 2/21/14. The supervised the rehaworked a few hours stated R1's nursing provided seven day At 10:47 a.m. the draw as week according as A policy regarding for requested and none 483.25(e)(2) INCRI IN RANGE OF MORE Based on the compresident, the facility with a limited range appropriate treatments.	o do it in his room. If the 31 opportunities for our times, zero was mes, and there were 18 days tion. On 3/29/14, and 3/30/14, on the back of the form "no p.m. the occupational ed R1 was seen on 1/27/14, for erapy (PT). The OT stated R1 orrect seated posture and with his left hand. The OT hab program was resumed for a OT stated a registered nurse ab program and she only a per week. The OT also rehab program was to be as a week. Irrector of nursing verified R1's not performed seven days per directed by the care plan. Incollowing a care plan was a was provided. EASE/PREVENT DECREASE TION Incorporation of a resident and services to increase ent and services to increase d/or to prevent further				5/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245545	B. WING		04/	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTH FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 318	This REQUIREME by: Based on observareview, the facility for motion services (Reprovided and docurassessed needs for reviewed for ROM. Findings include: R1's annual Minimary of the findings include: R1's annual Minimary of the findings include: R1's annual Minimary of the extremity. The Activate of the Activate of the contractures of the finding of the contractures of the contractures of the contractures of the contractures of the contracture of the contractures of the contracture of the contractur	NT is not met as evidenced tion, interview and document failed to ensure range of OM) were consistently mented according to the r 1 of 1 resident (R1) who was	F 318	The facility will ensure ROM so be consistently provided and do according to assessed needs. will ensure that the ROM programplemented as directed by the R1's care plan will be updated ROM exercises to provide a magoal since resident R1 often exeright to refuse. Other residents nursing rehab programs are requarterly by nursing rehab RN conference by primary RN and updated accordingly. A legend developed to achieve accurate consistent charting in our rehald department. The length of nurshifts will be extended as nece achieve nursing rehab goals. It rehab staff will be inserviced or updates. OTR will conduct rand weekly for 4 weeks. Rehab RN compliance by conducting qual audits. Results will be reported committee.	ocumented The facility am will be e care plan. to reflect ore realistic receiving viewed and at care care plans will be and o nursing sing rehab ssary to Nursing n the above dom audits I to monitor rterly	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245545	B. WING			04/	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		ВС	REET ADDRESS, CITY, STATE, ZIP CODE DX 8 300 GARFIELD AVENUE SOUTHEAS ERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	was observed to broobserved to hold his oral cares and shawn are care care care care care care care	a.m. nursing assistant (NA)-A ush R1s teeth. R1 was a rms across his chest while ring were done. Itled nursing rehab as from October 2013, through ed the following: of 31 opportunities for ROM, and zero was documented to documented two times, and a donce. There was no ation on the back of the form. Out of 30 opportunities for even times, zero was es, a line was documented were four days with no ere was no narrative the back of the form. Out of 31 opportunities for our times, zero was es, and there were 11 days etion. There was no narrative the back of the form. It rehab form was lacking the gram. Four refusals were est of the month was blank. It is of the seven opportunities and three times, zero was me, and four days were blank. The about of RA)-A documented orm that R1 refused and she of do it in his room. of the 31 opportunities for	F3	118			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245545	B. WING			04/	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		В	TREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	RA-A documented time one aide." On 4/9/14, at 12:10 therapist (OT) state OT and physical the had difficulty with coculd not lift a cup of stated a nursing rel R1 on 2/21/14. The supervised the rehaworked a few hours R1's nursing rehabseven days a week On 4/10/14, at 8:36 scheduled as a reh RA-A stated there of were scheduled pepp.m. and in addition were also expected meals at breakfast received ROM to his week. However, RA state he did not wan not cooperate and falso stated R1 woure-approached late there were 41 resid program per day art to do the ROM progwas only one rehab	p.m. the occupational and R1 was seen on 1/27/14, for erapy (PT). The OT stated R1 correct seated posture and with his left hand. The OT hab program was resumed for OT stated a registered nurse ab program and she only aper week. The OT stated program was to be provided program was to be provided or day from 7:00 a.m. to 1:00 to providing ROM services, I to assist residents with their and lunch. RA-A confirmed R1 s UE and LE seven days a A-A stated R1 would normally to do the exercises or would follow the directions. RA-A ld even refuse when r. In addition, RA-A stated ents on a rehab nursing the there was not enough time grams as sometimes there of aide working. RA-A stated on 1, 22nd, and 2/24/14, there	F3	18			
	she had discussed	ector of nursing (DON) stated with the administrator a goal rehab staff on duty. The DON					

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245545	B. WING			04/	10/2014
	PROVIDER OR SUPPLIER	ME		В	TREET ADDRESS, CITY, STATE, ZIP CODE OX 8 300 GARFIELD AVENUE SOUTHEAS ERTILE, MN 56540	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	stated she felt the ribe extended. In addrehab aides were githey would also neameant. At 9:20 a.m. RA-Aviready to do his exewas observed to briencouragement R1 with the UE ROM piand blue theraband observed to allow a contracted fingers. At 9:37 a.m. RA-Bismeant we asked Ritherapy and he said have had only one a second rehab aid. At 9:44 a.m. the DO the rehab schedule from March 2014, and the only one rehab aid. -October 2013: four scheduled (12, 13, -November 2013: sincheduled (13, 13, -November 2013: sincheduled (3, 5, 7, 26, 28, 29). -January 2014: 14 discheduled (3, 4, 5, 25, 26).	chab aides hours needed to dition, the DON stated if the oing to document a zero, then ed to document what that was heard to ask R1 if he was reises and R1 said "no." RA-A ing R1 into his room. With was observed to participate rogram by using the weight I with his left hand. R1 was a passive stretch of his right stated a documented zero 1 if he wanted to come to 1 mope." RA-B stated they staff in rehab, and if there was e she was "pulled" to the floor. ON stated we really tried to get aced. The DON reviewed the m October 2013, through the following dates indicated to was on duty: It days with one rehab aide 26, 27). even days with one rehab aide		318			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245545	B. WING		04/	10/2014	
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 318	-March 2014: seven scheduled (1, 2, 7, On 4/10/14, at 10:2 (RN)-A confirmed F staff continued to che did not know which documentation. At 10:31 a.m. the of stated R1 did have OT stated when R1 were obtained, R1 improvement from At 10:40 a.m. RN-A was not on the Jan was discontinued drives RN-A stated because	n days with one rehab aide 13, 15, 16, 21). 8 a.m. registered nurse R1 refused rehab therapy and offer the services. RN-A stated that zero meant for ccupational therapist (OT) a contracted right U/E. The 's contracture measurements showed no decline and some	F 3	18			
F 323 SS=D	program was not program was directed by his of DON confirmed the aides were documed documentation flow thought it was related A policy regarding the program was reques 483.25(h) FREE OF HAZARDS/SUPER The facility must energy in the program was reques 483.25(h) FREE OF HAZARDS/SUPER		F 3:	23		5/10/14	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245545	B. WING _		04/	10/2014
	ME			CODE	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE
adequate supervisi		F 3:	23		
by: Based on observareview, the facility fassess the continuarials for 1 of 1 residerals did not pose a Findings include: R28's significant chemology (MDS) dated 12/18 diagnosed with a standard R28's Area Assessment (indicated R28 requibed mobility. R28's also indicated R28 was unable to be in R28's Fall Risk assemble to be in R28's Side Rail assemble was in bed for transfers in & out of R28's current care R28 was at high ris	tion, interview and document ailed to comprehensively ed need of bilateral half side lent (R28) to ensure the side potential accident hazard. In ange Minimum Data Set /13, indicated R28 was troke and dementia, had a set and was unable to be Activity Of Daily Living Care CAA) dated 12/24/13, irred extensive assistance for quarterly MDS dated 3/12/14, had memory impairment and afterviewed. In essment dated 3/12/14, at high risk for falls. Seessment dated 6/5/13, I the bilateral top rails anytime fear of injury and to assist with f bed. I plan printed 4/9/14, indicated k for falls related to being		completed and it determine rails should be removed be does not purposefully use to bilateral half side rails were R28's low bed. All other in residents using side rails has assessed and care plans reappropriate use. A side rail will be performed for every admission. If it is determin comprehensive assessmer will be used, then side rail a will be completed annually significant change in condit residents using side rails. Be conducted accordingly, has been added to the chereviewed at care conference nursing staff were inservice on 4-15-14. Primary RNs we compliance at the time of expressions.	ed that side ecause R28 hem. The eremoved from house ave been effect their I assessment resident on ed by the ent that side rails assessments or with a cion for all Care plans will Side rail use cklist of items es. Licensed ed on the above will audit each residents	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa adequate supervisi prevent accidents. This REQUIREMEI by: Based on observar review, the facility f assess the continue rails for 1 of 1 resid rails did not pose a Findings include: R28's significant ch (MDS) dated 12/18 diagnosed with a si memory impairmen interviewed. R28's Area Assessment (indicated R28 requ bed mobility. R28's also indicated R28 requ bed mobility. R28's also indicated R28 was unable to be in R28's Fall Risk ass indicated R28 was R28's Side Rail ass indicated R28 used she was in bed for transfers in & out o R28's current care R28 was at high ris unaware of safety r	ACOVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the continued need of bilateral half side rails for 1 of 1 resident (R28) to ensure the side rails did not pose a potential accident hazard.	A. BUILDII 245545 B. WING ROVIDER OR SUPPLIER DOW NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the continued need of bilateral half side rails for 1 of 1 resident (R28) to ensure the side rails did not pose a potential accident hazard. Findings include: R28's significant change Minimum Data Set (MDS) dated 12/18/13, indicated R28 was diagnosed with a stroke and dementia, had a memory impairment and was unable to be interviewed. R28's Activity Of Daily Living Care Area Assessment (CAA) dated 12/24/13, indicated R28 required extensive assistance for bed mobility. R28's quarterly MDS dated 3/12/14, also indicated R28 had memory impairment and was unable to be interviewed. R28's Fall Risk assessment dated 3/12/14, indicated R28 was at high risk for falls. R28's Side Rail assessment dated 6/5/13, indicated R28 used the bilateral top rails anytime she was in bed for fear of injury and to assist with transfers in & out of bed. R28's current care plan printed 4/9/14, indicated R28 was at high risk for falls related to being unaware of safety needs, had poor	A BUILDING 245545 BUNING ROVIDER OR SUPPLIER DOW NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the continued need of bilateral half side rails for 1 of 1 resident (R28) to ensure the side rails for 1 of 1 resident (R28) to ensure the side rails for 1 of 1 resident (R28) to ensure the side rails for 1 of 1 resident (R28) to ensure the side rails for 1 of 1 resident (R28) to ensure the side rails for 1 of 1 resident (R28) assess the continued need of bilateral half side rails were R28's significant change Minimum Data Set (MDS) dated 12/18/13, indicated R28 was an indicated R28 to ensure the side amemory impairment and was unable to be interviewed. R28's Activity Of Daily Living Care Area Assessment (CAA) dated 12/24/13, indicated R28 was an high risk for falls. R28's Side Rail assessment dated 3/12/14, indicated R28 was at high risk for falls. R28's Side Rail assessment dated 6/5/13, indicated R28 used the bilateral top rails anytime she was in bed for fear of injury and to assist with transfers in & out of bed. R28's current care plan printed 4/9/14, indicated R28 was at high risk for falls called to being unaware of safety needs, had poor	A BUILDING B

AND DUAN OF CODDECTION IDENTIFICATION NUMBER		IPLE CONSTRUCT		` '	E SURVEY PLETED		
		245545	B. WING		 	04/	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME			SS, CITY, STATE, ZIP CODE RFIELD AVENUE SOUTHEAS 56540	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	with left sided weak The care plan indical a green gripper on recliner, a low bed weak to be sensor and a number of the fall report date indicated a NA enter alarm was sounding was found seated to bed, leaning her based on 4/9/14, at 8:07 and on her left side, as were observed to transfer of the order of the side rails to reposition At 11:52 a.m. NA-B have used the side a decline in her contract the side rails. At 12:20 p.m. the or stated the top side The OT thought the yearly unless there	ms, incontinence, a stroke these and a history of falls. ated fall interventions included the seat in the wheelchair and with mats, a tab chair alarm, ursing rehab program. d 4/3/14, at 9:10 p.m. ared R28s room as the bed g. The report indicated R28 on the floor mat next to her ck against the bed. a.m. R28 was observed in bed are R28 was observed to ral half side rails raised on the m was in place. g assistant (NA)-A and NA-B ansfer R28 into the ras observed to clip the chair a.m. NA-A stated when R28 top side rails were used. The stated R28 did not use the on herself. stated in 6/13, R28 would rails, however, since R28 had addition, she was unable to use occupational therapist (OT) rails should be reassessed. The OT stated g the side rails there would be grails there would be	F3	23			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245545	B. WING			04/	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		В	TREET ADDRESS, CITY, STATE, ZIP CODE OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356 SS=C	was placed on hosp returned from the h stated she had not since she returned At 12:38 p.m. regist R28 was on hospic through 12/18/13. At 12:42 p.m. the d stated R28's side raquarterly, annually assessments. On 4/10/14, at 8:20 rails were not addressed a.m. the DC slid out of her bed at A policy was request assessments and reference assessments.	y member (FM)-A stated R28 pice services after she ospital in June of 2013. FM-A seen R28 use the side rails from the hospital. tered nurse (RN)-A confirmed e services from 7/4/13, irrector of nursing (DON) gails should be assessed and with significant change a.m. RN-A verified the side essed on R28s care plan. ON stated on 4/3/14, R28 had and onto the floor.	F3				5/10/14
	a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sl - Registered nu - Licensed prace	and the actual hours worked egories of licensed and staff directly responsible for nift:					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		245545	B. WING _		04/	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		STREET ADDRESS, CITY, STATE, ZIP COD BOX 8 300 GARFIELD AVENUE SOUTH FERTILE, MN 56540	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 356	specified above on of each shift. Data o Clear and readals o In a prominent pl residents and visite. The facility must, u make nurse staffing for review at a cost standard. The facility must m staffing data for a required by State la. This REQUIREMED by: Based on observareview, the facility for licensed and unliper shift as require affect all 45 resider family members and view this information. Findings include: On 4/7/14, at approximitial tour of the fact dated 4/7/14, was of working hours per unlicensed staff.	e aides. Dest the nurse staffing data a daily basis at the beginning must be posted as follows: ble format. Dece readily accessible to Dece ors. Dece or an area of the public of the	F 35	The facility will post the actual licensed and unlicensed nursing working per individual shift in a the facility name, current date, resident census. Licensed nuwere inserviced on these required 4-15-14. DON to monitor communications and the second secon	ng staff addition to and rsing staff irements on	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	` '	E SURVEY IPLETED
		245545	B. WING		04/	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HOI	ме		STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	т	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	worked per each inc On 4/10/14 at 11:20 (DON) confirmed th lacked definition of individual shift. 483.65 INFECTION	, also lacked the actual hours	F 3			5/10/14
SS=F	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the of disease and infection Control The facility must es Program under which (1) Investigates, continuity in the facility; (2) Decides what proshould be applied to (3) Maintains a recolutions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact will trace (3) The facility must (3) The facility must contact will trace (4) The facility must contact wi	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission oction. I Program tablish an Infection Control och it - ntrols, and prevents infections occedures, such as isolation, or an individual resident; and ord of incidents and corrective fections. ad of Infection ion Control Program esident needs isolation to of infection, the facility must ase or infected skin lesions with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		245545	B. WING		04/10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME	1	STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 441	transport linens so infection.		F 441		
	by: Based on observareview, the facility of hand hygiene was of (R10) who was observed addition, the facility secured by electric side rails creating of cleaned and sanitize R10, R13, R43, R2 of foam padding wrape Lastly, the facility of trends of infections. This had the potent who resided in the Findings include: Wound Care: On 4/9/14, at 12:43 (LPN)-A was observed his hands, raise R1 shin protector and calf wound dressing discard it into the treatment of th	tion, interview and document ailed to ensure appropriate completed for 1 of 1 resident served during wound care. In implemented foam coverings al and / or duct tape to bed surfaces that were unable to be sed for 7 of 28 residents (R17, 7, R42, R25) observed with ped around the side rails. ailed to analyze patterns and for both staff and residents. tial to affect all 45 residents		The facility will ensure appropriate hygiene during wound care for reside R10. Licensed staff were inserviced appropriate hand hygiene during work care for all residents on 4-15-14. Not cleanable side rail covers were order for Residents R13, R43, R17, R10, R42 and R25. These type of cleanates ide rail covers will be used for other residents who need covers as well. DON will ensure that facilities infection control program includes tracking, evaluation, and interventions to prevent the spread of infection. The facility of analyze patterns and trends of infect for both staff and residents. Results actions taken will be reported to the committee. DON will conduct randor audits weekly for four weeks on hand hygiene, then monthly for 2 months. to monitor compliance.	ent on und ew red R27, ble The on ent will iions and QAA m d

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245545	B. WING _		04	/10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO			STREET ADDRESS, CITY, STATE, ZIP C BOX 8 300 GARFIELD AVENUE SOU FERTILE, MN 56540	ODE	, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 441	R10 removed and trash, reapplied a comproceeded to clear saline using an AB dressing). LPN-A Xeroform dressing bandage (non-adh Xeroform. LPN-A gloves and wrapp LPN-A was observed to raise If the shin protector and lower before the application before t	discard them into the trash. discarded his gloves into the clean pair of gloves and use R10's wound with normal D bandage (highly absorbent was observed to apply a new to the wound and place a Telfa erent cotton pad) over the removed and discarded his ed the wound with Kling.	F 44			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	G (X3) DATE : COMPI		TE SURVEY MPLETED
		245545	B. WING _		04	/10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		STREET ADDRESS, CITY, STATE, ZIP CO BOX 8 300 GARFIELD AVENUE SOUT FERTILE, MN 56540	DE	, 10, 20 1 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	(DON) stated for in would expect hand between the remove application of the close between the right a changes. A dressing change indicated the facility and they did not hat changes. Side Rails: On 4/7/14, at 4:19 pto have bilateral, upthe bed. The rails wfoam and secured wath 5:27 p.m. R43's bilateral, half, upper The rails were obsessed with duct to At 6:16 p.m. R17's bilateral, upper, had The right side rail was of approximately a 2.5 a flap. At 6:34 p.m. R10's bilateral, upper, side rails were obsessed flixed with black to On 4/8/14, at 8:43 at to have bilateral, had between the right side rails were obsessed flixed with black to the rails were obsessed flixed flix	15 a.m. the director of nursing fection control purposes, she hygiene be completed all of the dirty dressing and the lean dressing, as well as, and left leg wound dressing policy was requested but DON policies were being updated we a current policy for dressing one observed wrapped with with duct tape. Bed was observed to have a reside rails raised on the bed. The foam on the bed was observed wrapped in foam uct tape. The foam on the bed was observed to have a circular raised on the bed. The foam on the bed was observed to have the foam of the f		1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245545	B. WING _		04	/10/2014	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION		
F 441	bed. R27 stated s really needed a lot At 8:54 a.m. R42's right, half side rail was observed wrap black tape. At 8:59 a.m. R25's bilateral, half, uppe Both side rails wer At 9:01 a.m. R25 s already on the side R25 stated she did were wrapped with asked her if she wnot. R25 also stated dirty" and it bothers she turned over in not sure of how or had not observed a changing them. On 4/9/14, at 7:35 stated the foam was the maintenance of changing of the maintenance of cleaning of the foat stated they replaced. At 3:00 p.m. maint the maintenance of cleaning of the foat stated they replaced by nursing if was s On 4/10/14, at 8:33 stated housekeepi once a month on the needed. She stated	ered ever since she got the he used the rails to get up but of help from others. bed was observed to have a raised on the bed. The side rail oped in gray foam affixed with bed was observed to have er side rails raised on the bed. e observed wrapped with foam. It tated the taped-on foam was erails when she moved there. If not know why the side rails or end the foam looked "awfully ed her to to grab them when bed. R25 also stated she was when they were cleaned and anyone ever cleaning or a.m. nursing assistant (NA)-C as placed on the side rails by taff for some residents to uising. She stated when they hed, they were either wiped NA-C indicated nursing staff enance when the foam needed enance supervisor (MS) stated epartment did not do any m covered side rails. He end the foam padding if notified oiled or needed to be replaced. If a control is a control	F 44				

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

PRINTED: 05/02/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	· /	E SURVEY PLETED
		245545	B. WING		····	04/	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	ME		В	TREET ADDRESS, CITY, STATE, ZIP CODE SOX 8 300 GARFIELD AVENUE SOUTHEAS ERTILE, MN 56540	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	cleaner degraded the unsure of how ofter HK-A stated the foat but was wiped off at between residents. At 11:02 a.m. the D missed removing the rails between reside another intervention bruising. The DON created a surface us anitized. The facility's currentitled Periodic Routi Administrative Officiand the Staff Loung Infection Control-Ispolicy both lacked is related the cleaning replacement of foar rails. Infection Control Program with ongoin of infections and infections and infection Control Louginfections and infections and infection Control Louginfections and infection Control Louginfection Control L	ne foam, however, she was in the foam was replaced. Impadding was not removed and left on the side rails ON stated they had probably the foam padding from the side ents and they may need to find in for residents at risk for confirmed the foam padding mable to be cleaned and It, undated cleaning policy the Residents Rooms, the seed the policy and the undated collation & Terminal Cleaning dentification and direction padding maintenance or me padding for residents' side	F 4	41			

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

PRINTED: 05/02/2014 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245545	B. WING		04	/10/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP BOX 8 300 GARFIELD AVENUE SO FERTILE, MN 56540	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	registered nurse (performed a mont previous month for identify residents of documented this information includ Control Log include room number, unidate of onset, cult antibiotic type, and precautions needed. The Monthly Infective med quarterly create an Infection total numbers of in type of infection. brought to the fact Assessment (QAA review. The DON illnesses/infections sheet when an emin sheets were ser recorded on a mowas reviewed more of the facility's undal Infection Report, Elifections Illness I facility was to devenification control precognize/control,	ras reviewed with the DON and RN)-A. The DON indicated she hly computer review of the reach wing of the facility to with infections. She then information on a monthly loged on the Monthly Infection led: resident name, admit date, to the test to the test to the facility to with infection on a monthly loged on the Monthly Infection led: resident name, admit date, to the test to the test to sample to the facility of the test to have the test to the test test to the test test to the test test to the test test test test test test test	F 4	41		

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

Printed: 04/10/2014 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245545

B. WING

04/09/2014

NAME OF PROVIDER OR SUPPLIER

FAIR MEADOW NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

BOX 8 300 GARFIELD AVENUE SOUTHEAST

	ADOW NORSING HOWE	FERTILE, MN 56	540	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL R OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
	FIRE SAFETY			
	A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Marshal Division on April 09, 2014. At the this survey, the Fair Meadow Nursing How found to be in substantial compliance with requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the edition of National Fire Protection Association (NFPA) Standard 101, "The Life Safety CLSC), Chapter 19 Existing Health Care.	Fire e time of me was h the 2000 ation		
	Fair Meadow Nursing Home is a 1-story without a basement, and constructed at 2 different times. The original building was constructed in 1967 and was determined Type II(111) construction. In 1972 the sou was added to the original building and was determined to be of Type II (111) construction. The south wing is separated with at least fire barrier from an apartment building. T facility is divided into 4 separate smoke z 30 minute fire barriers.	to be of uth wing as ction. a 2 hour he		
	The facility has a fire alarm system with a detection throughout the corridor system all common areas installed in accordance NFPA 72 "The National Fire Alarm Code" edition with automatic fire department no The building is completely protected by a automatic fire sprinkler system installed i accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler System edition with quick response heads. Hazar areas have automatic fire detection that is	and in e with 1999 tification. n ne ns 1999 rdous		
LABORATO	fire alarm system in accordance with the RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESEN	ITATIVE'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.

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

Printed: 04/10/2014 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 245545 B. WING 04/09/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BOX 8 300 GARFIELD AVENUE SOUTHEAST** FAIR MEADOW NURSING HOME FERTILE, MN 56540 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 Continued From page 1 K 000 Minnesota State Fire Code 2007 edition. The facility also has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 50 beds and had a census of 45 at the time of the survey. The facility was surveyed a single building. The requirement at 42 CFR, Subpart 483.70(a) is MET.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted April 24, 2014

Mr. Barry Robertson, Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, Minnesota 56540

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5545023

Dear Mr. Robertson:

The above facility was surveyed on April 7, 2014 through April 10, 2014 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Fair Meadow Nursing Home April 24, 2014 Page 2

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

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

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

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

Please 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 letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900

Telephone: (651) 201-4118 Fax: (651) 215-9697

Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

PRINTED: 05/02/2014 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
			P WING			
		00460	B. WING		04/1	0/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MI	0 GARFIELD MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infe licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/02/14

TITLE

STATE FORM 6899 If continuation sheet 1 of 21 L32H11

			(X3) DATE COMF	SURVEY PLETED		
		00460	B. WING		04/1	10/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAIR ME	EADOW NURSING HO	ME	O GARFIELD MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to elements and the following corplease indicate in your correction that you and identify the date. Minnesota Department's sand the following correction that you and identify the date. Minnesota Department and identify the date. Minnesota Department and identify the date. Minnesota Department assigned to Minnesota Nursing Homes. The assigned tag in column entitled "ID statute/rule out of compartment and replaces the "Tour correction order. The findings which are in after the statement, evidence by." Follower the Suggested Time period for Corplease DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. April 10, 2014 surveyors of taff, visited the above provider correction orders are issued. Four electronic plan of have reviewed these orders, e when they will be completed. The order of Health is documenting. Correction Orders using ag numbers have been so ta state statutes/rules for the order of Deficiencies" column to Comply" portion of the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection. ARD THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 6899 L32H11 If continuation sheet 2 of 21

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00460	B. WING		04/1	0/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME	O GARFIELD MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents		2 560			5/10/14
	Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).					
	by: Based on interview facility failed to ens were addressed on	and document review, the ure bilateral half side rails the care plan for 1 of 2 iewed for accidents.		Corrected		
	Findings include:					
	(MDS) dated 12/18	ange Minimum Data Set /13, indicated R28 was roke and dementia.				
	indicated R28 used	essment dated 6/5/13, bilateral top rails when in bed and to assist with transfers in				
		plan printed 4/9/14, indicated k for falls related to being				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	B) DATE SURVEY COMPLETED		
		00460	B. WING		04/10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HOI	MF BOX 8 30		STATE, ZIP CODE AVENUE SOUTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 560 2 565	indicated R28 had p communication/con problems, incontine weakness, and a hi did not address the on the bed. On 4/10/14, at 8:20 rails were not address were not address. A policy related to incare plan was required a policy related to incare plan was required interventions for side program could be eon-going and effect response to resider TIME PERIOD FOR (21) days.	leeds. The care plan also poor aprehension, gait/balance ance, a stroke with left sided story of falls. R28's care plan use of bilateral top side rails a.m. RN-A verified the side essed on R28s care plan. Interventions documented on a ested and none was provided. In of Correction: The Director nee could direct staff to revise plan to include appropriate the rail use. A monitoring stablished in order to assure live care plan interventions in	2 560 2 565		5/10/14
	Subp. 3. Use. A co	omprehensive plan of care personnel involved in the			
	by: Based on interview facility failed to ensi	and document review, the ure a range of motion (ROM) mented as directed by the		Correctedcompletion date 05/10/2	014.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			K3) DATE SURVEY COMPLETED	
		00460	B. WING		04/1	0/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EAID ME	A DOW AU DOING LIGH	BOX 8 30	0 GARFIELD	AVENUE SOUTHEAST		
FAIR ME	ADOW NURSING HO	ME FERTILE,	MN 56540			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	care plan for 1 of 1 reviewed for ROM s Findings include: R1's quarterly Mining 2/19/14, indicated Findementia, cerebral muscle coordination impairment. The MI ROM limitations to and limitations to and limitations to or R1's current care plant received active t-band to the left up pound weight for the tothe right finger are limitations. Passive knees and ankles. R1's contractures where and ankles and ankles and ankles and ankles and ankles. R1's contractures where and ankles ankles and ankles an	resident (R1) who was services. num Data Set (MDS) dated R1 was diagnosed with palsy (CP) with impaired and had severe cognitive DS also indicated R1 had both lower extremities (LE), ne upper extremity. lan printed 4/10/14, indicated ROM exercises with a blue per extremity (UE) and a four e left shoulder. Passive ROM and wrist extension within pain ROM to both legs, hips, The care plan also indicated yould be measured quarterly.				
	narrative document -November 2103: C ROM, R1 refused s documented 18 tim one time, and there documentation. The documentation on t -December 2013: C ROM, R1 refused fo	ation on the back of the form. Out of 30 opportunities for even times, zero was es, a line was documented were four days with no ere was no narrative he back of the form. Out of 31 opportunities for				

Minnesota Department of Health

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND LAN	o. John Lorion	DENTI IOM NOMBER.	A. BUILDING:		JOIVII	,
		00460	B. WING		04/1	0/2014
					<u> U4/1</u>	0/2014
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
L FAIR MEADOW NURSING HOME			MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	with no documentated documentation on table January 2014: The identified ROM programment. There was no narraback of the form. -February 2014:, Offor ROM, R1 refused documented one tirton 2/21/14, the rehon the back of the fidid not have time to March 2014: Out on ROM, R1 refused for documented nine tiwith no documentated RA-A documented time one aide." On 4/9/14, at 12:10 therapist (OT) state OT and physical the had difficulty with cocould not lift a cup of stated a nursing reference R1 on 2/21/14. The supervised the rehaworked a few hours stated R1's nursing provided seven day At 10:47 a.m. the di ROM program was week according as	tion. There was no narrative he back of the form. There was lacking the gram. Four refusals were est of the month was blank. The documentation on the set of the seven opportunities and three times, zero was me, and four days were blank. The documented form that R1 refused and she to do it in his room. The documented form that R1 refused and she to do it in his room. The documented form the second of the form second of the second of the form second of the secon				

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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FAIR ME	ADOW NURSING HO	MF) GARFIELD MN 56540	AVENUE SOUTHEAST		
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2 565	Continued From pa	ge 6	2 565			
	Nursing or designed system to ensure the being implemented delegate to nursing ensure compliance.	of Correction: The Director of e could establish a monitoring he residents care plans are. The Director of Nursing could staff to monitor the system to a CORRECTION: Twenty-one				
2 895	MN Rule 4658.0525 Motion	5 Subp. 2.B Rehab - Range of	2 895			5/10/14
	that is directed towa through positioning implemented and m comprehensive resi of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	receives appropriat	h a limited range of motion e treatment and services to notion and to prevent further of motion.				
	by: Based on observati review, the facility fa motion services (RG provided and docur	ent is not met as evidenced on, interview and document ailed to ensure range of DM) were consistently mented according to the r 1 of 1 resident (R1) who was services.		Corrected.		

Minnesota Department of Health STATE FORM

E FORM 6899 L32H11 If continuation sheet 7 of 21

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00460	B. WING		04/1	10/2014
	PROVIDER OR SUPPLIER ADOW NURSING HO	BOX 8 30		TATE, ZIP CODE AVENUE SOUTHEAST		
FAIR WE	ADOW NURSING HO	FERTILE,	MN 56540			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 895	R1's annual Minimus 9/4/13, indicated R1 lower extremities, a extremity. The Activ Assessment (CAA) had contractures of related to cerebral proordination with rigalso indicated R1 with goal for the contractures of indicated R1 with goal for the contractures of indicated R1 with goal for the contractures in the goal for the contractures was diagnosed with severe cognitive im R1 had ROM limitations. R1's current care propound weight for the tothe right finger at limitations. Passive knees and ankles. R1's contractures with contractures with goal of R1's until documentation form March 2014, reveal to Cotober 2013: Out of Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014, reveal to Cotober 2013: Out of R1's until documentation form March 2014.	um Data Set (MDS) dated 1 had ROM limitations to both and limitations to one upper vity of Daily Living Care Area dated 9/7/13, indicated R1 the right hand and wrist balsy (CP) impaired muscle ght sided weakness. The CAA vas on a rehab program with a vitures not to worsen. The CAA sed a mechanical lift for all dated 2/19/14, indicated R1 dementia, CP and had pairment. The MDS indicated tions to both lower extremities to one upper extremity. Ian printed 4/10/14, indicated ROM exercises with a blue oper extremity (UE) and a four e left shoulder. Passive ROM and wrist extension within pain ROM to both legs, hips, The care plan also indicated would be measured quarterly. a.m. nursing assistant (NA)-A ush R1s teeth. R1 was s arms across his chest while ving were done. tled nursing rehab as from October 2013, through	2 895			
		s documented two times, and a				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00460	B. WING		04/1	0/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
FAIR ME	ADOW NURSING HO	МЕ	GARFIELD MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 895	"5" was documented narrative documented 18 time one time, and there documentation. The documentation on the December 2013: CROM, R1 refused for documentation on the January 2014: The identified ROM product and the form. February 2014: The identified ROM product and the form. February 2014: Out for ROM, R1 refused for ROM, R1 refused documented one time on the back of the form. February 2014: Out for ROM, R1 refused for the back of the form. February 2014: Out for ROM, R1 refused for the back of the form the back of the form. On 4/9/14, the refused for the form the back of the form the form the form the back of the form t	ed once. There was no tation on the back of the form. Out of 30 opportunities for seven times, zero was les, a line was documented e were four days with no ere was no narrative the back of the form. Out of 31 opportunities for our times, zero was les, and there were 11 days tion. There was no narrative the back of the form. It is rehab form was lacking the gram. Four refusals were lest of the month was blank. The tative documentation on the left of the seven opportunities and three times, zero was lest and four days were blank. The lab aide (RA)-A documented form that R1 refused and she	2 895			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME	O GARFIELD MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 895	R1's nursing rehabseven days a week On 4/10/14, at 8:36 scheduled as a reh RA-A stated there were scheduled pe p.m. and in addition were also expected meals at breakfast received ROM to h week. However, RA state he did not wa not cooperate and also stated R1 wou re-approached late there were 41 resid program per day ar to do the ROM prog was only one rehab March 2nd, 3rd, 5th were no rehab aide At 8:58 a.m. the dir she had discussed to always have two stated she felt the r be extended. In add rehab aides were g they would also nee meant. At 9:20 a.m. RA-A ready to do his exe was observed to br encouragement R1 with the UE ROM p and blue therabance	program was to be provided. a.m. RA-A stated she was ab aide four days a week. Were four rehab aides and two r day from 7:00 a.m. to 1:00 to providing ROM services, I to assist residents with their and lunch. RA-A confirmed R1 is UE and LE seven days a A-A stated R1 would normally not to do the exercises or would follow the directions. RA-A ld even refuse when r. In addition, RA-A stated lents on a rehab nursing and there was not enough time grams as sometimes there of aide working. RA-A stated on a, 22nd, and 2/24/14, there	2 895			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00460	B. WING		04/1	10/2014
	PROVIDER OR SUPPLIER	MF BOX 8 30	, ,	STATE, ZIP CODE AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	OULD BE	(X5) COMPLETE DATE
2 895	At 9:37 a.m. RA-B s meant we asked Ratherapy and he said have had only one sa second rehab aid. At 9:44 a.m. the DC the rehab schedule from March 2014, and tho only one rehab aide. October 2013: four scheduled (12, 13, 14). November 2013: s scheduled (9,10, 22). December 2013: 1 scheduled (3, 5, 7, 126, 28, 29). January 2014: 14 c scheduled (3, 4, 5, 125, 26). February 2014: seven scheduled (1, 2, 7, 126, 28, 29). March 2014: seven scheduled (1, 2, 7, 126, 28, 29). On 4/10/14, at 10:2 (RN)-A confirmed F staff continued to c she did not know w documentation. At 10:31 a.m. the or stated R1 did have OT stated when R1	stated a documented zero I if he wanted to come to I "nope." RA-B stated they staff in rehab, and if there was e she was "pulled" to the floor. ON stated we really tried to get aced. The DON reviewed the m October 2013, through e following dates indicated was on duty: I days with one rehab aide 26, 27). even days with one rehab aide 27, 23, 24, 29, 30). 4 days with one rehab aide 8, 9, 14, 15, 20, 21, 22, 25, I days with one rehab aide 6, 7, 11, 12, 13, 16, 18, 19, 21, I wen days with one rehab aide 15, 16, 22, 23). In days with one rehab aide 13, 15, 16, 21). 8 a.m. registered nurse 11 refused rehab therapy and offer the services. RN-A stated hat zero meant for Ccupational therapist (OT) a contracted right U/E. The 's contracture measurements showed no decline and some	2 895			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	At 10:40 a.m. RN-A was not on the Januwas discontinued d RN-A stated because ROM therapy was r PT/OT. At 10:47 a.m. the D program was not program was not program was not program was not program was related by his composition of DON confirmed the aides were documentation flow thought it was related A policy regarding to program was requestionable of Nursing or designin-service to address receiving appropriate range of motion lime appropriate treatment provided by the statement of the program for resider program for resider program for resider to the progr	ge 11 A stated R1's rehab program pary rehab form because it the to R1's refusals. However, se R1 had contractures and needed, R1 was referred to convided seven days per week are plan. Both RN-A and the year end aware the rehab enting zeros on the rehab enting zeros on the rehab enting zeros on the rehab enting the second of the second of the rehab enting the second of the second of the rehab enting the second of	2 895			
21375	Program Subpart 1. Infection home must establis	Subp. 1 Infection Control; on control program. A nursing th and maintain an infection	21375			5/10/14
	control program des sanitary environmen	signed to provide a safe and nt.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00460	B. WING	·····	04/1	0/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE		
		BOX 8 30		AVENUE SOUTHEAST		
FAIR ME	ADOW NURSING HO	ME FERTILE	, MN 56540			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 12	21375			
	by: Based on observation review, the facility of hand hygiene was of (R10) who was obstaddition, the facility secured by electrical side rails creating of cleaned and sanitize R10, R13, R43, R2 foam padding wrap Lastly, the facility factions	ent is not met as evidenced fon, interview and document ailed to ensure appropriate completed for 1 of 1 resident served during wound care. In implemented foam coverings al and / or duct tape to bed surfaces that were unable to be sed for 7 of 28 residents (R17, 7, R42, R25) observed with ped around the side rails. Ailed to analyze patterns and for both staff and residents facility.		Corrected.		
	Findings include:					
	(LPN)-A was obsernish hands, raise R1 shin protector and particular calf wound dressing discard it into the transport donne clean gloves Xeroform (sterile, fiwith a blend of 3% (Xeroform) and US R10's wound and dR10 removed and drash, reapplied a coproceeded to clean saline using an ABI dressing). LPN-A varoform dressing	p.m. licensed practical nurse ved to enter R10's room, wash 0's right pant leg, lower her proceeded to cut R10's right g (Kling) off with a scissor and ash. LPN-A was observed to and remove a gauze pad and ne mesh gauze impregnated Bismuth Tribromophenate P Petrolatum) dressing from iscard them into the trash. discarded his gloves into the lean pair of gloves and se R10's wound with normal D bandage (highly absorbent was observed to apply a new to the wound and place a Telfaerent cotton pad) over the				

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00460	B. WING		04/1	0/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
FAIR MEADOW NURSING HOME			MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 13	21375			
	Xeroform. LPN-A removed and discarded his gloves and wrapped the wound with Kling. LPN-A was observed to replaced R10's shin protector and lowered her pant leg.					
	observed to raise R the shin protector e left lower leg just be observed to apply o dressing off with a p into the trash. LPN discarded his glove LPN-A was observe (absorbent soft silic wound. LPN-A rem gloves, replaced R lowered her pant le garbage with the di trash can liner and not observed to was sanitizer between th before the application	e observation, LPN-A was alors left pant leg and lower exposing a dressing to R10's below the knee. LPN-A was alean gloves and cut the pair of scissors and discard it alors and applied clean gloves. The then removed and some foam) dressing to the loved and discarded his lo's shin protector and g. LPN-A bagged the lowest part of the washed his hands. LPN-A was she his hands or use hand he removal of dirty dressings, on of clean dressings nor and left leg wound dressing				
	On 4/9/14, at 2:05 p not washed his han between the remov before the application	o.m. LPN-A confirmed he had ds or used hand sanitizer al of the dirty dressings or on of the clean dressings nor and left leg dressing changes.				
	(DON) stated for int would expect hand between the remov application of the cl	5 a.m. the director of nursing fection control purposes, she hygiene be completed al of the dirty dressing and the ean dressing, as well as, and left leg wound dressing				

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		00460	B. WING		04/1	0/2014
NAME OF			ODECC OITY O	STATE ZID CODE	04/1	0/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE AVENUE SOUTHEAST		
FAIR ME	ADOW NURSING HO	MF	MN 56540	AVENUE SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
21375	Continued From pa	ge 14	21375			
	A dressing change policy was requested but DON indicated the facility policies were being updated and they did not have a current policy for dressing changes.					
	Side Rails:					
	to have bilateral, up the bed. The rails w foam and secured of At 5:27 p.m. R43's bilateral, half, uppe The rails were obsesecured with duct to At 6:16 p.m. R17's bilateral, upper, ha The right side rail was of approximately a 2.5 a flap. At 6:34 p.m. R10's bilateral, upper, sid side rails were obsesfixed with black to At 8:54 p.m. R10's bilateral, upper, sid side rails were obsesfixed with black to At 8:54 a.m. R42's right, half side rail rwas observed wrap black tape. At 8:59 a.m. R25's bilateral, half, upper side of At 8:59 a.m. R25's bi	bed was observed to have r side rails raised on the bed. erved wrapped in foam and ape. bed was observed to have observed wrapped in foam on the bed. The foam on the bed of inch long tear which created bed was observed to have er ails raised on the bed. The berved wrapped in foam and				

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		00460	B. WING		04/1	0/2014			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
EAID ME	FAIR MEADOW NURSING HOME BOX 8 300 GARFIELD AVENUE SOUTHEAST								
FAIR ME	ADOW NURSING HO	ME FERTILE,	MN 56540						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE			
21375	At 9:01 a.m. R25 stalready on the side R25 stated she did were wrapped with asked her if she wanot. R25 also stated dirty" and it bothere she turned over in the not sure of how or whad not observed a changing them. On 4/9/14, at 7:35 a stated the foam wathe maintenance streduce/prevent bruineeded to be clean down or replaced. would notify mainte to be replaced. At 3:00 p.m. mainte the maintenance decleaning of the foar stated they replace by nursing if was so On 4/10/14, at 8:33 stated housekeepir once a month on the needed. She stated sprayed the side racleaner with bleach cleaner degraded the unsure of how ofter HK-A stated the foar	ge 15 ated the taped-on foam was rails when she moved there. not know why the side rails foam and stated no one had anted the foam on the rails or dithe foam looked "awfully of her to to grab them when bed. R25 also stated she was when they were cleaned and anyone ever cleaning or a.m. nursing assistant (NA)-C is placed on the side rails by aff for some residents to ising. She stated when they ed, they were either wiped NA-C indicated nursing staff nance when the foam needed enance supervisor (MS) stated epartment did not do any in covered side rails. He did the foam padding if notified biled or needed to be replaced. a.m. housekeeper (HK)-A ing washed the residents' beds is e residents' bath day and as did they sometimes also ils with Comet disinfecting. HK-A confirmed the spray the foam, however, she was in the foam was replaced. It is not the side rails	21375	DEFICIENCY)					
	between residents. At 11:02 a.m. the D missed removing th rails between reside another intervention	ON stated they had probably ne foam padding from the side ents and they may need to find n for residents at risk for confirmed the foam padding							

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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME	GARFIELD MN 56540	AVENUE SOUTHEAST		
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	created a surface usanitized. The facility's currentitled Periodic Rout Administrative Officiand the Staff Loung Infection Control-Is policy both lacked i related the cleaning replacement of foar rails. Infection Control Program with ongoing of infections and infections and infection Control Lought 103/14, revealed on antibiotics were transystem lacked tremantibiotics. In additionable en established. On 4/9/14, at 12:08 control program waregistered nurse (Performed a month previous month for identify residents with documented this in Information include Control Log includer oom number, unit, date of onset, culture antibiotic type, antiliprecautions needed.	inable to be cleaned and it, undated cleaning policy ine Residents Rooms, ites, Director of Nursing Office ge policy and the undated olation & Terminal Cleaning dentification and direction g/sanitizing, maintenance or m padding for residents' side	21375			

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		00460	B. WING		04/10/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	GARFIELD MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	reviewed quarterly create an Infection total numbers of inf type of infection. Throught to the facility Assessment (QAA) review. The DON fillnesses/infections sheet when an empin sheets were sent recorded on a monwas reviewed monton on 4/9/14, at 2:16 panalysis of resident comparison to empdocumented. The facility's undate Infection Report, Ellnfections Illness la facility was to develon fection control program to and spread of the strength of the strength of the surfaces are cleans designee could impensure compliance.	by the DON and used to Report which summarized rections by month, unit and his Infection Report was ty's Quality Assurance and committee for quarterly rurther indicated employee were recorded on a call in ployee called in sick. The call to the office where they were they call in sheet. This report they by the DON. D.m. The DON confirmed no infection trends with ployee infections/illnesses was red policies entitled Resident mployee Health Policies and cked direction for how the report in order to prevent, to the extent possible, the infection within the facility. THOD OF CORRECTION: The (DON) or designee could responsible for the infection include tracking, evaluation, to prevent the spread of a propriate hand hygiene and and products to ensure able and sanitary. The DON or olement a monitoring system to	21375			

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		00460	B. WING		04/1	0/2014		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
FAIR ME	FAIR MEADOW NURSING HOME BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
21375	Continued From pa	ge 18	21375					
	(21) days.							
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			5/10/14		
	Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.							
	This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure an enhanced and dignified dining experience was maintained for 6 of 6 (R31, R28, R13, R43, R15, R3) residents who dined in the activity room during 2 of 3 meal observations.			Corrected.				
	Findings include:							
	evening meal in the R28, R13, R43 and their meals. R43 and their meals. R43 and side by side, up againdependently eatin observed seated at table and assisted to observed seated at staff member, seated to eat. All residents tray with their food of throughout the mean room were observed dishware without a staff member, seated to eat.	•						
	On 4/9/14, at 8:01 a	a.m. R43 and R13 were						

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		00460	B. WING		04/	10/2014
	PROVIDER OR SUPPLIER	MF BOX 8 30		TATE, ZIP CODE AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21805	observed eating bra room. R43 was see eating independent with a staff member residents were served without a tray, as wobserved eating in On 04/09/14, at 11: and R3 were observed the trays. The dishware the trays while the robserved in the mato be served their natray. R43 was interviewed stated she didn't rethe tray it was served complain. On 4/10/14, at 8:49 stated she didn't known din the activity on trays. She stated tell you." At 8:52 a.m. activity served residents in meal. AA-B confir trays. She stated the off of the trays but so didn't do that all the activity room were soon't known why we don't known why we	eakfast in the main dining ated at a table by herself, ly. R13 was seated at a table r assisting her to eat. Both red their meal on dishware ere all the other resident's the main dining room. 30 a.m. R31, R28, R43, R15 wed eating in the activity room. ir meal with the dishware on was observed to remain on residents ate. Residents in dining room were observed neal on dishware without a led on 4/9/14, at 12:20 p.m. and ally like eating her meal off of ed on, but didn't like to a.m. nursing assistant (NA)-A ow why the residents who room were served their meals d "maybe it's easier, I couldn't like activity room for the noon med the meals were served on ney sometimes took the dishes she was not sure why they time. confirmed the meals in the served on trays. She stated "I do that." She stated she had y for 1 1/2 years and "it's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00460	B. WING		04/1	0/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE AVENUE SOUTHEAST		
FAIR ME	ADOW NURSING HO	ME	MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	Continued From page 20		21805			
	4/10/14, at 8:56 a.m to be served on tray supposed to put the it was done in the m On 4/10/14, at 11:1 (DON) confirmed the served their meals residents who receiding area should manner as the residente main dining roo A dining policy was provided. Suggested Method Nursing (DON) or demployees responsensure and enhance experienced is proving the facility. The Emonitoring program compliance.	5 a.m. director of nursing nat residents should not be on trays. She stated those ived meals in the activity room have been served in the same dents who received meals in m. requested but none was of Correction: The Director of designee could in-service sible for dining services to seed and dignified dining vided to all residents residing DON could establish a				