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.
(L1) **245545**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/11/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel , HFE NE II 06/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/27/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5545

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245545	A. Building B. Wing	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
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/10/2014**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **05/10/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/10/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/AK	06/17/2014	32981	06/11/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/10/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00460	A. Building B. Wing	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 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	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **05/10/2014**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **05/10/2014**	ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **05/10/2014**
ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **05/10/2014**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **05/10/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/AK	06/17/2014	32981	06/11/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/10/2014				

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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

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.
(L1) **245545**

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/10/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Deb Vincent, HFE NEII 05/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/27/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA MDH DEPARTMENT OF HEALTH

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	04/10/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This 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. Findings include: On 4/7/14, at 5:30 p.m. during observation of the evening meal in the activity dining room, R31, R28, R13, R43 and R15 were observed eating their meals. R43 and R15 were observed seated side by side, up against bedside tables,	F 241	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 a tray. All residents will be served their meals on dishware without a tray. A dining policy addressing the subject has been written and implemented. Licensed 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	5/10/14

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

Electronically Signed | 05/02/2014

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F 241	Continued From page 1 independently eating. R13 and R28 were observed seated across from each other at a table and assisted by two aides to eat. R31 was observed seated at a separate table with one staff member, seated next to him, assisting him to eat. All residents were served their meal on a tray with their food remaining on the tray throughout the meal. Residents in the main dining room were observed to be served their meal on dishware without a tray. On 4/9/14, at 8:01 a.m. R43 and R13 were observed eating breakfast in the main dining room. R43 was seated at a table by herself, eating independently. R13 was seated at a table with a staff member assisting her to eat. Both residents were served their meal on dishware without a tray, as were all the other resident's observed eating in the main dining room. On 04/09/14, at 11:30 a.m. R31, R28, R43, R15 and R3 were observed eating in the activity room. All were served their meal with the dishware on trays. The dishware was observed to remain on the trays while the residents ate. Residents observed in the main dining room were observed to be served their meal on dishware without a tray. R43 was interviewed on 4/9/14, at 12:20 p.m. and stated she didn't really like eating her meal off of the tray it was served on, but didn't like to complain. On 4/10/14, at 8:49 a.m. nursing assistant (NA)-A stated she didn't know why the residents who dined in the activity room were served their meals on trays. She stated "maybe it's easier, I couldn't tell you."	F 241	their dining experience. OTR and Activity Aides were also updated on this issue as well because they are present during the time meals are served in the Activity Room. Daily audits were conducted for 1 week nursing assistants were removing dishware from trays prior to residents consuming meals. No reminders were needed. Random QA audits will be conducted by charge nurses weekly for one month, then monthly for 2 months. Results will be reported to QAA committee. DON to monitor compliance.	

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F 241	Continued From page 2 At 8:52 a.m. activity assistant (AA)-B stated she served residents in the activity room for the noon meal. AA-B confirmed the meals were served on trays. She stated they sometimes took the dishes off of the trays but she was not sure why they didn't do that all the time. At 8:55 a.m. NA-B confirmed the meals in the activity room were served on trays. She stated "I don't know why we do that." She stated she had worked at the facility for 1 1/2 years and "it's always been that way." Dietary supervisor (DS) was interviewed on 4/10/14, at 8:56 a.m. and stated meals were not to be served on trays. She stated staff were supposed to put the dishes on the table, just like it was done in the main dining room. On 4/10/14, at 11:15 a.m. director of nursing (DON) confirmed that residents should not be served their meals on trays. She stated those residents who received meals in the activity room dining area should have been served in the same manner as the residents who received meals in the main dining room. A dining policy was requested but none was provided.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279		5/10/14

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F 279	Continued From page 3 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bilateral half side rails were addressed on the care plan for 1 of 2 residents (R28) reviewed for accidents. Findings include: R28's significant change Minimum Data Set (MDS) dated 12/18/13, indicated R28 was diagnosed with a stroke and dementia. R28's side rail assessment dated 6/5/13, indicated R28 used bilateral top rails when in bed due to 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. The care plan also indicated R28 had poor	F 279	R28's side rail assessment was completed and it determined that side rails should be removed because R28 does not purposefully use them. The bilateral half side rails were removed from R28's low bed. All other in house residents using side rails have been assessed and care plans reflect their appropriate use. A side rail assessment will be performed for every resident on admission. If it is determined by the comprehensive assessment that side rails will be used, then side rail assessments will be completed annually or with a significant change in condition for all residents using side rails. Care plans will be conducted accordingly. Side rail use has been added to the checklist of items reviewed at care conferences. Licensed nursing staff were inserviced on the above	

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F 279	Continued From page 4 communication/comprehension, gait/balance problems, incontinence, a stroke with left sided weakness, and a history of falls. R28's care plan did not address the use of bilateral top side rails on the bed. On 4/10/14, at 8:20 a.m. RN-A verified the side rails were not addressed on R28s care plan. A policy related to interventions documented on a care plan was requested and none was provided.	F 279	on 4-15-14. Primary RNs will audit compliance at the time of each residents care conference. Results will be reported to QAA committee.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a range of motion (ROM) program was implemented as directed by the care plan for 1 of 1 resident (R1) who was reviewed for ROM services. Findings include: R1's quarterly Minimum Data Set (MDS) dated 2/19/14, indicated R1 was diagnosed with dementia, cerebral palsy (CP) with impaired muscle coordination and had severe cognitive impairment. The MDS also indicated R1 had ROM limitations to both lower extremities (LE), and limitations to one upper extremity.	F 282	The facility will ensure that the ROM program will be implemented as directed by the care plan. R1's care plan will be updated to reflect ROM exercises to provide a more realistic goal since resident R1 often exercises his right to refuse. Other residents receiving nursing rehab programs are reviewed quarterly by nursing rehab RN and at care conference by primary RN and care plans updated accordingly. A legend will be developed to achieve accurate and consistent charting in our rehab nursing department. The length of nursing rehab shifts will be extended as necessary to achieve nursing rehab goals. Nursing rehab staff to be	5/10/14

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F 282	Continued From page 5 R1's current care plan printed 4/10/14, indicated R1 received active ROM exercises with a blue t-band to the left upper extremity (UE) and a four pound weight for the left shoulder. Passive ROM to the right finger and wrist extension within pain limitations. Passive ROM to both legs, hips, knees and ankles. The care plan also indicated R1's contractures would be measured quarterly. Review of R1's untitled nursing rehab documentation forms from October 2013, through March 2014, revealed the following: -October 2013: Out of 31 opportunities for ROM, R1 refused 17 times, and zero was documented 11 times, a line was documented two times, and a "5" was documented once. There was no narrative documentation on the back of the form. -November 2103: Out of 30 opportunities for ROM, R1 refused seven times, zero was documented 18 times, a line was documented one time, and there were four days with no documentation. There was no narrative documentation on the back of the form. -December 2013: Out of 31 opportunities for ROM, R1 refused four times, zero was documented 16 times, and there were 11 days with no documentation. There was no narrative documentation on the back of the form. -January 2014: The rehab form was lacking the identified ROM program. Four refusals were documented. The rest of the month was blank. There was no narrative documentation on the back of the form. -February 2014:, Out of the seven opportunities for ROM, R1 refused three times, zero was documented one time, and four days were blank. On 2/21/14, the rehab aide (RA)-A documented on the back of the form that R1 refused and she	F 282	inserviced and the above updates. Results will be reported to QAA committee. Rehab RN to monitor compliance.	

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F 282	Continued From page 6 did not have time to do it in his room. -March 2014: Out of the 31 opportunities for ROM, R1 refused four times, zero was documented nine times, and there were 18 days with no documentation. On 3/29/14, and 3/30/14, RA-A documented on the back of the form "no time one aide." On 4/9/14, at 12:10 p.m. the occupational therapist (OT) stated R1 was seen on 1/27/14, for OT and physical therapy (PT). The OT stated R1 had difficulty with correct seated posture and could not lift a cup with his left hand. The OT stated a nursing rehab program was resumed for R1 on 2/21/14. The OT stated a registered nurse supervised the rehab program and she only worked a few hours per week. The OT also stated R1's nursing rehab program was to be provided seven days a week. At 10:47 a.m. the director of nursing verified R1's ROM program was not performed seven days per week according as directed by the care plan. A policy regarding following a care plan was requested and none was provided.	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		5/10/14

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F 318	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion services (ROM) were consistently provided and documented according to the assessed needs for 1 of 1 resident (R1) who was reviewed for ROM services. Findings include: R1's annual Minimum Data Set (MDS) dated 9/4/13, indicated R1 had ROM limitations to both lower extremities, and limitations to one upper extremity. The Activity of Daily Living Care Area Assessment (CAA) dated 9/7/13, indicated R1 had contractures of the right hand and wrist related to cerebral palsy (CP) impaired muscle coordination with right sided weakness. The CAA also indicated R1 was on a rehab program with a goal for the contractures not to worsen. The CAA also indicated R1 used a mechanical lift for all transfers. R1's quarterly MDS dated 2/19/14, indicated R1 was diagnosed with dementia, CP and had severe cognitive impairment. The MDS indicated R1 had ROM limitations to both lower extremities (LE), and limitations to one upper extremity. R1's current care plan printed 4/10/14, indicated R1 received active ROM exercises with a blue t-band to the left upper extremity (UE) and a four pound weight for the left shoulder. Passive ROM to the right finger and wrist extension within pain limitations. Passive ROM to both legs, hips, knees and ankles. The care plan also indicated R1's contractures would be measured quarterly.	F 318	The facility will ensure ROM services will be consistently provided and documented according to assessed needs. The facility will ensure that the ROM program will be implemented as directed by the care plan. R1's care plan will be updated to reflect ROM exercises to provide a more realistic goal since resident R1 often exercises his right to refuse. Other residents receiving nursing rehab programs are reviewed quarterly by nursing rehab RN and at care conference by primary RN and care plans updated accordingly. A legend will be developed to achieve accurate and consistent charting in our rehab nursing department. The length of nursing rehab shifts will be extended as necessary to achieve nursing rehab goals. Nursing rehab staff will be inserviced on the above updates. OTR will conduct random audits weekly for 4 weeks. Rehab RN to monitor compliance by conducting quarterly audits. Results will be reported to QAA committee.	

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F 318	Continued From page 8 On 4/9/14, at 8:03 a.m. nursing assistant (NA)-A was observed to brush R1s teeth. R1 was observed to hold his arms across his chest while oral cares and shaving were done. Review of R1's untitled nursing rehab documentation forms from October 2013, through March 2014, revealed the following: -October 2013: Out of 31 opportunities for ROM, R1 refused 17 times, and zero was documented 11 times, a line was documented two times, and a "5" was documented once. There was no narrative documentation on the back of the form. -November 2013: Out of 30 opportunities for ROM, R1 refused seven times, zero was documented 18 times, a line was documented one time, and there were four days with no documentation. There was no narrative documentation on the back of the form. -December 2013: Out of 31 opportunities for ROM, R1 refused four times, zero was documented 16 times, and there were 11 days with no documentation. There was no narrative documentation on the back of the form. -January 2014: The rehab form was lacking the identified ROM program. Four refusals were documented. The rest of the month was blank. There was no narrative documentation on the back of the form. -February 2014: Out of the seven opportunities for ROM, R1 refused three times, zero was documented one time, and four days were blank. On 2/21/14, the rehab aide (RA)-A documented on the back of the form that R1 refused and she did not have time to do it in his room. -March 2014: Out of the 31 opportunities for ROM, R1 refused four times, zero was documented nine times, and there were 18 days	F 318		

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F 318	Continued From page 9	F 318		

with no documentation. On 3/29/14, and 3/30/14, RA-A documented on the back of the form "no time one aide."

On 4/9/14, at 12:10 p.m. the occupational therapist (OT) stated R1 was seen on 1/27/14, for OT and physical therapy (PT). The OT stated R1 had difficulty with correct seated posture and could not lift a cup with his left hand. The OT stated a nursing rehab program was resumed for R1 on 2/21/14. The OT stated a registered nurse supervised the rehab program and she only worked a few hours per week. The OT stated R1's nursing rehab program was to be provided seven days a week.

On 4/10/14, at 8:36 a.m. RA-A stated she was scheduled as a rehab aide four days a week. RA-A stated there were four rehab aides and two were scheduled per day from 7:00 a.m. to 1:00 p.m. and in addition to providing ROM services, were also expected to assist residents with their meals at breakfast and lunch. RA-A confirmed R1 received ROM to his UE and LE seven days a week. However, RA-A stated R1 would normally state he did not want to do the exercises or would not cooperate and follow the directions. RA-A also stated R1 would even refuse when re-approached later. In addition, RA-A stated there were 41 residents on a rehab nursing program per day and there was not enough time to do the ROM programs as sometimes there was only one rehab aide working. RA-A stated on March 2nd, 3rd, 5th, 22nd, and 2/24/14, there were no rehab aides available.

At 8:58 a.m. the director of nursing (DON) stated she had discussed with the administrator a goal to always have two rehab staff on duty. The DON

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stated she felt the rehab aides hours needed to be extended. In addition, the DON stated if the rehab aides were going to document a zero, then they would also need to document what that meant.

At 9:20 a.m. RA-A was heard to ask R1 if he was ready to do his exercises and R1 said "no." RA-A was observed to bring R1 into his room. With encouragement R1 was observed to participate with the UE ROM program by using the weight and blue theraband with his left hand. R1 was observed to allow a passive stretch of his right contracted fingers.

At 9:37 a.m. RA-B stated a documented zero meant we asked R1 if he wanted to come to therapy and he said "nope." RA-B stated they have had only one staff in rehab, and if there was a second rehab aide she was "pulled" to the floor.

At 9:44 a.m. the DON stated we really tried to get the rehab aide replaced. The DON reviewed the rehab schedule from October 2013, through March 2014, and the following dates indicated only one rehab aide was on duty:

-October 2013: four days with one rehab aide scheduled (12, 13, 26, 27).
-November 2013: seven days with one rehab aide scheduled (9,10, 22, 23, 24, 29, 30).
-December 2013: 14 days with one rehab aide scheduled (3, 5, 7, 8, 9, 14, 15, 20, 21, 22, 25, 26, 28, 29).
-January 2014: 14 days with one rehab aide scheduled (3, 4, 5, 6, 7, 11, 12, 13, 16, 18, 19, 21, 25, 26).
-February 2014: seven days with one rehab aide scheduled (1, 8, 9, 15, 16, 22, 23).

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F 318	Continued From page 11 -March 2014: seven days with one rehab aide scheduled (1, 2, 7, 13, 15, 16, 21). On 4/10/14, at 10:28 a.m. registered nurse (RN)-A confirmed R1 refused rehab therapy and staff continued to offer the services. RN-A stated she did not know what zero meant for documentation. At 10:31 a.m. the occupational therapist (OT) stated R1 did have a contracted right U/E. The OT stated when R1's contracture measurements were obtained, R1 showed no decline and some improvement from 9/13. At 10:40 a.m. RN-A stated R1's rehab program was not on the January rehab form because it was discontinued due to R1's refusals. However, RN-A stated because R1 had contractures and ROM therapy was needed, R1 was referred to PT/OT. At 10:47 a.m. the DON verified R1's ROM program was not provided seven days per week as directed by his care plan. Both RN-A and the DON confirmed they were not aware the rehab aides were documenting zeros on the rehab documentation flow sheets. The DON stated she thought it was related to a lack of communication. A policy regarding the documentation of the rehab program was requested and none was provided.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		5/10/14

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	245545	A. BUILDING _____ B. WING _____	04/10/2014

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

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F 323	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 communication/comprehension skills,	F 323	R28's side rail assessment was completed and it determined that side rails should be removed because R28 does not purposefully use them. The bilateral half side rails were removed from R28's low bed. All other in house residents using side rails have been assessed and care plans reflect their appropriate use. A side rail assessment will be performed for every resident on admission. If it is determined by the comprehensive assessment that side rails will be used, then side rail assessments will be completed annually or with a significant change in condition for all residents using side rails. Care plans will be conducted accordingly. Side rail use has been added to the checklist of items reviewed at care conferences. Licensed nursing staff were inserviced on the above on 4-15-14. Primary RNs will audit compliance at the time of each residents care conference. Results will be reported to QAA Committee.	

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F 323	Continued From page 13	F 323		

gait/balance problems, incontinence, a stroke with left sided weakness and a history of falls. The care plan indicated fall interventions included a green gripper on the seat in the wheelchair and recliner, a low bed with mats, a tab chair alarm, bed sensor and a nursing rehab program.

The fall report dated 4/3/14, at 9:10 p.m. indicated a NA entered R28s room as the bed alarm was sounding. The report indicated R28 was found seated on the floor mat next to her bed, leaning her back against the bed.

On 4/9/14, at 8:07 a.m. R28 was observed in bed on her left side, asleep. R28 was observed to have two top bilateral half side rails raised on the bed and a bed alarm was in place.

At 8:42 a.m. nursing assistant (NA)-A and NA-B were observed to transfer R28 into the wheelchair. NA-A was observed to clip the chair alarm to R28.

On 4/9/14, at 8:43 a.m. NA-A stated when R28 was in bed, the two top side rails were used. NA-A and NA-B both stated R28 did not use the side rails to reposition herself.

At 11:52 a.m. NA-B stated in 6/13, R28 would have used the side rails, however, since R28 had a decline in her condition, she was unable to use the side rails.

At 12:20 p.m. the occupational therapist (OT) stated the top side rails should be reassessed. The OT thought the side rails were assessed yearly unless there was an issue. The OT stated if R28 was not using the side rails there would be no need to have them on the bed.

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F 323	Continued From page 14 At 12:30 p.m. family member (FM)-A stated R28 was placed on hospice services after she returned from the hospital in June of 2013. FM-A stated she had not seen R28 use the side rails since she returned from the hospital. At 12:38 p.m. registered nurse (RN)-A confirmed R28 was on hospice services from 7/4/13, through 12/18/13. At 12:42 p.m. the director of nursing (DON) stated R28's side rails should be assessed quarterly, annually and with significant change assessments. On 4/10/14, at 8:20 a.m. RN-A verified the side rails were not addressed on R28s care plan. At 8:26 a.m. the DON stated on 4/3/14, R28 had slid out of her bed and onto the floor. A policy was requested regarding side rail assessments and none was provided.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		5/10/14

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F 356	Continued From page 15 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the actual hours of licensed and unlicensed nursing staff working per shift as required. This had the potential to affect all 45 residents residing in the facility, family members and any visitors who chose to view this information. Findings include: On 4/7/14, at approximately 1:30 p.m. during the initial tour of the facility, the nurse staff posting dated 4/7/14, was observed to lack actual working hours per individual shift for licensed and unlicensed staff. Subsequent daily staff postings dated 4/8/14,	F 356	The facility will post the actual hours of licensed and unlicensed nursing staff working per individual shift in addition to the facility name, current date, and resident census. Licensed nursing staff were inserviced on these requirements on 4-15-14. DON to monitor compliance.	

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F 356	Continued From page 16 4/9/14, and 4/10/14, also lacked the actual hours worked per each individual shift. On 4/10/14 at 11:20 a.m. the director of nursing (DON) confirmed the daily nurse staff postings lacked definition of actual hours worked for each individual shift.	F 356		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		5/10/14

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F 441	Continued From page 17 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed for 1 of 1 resident (R10) who was observed during wound care. In addition, the facility implemented foam coverings secured by electrical and / or duct tape to bed side rails creating surfaces that were unable to be cleaned and sanitized for 7 of 28 residents (R17, R10, R13, R43, R27, R42, R25) observed with foam padding wrapped around the side rails. Lastly, the facility failed to analyze patterns and trends of infections for both staff and residents. This had the potential to affect all 45 residents who resided in the facility. Findings include: Wound Care: On 4/9/14, at 12:43 p.m. licensed practical nurse (LPN)-A was observed to enter R10's room, wash his hands, raise R10's right pant leg, lower her shin protector and proceeded to cut R10's right calf wound dressing (Kling) off with a scissor and discard it into the trash. LPN-A was observed to donne clean gloves and remove a gauze pad and Xeroform (sterile, fine mesh gauze impregnated with a blend of 3% Bismuth Tribromophenate (Xeroform) and USP Petrolatum) dressing from	F 441	The facility will ensure appropriate hand hygiene during wound care for resident R10. Licensed staff were inserviced on appropriate hand hygiene during wound care for all residents on 4-15-14. New cleanable side rail covers were ordered for Residents R13, R43, R17, R10, R27, R42 and R25. These type of cleanable side rail covers will be used for other residents who need covers as well. The DON will ensure that facilities infection control program includes tracking, evaluation, and interventions to prevent the spread of infection. The facility will analyze patterns and trends of infections for both staff and residents. Results and actions taken will be reported to the QAA committee. DON will conduct random audits weekly for four weeks on hand hygiene, then monthly for 2 months. DON to monitor compliance.	

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R10's wound and discard them into the trash. R10 removed and discarded his gloves into the trash, reapplied a clean pair of gloves and proceeded to cleanse R10's wound with normal saline using an ABD bandage (highly absorbent dressing). LPN-A was observed to apply a new Xeroform dressing to the wound and place a Telfa bandage (non-adherent cotton pad) over the 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.

Following the above observation, LPN-A was observed to raise R10's left pant leg and lower the shin protector exposing a dressing to R10's left lower leg just below the knee. LPN-A was observed to apply clean gloves and cut the dressing off with a pair of scissors and discard it into the trash. LPN-A then removed and discarded his gloves and applied clean gloves. LPN-A was observed to apply a Mepilex (absorbent soft silicone foam) dressing to the wound. LPN-A removed and discarded his gloves, replaced R10's shin protector and lowered her pant leg. LPN-A bagged the garbage with the dirty dressings, replaced the trash can liner and washed his hands. LPN-A was not observed to wash his hands or use hand sanitizer between the removal of dirty dressings, before the application of clean dressings nor between the right and left leg wound dressing changes.

On 4/9/14, at 2:05 p.m. LPN-A confirmed he had not washed his hands or used hand sanitizer between the removal of the dirty dressings or before the application of the clean dressings nor between the right and left leg dressing changes.

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F 441	Continued From page 19 On 4/10/14, at 10:55 a.m. the director of nursing (DON) stated for infection control purposes, she would expect hand hygiene be completed between the removal of the dirty dressing and the application of the clean dressing, as well as, between the right and left leg wound dressing changes. 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: On 4/7/14, at 4:19 p.m. R13's bed was observed to have bilateral, upper, half side rails raised on the bed. The rails were observed wrapped with foam and secured with duct tape. At 5:27 p.m. R43's bed was observed to have bilateral, half, upper side rails raised on the bed. The rails were observed wrapped in foam and secured with duct tape. At 6:16 p.m. R17's bed was observed to have bilateral, upper, half side rails raised on the bed. The right side rail was observed wrapped in foam and secured with duct tape. The foam on the right side rail was observed to have approximately a 2.5 inch long tear which created a flap. At 6:34 p.m. R10's bed was observed to have bilateral, upper, side rails raised on the bed. The side rails were observed wrapped in foam and affixed with black tape. On 4/8/14, at 8:43 a.m. R27's bed was observed to have bilateral, half, upper side rails raised on the bed and wrapped in foam. R27 stated the	F 441		

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rails had been covered ever since she got the bed. R27 stated she used the rails to get up but really needed a lot of help from others.
At 8:54 a.m. R42's bed was observed to have a right, half side rail raised on the bed. The side rail was observed wrapped in gray foam affixed with black tape.
At 8:59 a.m. R25's bed was observed to have bilateral, half, upper side rails raised on the bed. Both side rails were observed wrapped with foam.
At 9:01 a.m. R25 stated the taped-on foam was already on the side rails when she moved there. R25 stated she did not know why the side rails were wrapped with foam and stated no one had asked her if she wanted the foam on the rails or not. R25 also stated the foam looked "awfully dirty" and it bothered her to to grab them when she turned over in bed. R25 also stated she was not sure of how or when they were cleaned and had not observed anyone ever cleaning or changing them.
On 4/9/14, at 7:35 a.m. nursing assistant (NA)-C stated the foam was placed on the side rails by the maintenance staff for some residents to reduce/prevent bruising. She stated when they needed to be cleaned, they were either wiped down or replaced. NA-C indicated nursing staff would notify maintenance when the foam needed to be replaced.
At 3:00 p.m. maintenance supervisor (MS) stated the maintenance department did not do any cleaning of the foam covered side rails. He stated they replaced the foam padding if notified by nursing if was soiled or needed to be replaced.
On 4/10/14, at 8:33 a.m. housekeeper (HK)-A stated housekeeping washed the residents' beds once a month on the residents' bath day and as needed. She stated they sometimes also sprayed the side rails with Comet disinfecting

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cleaner with bleach. HK-A confirmed the spray cleaner degraded the foam, however, she was unsure of how often the foam was replaced. HK-A stated the foam padding was not removed but was wiped off and left on the side rails between residents.
At 11:02 a.m. the DON stated they had probably missed removing the foam padding from the side rails between residents and they may need to find another intervention for residents at risk for bruising. The DON confirmed the foam padding created a surface unable to be cleaned and sanitized.
The facility's current, undated cleaning policy titled Periodic Routine Residents Rooms, Administrative Offices, Director of Nursing Office and the Staff Lounge policy and the undated Infection Control-Isolation & Terminal Cleaning policy both lacked identification and direction related the cleaning/sanitizing, maintenance or replacement of foam padding for residents' side rails.

Infection Control Program:

Review of the facility's infection control program revealed a system which lacked a surveillance program with ongoing analysis and interpretation of infections and infection risks. The Monthly Infection Control Logs for 01/14, 02/14, and 03/14, revealed only infections with prescribed antibiotics were tracked. The facility's tracking system lacked trending of infections without antibiotics. In addition, a tracking system for employee infections and comparison surveillance between resident and employee illnesses had not been established.

On 4/9/14, at 12:08 p.m. the facility infection

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control program was reviewed with the DON and registered nurse (RN)-A. The DON indicated she performed a monthly computer review of the previous month for each wing of the facility to identify residents with infections. She then documented this information on a monthly log. Information included on the Monthly Infection Control Log included: resident name, admit date, room number, unit, type of infection, body site, date of onset, culture (if taken), organism, antibiotic type, antibiotic start date, isolation precautions needed, and infection resolve date. The Monthly Infection Control Logs were reviewed quarterly by the DON and used to create an Infection Report which summarized total numbers of infections by month, unit and type of infection. This Infection Report was brought to the facility's Quality Assurance and Assessment (QAA) committee for quarterly review. The DON further indicated employee illnesses/infections were recorded on a call in sheet when an employee called in sick. The call in sheets were sent to the office where they were recorded on a monthly call in sheet. This report was reviewed monthly by the DON.

On 4/9/14, at 2:16 p.m. The DON confirmed no analysis of resident infection trends with comparison to employee infections/illnesses was documented.

The facility's undated policies entitled Resident Infection Report, Employee Health Policies and Infectious Illness lacked direction for how the facility was to develop, implement or maintain an infection control program in order to prevent, recognize/control, to the extent possible, the onset and spread of infection within the facility.

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

F5545022

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	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/09/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on April 09, 2014. At the time of this survey, the Fair Meadow Nursing Home was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, "The Life Safety Code" (LSC), Chapter 19 Existing Health Care. Fair Meadow Nursing Home is a 1-story building, without a basement, and constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1972 the south wing was added to the original building and was determined to be of Type II (111) construction. The south wing is separated with at least a 2 hour fire barrier from an apartment building. The facility is divided into 4 separate smoke zones by 30 minute fire barriers. The facility has a fire alarm system with smoke detection throughout the corridor system and in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition with automatic fire department notification. The building is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems 1999 edition with quick response heads. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/09/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 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.	K 000		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	04/10/2014

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

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On April 7, 2014 to April 10, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents 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). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure bilateral half side rails were addressed on the care plan for 1 of 2 residents (R28) reviewed for accidents. Findings include: R28's significant change Minimum Data Set (MDS) dated 12/18/13, indicated R28 was diagnosed with a stroke and dementia. R28's side rail assessment dated 6/5/13, indicated R28 used bilateral top rails when in bed due to 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	2 560	Corrected	5/10/14

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2 560	Continued From page 3 unaware of safety needs. The care plan also indicated R28 had poor communication/comprehension, gait/balance problems, incontinence, a stroke with left sided weakness, and a history of falls. R28's care plan did not address the use of bilateral top side rails on the bed. On 4/10/14, at 8:20 a.m. RN-A verified the side rails were not addressed on R28s care plan. A policy related to interventions documented on a care plan was requested and none was provided. Suggested Method of Correction: The Director of Nursing or designee could direct staff to revise the resident's care plan to include appropriate interventions for side rail use. A monitoring program could be established in order to assure on-going and effective care plan interventions in response to resident side rail use. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a range of motion (ROM) program was implemented as directed by the	2 565	Corrected....completion date 05/10/2014.	5/10/14

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2 565	Continued From page 4 care plan for 1 of 1 resident (R1) who was reviewed for ROM services. Findings include: R1's quarterly Minimum Data Set (MDS) dated 2/19/14, indicated R1 was diagnosed with dementia, cerebral palsy (CP) with impaired muscle coordination and had severe cognitive impairment. The MDS also indicated R1 had ROM limitations to both lower extremities (LE), and limitations to one upper extremity. R1's current care plan printed 4/10/14, indicated R1 received active ROM exercises with a blue t-band to the left upper extremity (UE) and a four pound weight for the left shoulder. Passive ROM to the right finger and wrist extension within pain limitations. Passive ROM to both legs, hips, knees and ankles. The care plan also indicated R1's contractures would be measured quarterly. Review of R1's untitled nursing rehab documentation forms from October 2013, through March 2014, revealed the following: -October 2013: Out of 31 opportunities for ROM, R1 refused 17 times, and zero was documented 11 times, a line was documented two times, and a "5" was documented once. There was no narrative documentation on the back of the form. -November 2103: Out of 30 opportunities for ROM, R1 refused seven times, zero was documented 18 times, a line was documented one time, and there were four days with no documentation. There was no narrative documentation on the back of the form. -December 2013: Out of 31 opportunities for ROM, R1 refused four times, zero was documented 16 times, and there were 11 days	2 565		

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2 565	Continued From page 5	2 565		

with no documentation. There was no narrative documentation on the back of the form.
-January 2014: The rehab form was lacking the identified ROM program. Four refusals were documented. The rest of the month was blank. There was no narrative documentation on the back of the form.
-February 2014:, Out of the seven opportunities for ROM, R1 refused three times, zero was documented one time, and four days were blank. On 2/21/14, the rehab aide (RA)-A documented on the back of the form that R1 refused and she did not have time to do it in his room.
-March 2014: Out of the 31 opportunities for ROM, R1 refused four times, zero was documented nine times, and there were 18 days with no documentation. On 3/29/14, and 3/30/14, RA-A documented on the back of the form "no time one aide."

On 4/9/14, at 12:10 p.m. the occupational therapist (OT) stated R1 was seen on 1/27/14, for OT and physical therapy (PT). The OT stated R1 had difficulty with correct seated posture and could not lift a cup with his left hand. The OT stated a nursing rehab program was resumed for R1 on 2/21/14. The OT stated a registered nurse supervised the rehab program and she only worked a few hours per week. The OT also stated R1's nursing rehab program was to be provided seven days a week.

At 10:47 a.m. the director of nursing verified R1's ROM program was not performed seven days per week according as directed by the care plan.

A policy regarding following a care plan was requested and none was provided.

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2 565	Continued From page 6 Suggested Method of Correction: The Director of Nursing or designee could establish a monitoring system to ensure the residents care plans are being implemented. The Director of Nursing could delegate to nursing staff to monitor the system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion services (ROM) were consistently provided and documented according to the assessed needs for 1 of 1 resident (R1) who was reviewed for ROM services. Findings include:	2 895	Corrected.	5/10/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 895	Continued From page 7 R1's annual Minimum Data Set (MDS) dated 9/4/13, indicated R1 had ROM limitations to both lower extremities, and limitations to one upper extremity. The Activity of Daily Living Care Area Assessment (CAA) dated 9/7/13, indicated R1 had contractures of the right hand and wrist related to cerebral palsy (CP) impaired muscle coordination with right sided weakness. The CAA also indicated R1 was on a rehab program with a goal for the contractures not to worsen. The CAA also indicated R1 used a mechanical lift for all transfers. R1's quarterly MDS dated 2/19/14, indicated R1 was diagnosed with dementia, CP and had severe cognitive impairment. The MDS indicated R1 had ROM limitations to both lower extremities (LE), and limitations to one upper extremity. R1's current care plan printed 4/10/14, indicated R1 received active ROM exercises with a blue t-band to the left upper extremity (UE) and a four pound weight for the left shoulder. Passive ROM to the right finger and wrist extension within pain limitations. Passive ROM to both legs, hips, knees and ankles. The care plan also indicated R1's contractures would be measured quarterly. On 4/9/14, at 8:03 a.m. nursing assistant (NA)-A was observed to brush R1s teeth. R1 was observed to hold his arms across his chest while oral cares and shaving were done. Review of R1's untitled nursing rehab documentation forms from October 2013, through March 2014, revealed the following: -October 2013: Out of 31 opportunities for ROM, R1 refused 17 times, and zero was documented 11 times, a line was documented two times, and a	2 895		

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2 895	Continued From page 8 "5" was documented once. There was no narrative documentation on the back of the form. -November 2013: Out of 30 opportunities for ROM, R1 refused seven times, zero was documented 18 times, a line was documented one time, and there were four days with no documentation. There was no narrative documentation on the back of the form. -December 2013: Out of 31 opportunities for ROM, R1 refused four times, zero was documented 16 times, and there were 11 days with no documentation. There was no narrative documentation on the back of the form. -January 2014: The rehab form was lacking the identified ROM program. Four refusals were documented. The rest of the month was blank. There was no narrative documentation on the back of the form. -February 2014: Out of the seven opportunities for ROM, R1 refused three times, zero was documented one time, and four days were blank. On 2/21/14, the rehab aide (RA)-A documented on the back of the form that R1 refused and she did not have time to do it in his room. -March 2014: Out of the 31 opportunities for ROM, R1 refused four times, zero was documented nine times, and there were 18 days with no documentation. On 3/29/14, and 3/30/14, RA-A documented on the back of the form "no time one aide." On 4/9/14, at 12:10 p.m. the occupational therapist (OT) stated R1 was seen on 1/27/14, for OT and physical therapy (PT). The OT stated R1 had difficulty with correct seated posture and could not lift a cup with his left hand. The OT stated a nursing rehab program was resumed for R1 on 2/21/14. The OT stated a registered nurse supervised the rehab program and she only worked a few hours per week. The OT stated	2 895		

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2 895	Continued From page 9 R1's nursing rehab program was to be provided seven days a week. On 4/10/14, at 8:36 a.m. RA-A stated she was scheduled as a rehab aide four days a week. RA-A stated there were four rehab aides and two were scheduled per day from 7:00 a.m. to 1:00 p.m. and in addition to providing ROM services, were also expected to assist residents with their meals at breakfast and lunch. RA-A confirmed R1 received ROM to his UE and LE seven days a week. However, RA-A stated R1 would normally state he did not want to do the exercises or would not cooperate and follow the directions. RA-A also stated R1 would even refuse when re-approached later. In addition, RA-A stated there were 41 residents on a rehab nursing program per day and there was not enough time to do the ROM programs as sometimes there was only one rehab aide working. RA-A stated on March 2nd, 3rd, 5th, 22nd, and 2/24/14, there were no rehab aides available. At 8:58 a.m. the director of nursing (DON) stated she had discussed with the administrator a goal to always have two rehab staff on duty. The DON stated she felt the rehab aides hours needed to be extended. In addition, the DON stated if the rehab aides were going to document a zero, then they would also need to document what that meant. At 9:20 a.m. RA-A was heard to ask R1 if he was ready to do his exercises and R1 said "no." RA-A was observed to bring R1 into his room. With encouragement R1 was observed to participate with the UE ROM program by using the weight and blue theraband with his left hand. R1 was observed to allow a passive stretch of his right contracted fingers.	2 895		

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2 895	Continued From page 10 At 9:37 a.m. RA-B stated a documented zero meant we asked R1 if he wanted to come to therapy and he said "nope." RA-B stated they have had only one staff in rehab, and if there was a second rehab aide she was "pulled" to the floor. At 9:44 a.m. the DON stated we really tried to get the rehab aide replaced. The DON reviewed the rehab schedule from October 2013, through March 2014, and the following dates indicated only one rehab aide was on duty: -October 2013: four days with one rehab aide scheduled (12, 13, 26, 27). -November 2013: seven days with one rehab aide scheduled (9,10, 22, 23, 24, 29, 30). -December 2013: 14 days with one rehab aide scheduled (3, 5, 7, 8, 9, 14, 15, 20, 21, 22, 25, 26, 28, 29). -January 2014: 14 days with one rehab aide scheduled (3, 4, 5, 6, 7, 11, 12, 13, 16, 18, 19, 21, 25, 26). -February 2014: seven days with one rehab aide scheduled (1, 8, 9, 15, 16, 22, 23). -March 2014: seven days with one rehab aide scheduled (1, 2, 7, 13, 15, 16, 21). On 4/10/14, at 10:28 a.m. registered nurse (RN)-A confirmed R1 refused rehab therapy and staff continued to offer the services. RN-A stated she did not know what zero meant for documentation. At 10:31 a.m. the occupational therapist (OT) stated R1 did have a contracted right U/E. The OT stated when R1's contracture measurements were obtained, R1 showed no decline and some improvement from 9/13.	2 895		

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2 895	Continued From page 11 At 10:40 a.m. RN-A stated R1's rehab program was not on the January rehab form because it was discontinued due to R1's refusals. However, RN-A stated because R1 had contractures and ROM therapy was needed, R1 was referred to PT/OT. At 10:47 a.m. the DON verified R1's ROM program was not provided seven days per week as directed by his care plan. Both RN-A and the DON confirmed they were not aware the rehab aides were documenting zeros on the rehab documentation flow sheets. The DON stated she thought it was related to a lack of communication. A policy regarding the documentation of the rehab program was requested and none was provided. Suggested Method of Correction: The Director of Nursing or designee could schedule an in-service to address the importance of residents receiving appropriate treatment and services for range of motion limitations. An assessment and appropriate treatment intervention plan could be provided by the staff for these residents. A monitoring program could be established in order to assure an on-going effective rehabilitative program for residents with range of motion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		5/10/14

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21375	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was completed for 1 of 1 resident (R10) who was observed during wound care. In addition, the facility implemented foam coverings secured by electrical and / or duct tape to bed side rails creating surfaces that were unable to be cleaned and sanitized for 7 of 28 residents (R17, R10, R13, R43, R27, R42, R25) observed with foam padding wrapped around the side rails. Lastly, the facility failed to analyze patterns and trends of infections for both staff and residents. This had the potential to affect all 45 residents who resided in the facility. Findings include: Wound Care: On 4/9/14, at 12:43 p.m. licensed practical nurse (LPN)-A was observed to enter R10's room, wash his hands, raise R10's right pant leg, lower her shin protector and proceeded to cut R10's right calf wound dressing (Kling) off with a scissor and discard it into the trash. LPN-A was observed to donne clean gloves and remove a gauze pad and Xeroform (sterile, fine mesh gauze impregnated with a blend of 3% Bismuth Tribromophenate (Xeroform) and USP Petrolatum) dressing from R10's wound and discard them into the trash. R10 removed and discarded his gloves into the trash, reapplied a clean pair of gloves and proceeded to cleanse R10's wound with normal saline using an ABD bandage (highly absorbent dressing). LPN-A was observed to apply a new Xeroform dressing to the wound and place a Telfa bandage (non-adherent cotton pad) over the	21375	Corrected.	

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21375	Continued From page 13 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. Following the above observation, LPN-A was observed to raise R10's left pant leg and lower the shin protector exposing a dressing to R10's left lower leg just below the knee. LPN-A was observed to apply clean gloves and cut the dressing off with a pair of scissors and discard it into the trash. LPN-A then removed and discarded his gloves and applied clean gloves. LPN-A was observed to apply a Mepilex (absorbent soft silicone foam) dressing to the wound. LPN-A removed and discarded his gloves, replaced R10's shin protector and lowered her pant leg. LPN-A bagged the garbage with the dirty dressings, replaced the trash can liner and washed his hands. LPN-A was not observed to wash his hands or use hand sanitizer between the removal of dirty dressings, before the application of clean dressings nor between the right and left leg wound dressing changes. On 4/9/14, at 2:05 p.m. LPN-A confirmed he had not washed his hands or used hand sanitizer between the removal of the dirty dressings or before the application of the clean dressings nor between the right and left leg dressing changes. On 4/10/14, at 10:55 a.m. the director of nursing (DON) stated for infection control purposes, she would expect hand hygiene be completed between the removal of the dirty dressing and the application of the clean dressing, as well as, between the right and left leg wound dressing changes.	21375		

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21375	Continued From page 14 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: On 4/7/14, at 4:19 p.m. R13's bed was observed to have bilateral, upper, half side rails raised on the bed. The rails were observed wrapped with foam and secured with duct tape. At 5:27 p.m. R43's bed was observed to have bilateral, half, upper side rails raised on the bed. The rails were observed wrapped in foam and secured with duct tape. At 6:16 p.m. R17's bed was observed to have bilateral, upper, half side rails raised on the bed. The right side rail was observed wrapped in foam and secured with duct tape. The foam on the right side rail was observed to have approximately a 2.5 inch long tear which created a flap. At 6:34 p.m. R10's bed was observed to have bilateral, upper, side rails raised on the bed. The side rails were observed wrapped in foam and affixed with black tape. On 4/8/14, at 8:43 a.m. R27's bed was observed to have bilateral, half, upper side rails raised on the bed and wrapped in foam. R27 stated the rails had been covered ever since she got the bed. R27 stated she used the rails to get up but really needed a lot of help from others. At 8:54 a.m. R42's bed was observed to have a right, half side rail raised on the bed. The side rail was observed wrapped in gray foam affixed with black tape. At 8:59 a.m. R25's bed was observed to have bilateral, half, upper side rails raised on the bed. Both side rails were observed wrapped with foam.	21375		

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21375	Continued From page 15 At 9:01 a.m. R25 stated the taped-on foam was already on the side rails when she moved there. R25 stated she did not know why the side rails were wrapped with foam and stated no one had asked her if she wanted the foam on the rails or not. R25 also stated the foam looked "awfully dirty" and it bothered her to to grab them when she turned over in bed. R25 also stated she was not sure of how or when they were cleaned and had not observed anyone ever cleaning or changing them. On 4/9/14, at 7:35 a.m. nursing assistant (NA)-C stated the foam was placed on the side rails by the maintenance staff for some residents to reduce/prevent bruising. She stated when they needed to be cleaned, they were either wiped down or replaced. NA-C indicated nursing staff would notify maintenance when the foam needed to be replaced. At 3:00 p.m. maintenance supervisor (MS) stated the maintenance department did not do any cleaning of the foam covered side rails. He stated they replaced the foam padding if notified by nursing if was soiled or needed to be replaced. On 4/10/14, at 8:33 a.m. housekeeper (HK)-A stated housekeeping washed the residents' beds once a month on the residents' bath day and as needed. She stated they sometimes also sprayed the side rails with Comet disinfecting cleaner with bleach. HK-A confirmed the spray cleaner degraded the foam, however, she was unsure of how often the foam was replaced. HK-A stated the foam padding was not removed but was wiped off and left on the side rails between residents. At 11:02 a.m. the DON stated they had probably missed removing the foam padding from the side rails between residents and they may need to find another intervention for residents at risk for bruising. The DON confirmed the foam padding	21375		

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21375	Continued From page 16	21375		

created a surface unable to be cleaned and sanitized.
The facility's current, undated cleaning policy titled Periodic Routine Residents Rooms, Administrative Offices, Director of Nursing Office and the Staff Lounge policy and the undated Infection Control-Isolation & Terminal Cleaning policy both lacked identification and direction related the cleaning/sanitizing, maintenance or replacement of foam padding for residents' side rails.

Infection Control Program:
Review of the facility's infection control program revealed a system which lacked a surveillance program with ongoing analysis and interpretation of infections and infection risks. The Monthly Infection Control Logs for 01/14, 02/14, and 03/14, revealed only infections with prescribed antibiotics were tracked. The facility's tracking system lacked trending of infections without antibiotics. In addition, a tracking system for employee infections and comparison surveillance between resident and employee illnesses had not been established.

On 4/9/14, at 12:08 p.m. the facility infection control program was reviewed with the DON and registered nurse (RN)-A. The DON indicated she performed a monthly computer review of the previous month for each wing of the facility to identify residents with infections. She then documented this information on a monthly log. Information included on the Monthly Infection Control Log included: resident name, admit date, room number, unit, type of infection, body site, date of onset, culture (if taken), organism, antibiotic type, antibiotic start date, isolation precautions needed, and infection resolve date. The Monthly Infection Control Logs were

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reviewed quarterly by the DON and used to create an Infection Report which summarized total numbers of infections by month, unit and type of infection. This Infection Report was brought to the facility's Quality Assurance and Assessment (QAA) committee for quarterly review. The DON further indicated employee illnesses/infections were recorded on a call in sheet when an employee called in sick. The call in sheets were sent to the office where they were recorded on a monthly call in sheet. This report was reviewed monthly by the DON.

On 4/9/14, at 2:16 p.m. The DON confirmed no analysis of resident infection trends with comparison to employee infections/illnesses was documented.

The facility's undated policies entitled Resident Infection Report, Employee Health Policies and Infectious Illness lacked direction for how the facility was to develop, implement or maintain an infection control program in order to prevent, recognize/control, to the extent possible, the onset and spread of infection within the facility.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could in-service employees responsible for the infection control program to include tracking, evaluation, and interventions to prevent the spread of infection. Additional in-services could be implemented for appropriate hand hygiene and use of equipment and products to ensure surfaces are cleanable and sanitary. The DON or designee could implement a monitoring system to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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21375	Continued From page 18 (21) days.	21375		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights 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. Findings include: On 4/7/14, at 5:30 p.m. during observation of the evening meal in the activity dining room, R31, R28, R13, R43 and R15 were observed eating their meals. R43 and R15 were observed seated side by side, up against bedside tables, independently eating. R13 and R28 were observed seated across from each other at a table and assisted by two aides to eat. R31 was observed seated at a separate table with one staff member, seated next to him, assisting him to eat. All residents were served their meal on a tray with their food remaining on the tray throughout the meal. Residents in the main dining room were observed to be served their meal on dishware without a tray. On 4/9/14, at 8:01 a.m. R43 and R13 were	21805	Corrected.	5/10/14

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21805	Continued From page 19 observed eating breakfast in the main dining room. R43 was seated at a table by herself, eating independently. R13 was seated at a table with a staff member assisting her to eat. Both residents were served their meal on dishware without a tray, as were all the other resident's observed eating in the main dining room. On 04/09/14, at 11:30 a.m. R31, R28, R43, R15 and R3 were observed eating in the activity room. All were served their meal with the dishware on trays. The dishware was observed to remain on the trays while the residents ate. Residents observed in the main dining room were observed to be served their meal on dishware without a tray. R43 was interviewed on 4/9/14, at 12:20 p.m. and stated she didn't really like eating her meal off of the tray it was served on, but didn't like to complain. On 4/10/14, at 8:49 a.m. nursing assistant (NA)-A stated she didn't know why the residents who dined in the activity room were served their meals on trays. She stated "maybe it's easier, I couldn't tell you." At 8:52 a.m. activity assistant (AA)-B stated she served residents in the activity room for the noon meal. AA-B confirmed the meals were served on trays. She stated they sometimes took the dishes off of the trays but she was not sure why they didn't do that all the time. At 8:55 a.m. NA-B confirmed the meals in the activity room were served on trays. She stated "I don't know why we do that." She stated she had worked at the facility for 1 1/2 years and "it's always been that way."	21805		

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21805	Continued From page 20 Dietary supervisor (DS) was interviewed on 4/10/14, at 8:56 a.m. and stated meals were not to be served on trays. She stated staff were supposed to put the dishes on the table, just like it was done in the main dining room. On 4/10/14, at 11:15 a.m. director of nursing (DON) confirmed that residents should not be served their meals on trays. She stated those residents who received meals in the activity room dining area should have been served in the same manner as the residents who received meals in the main dining room. A dining policy was requested but none was provided. Suggested Method of Correction: The Director of Nursing (DON) or designee could in-service employees responsible for dining services to ensure and enhanced and dignified dining experienced is provided to all residents residing in the facility. The DON could establish a monitoring program in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		