#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDIC	CARE/MEDICAI	D CERTIFICATIO	ON AND TRANSMITTA
DIDET	TO DE GOL		

	CARE/MEDICAID CERTIFICATI I - TO BE COMPLETED BY THE S		ID: YBGW Facility ID: 00460
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245545     2.STATE VENDOR OR MEDICAID NO.     (L2) 804740500     5. EFFECTIVE DATE CHANGE OF OWNERSHIP	3. NAME AND ADDRESS OF FACILITY (L3) FAIR MEADOW NURSING HOI (L4) BOX 8 300 GARFIELD AVENUE (L5) FERTILE, MN	E SOUTHEAST (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
(L9)	7. PROVIDER/SUPPLIER CATEGORY       01 Hospital     05 HHA     09 E	<u>02</u> (L7) SRD 13 PTIP 22 CLIA	8. Full Survey After Complaint
6.     DATE OF SURVEY     09/26/2018     (L34)       8.     ACCREDITATION STATUS:     (L10)       0     Unaccredited     1       2     AOA     3	02 SNF/NF/Dual         06 PRTF         10 N           03 SNF/NF/Distinct         07 X-Ray         11 I           04 SNF         08 OPT/SP         12 R	CF/IID 15 ASC	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12.Total Facility Beds         42 (L18)         13.Total Certified Beds	10.THE FACILITY IS CERTIFIED AS:         X       A. In Compliance With         Program Requirements         Compliance Based On:        1.       Acceptable POC         B.       Not in Compliance with Program         Requirements and/or Applied Waivers:	And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code	6. Scope of Services Limit     7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 42	ICF IID	* Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICAE	(L42) (L43) LE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE Debra Vincent, HFE - NE II	Date : 10/08/2018	18. STATE SURVEY AGENCY A	
PART II - TO E	E COMPLETED BY HCFA REGIO	19)	• (L20)
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Participate        2. Facility is not Eligible         (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		l Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNIN 02/01/1991		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	05-Fail to Meet Health/Safety
	(L25) TVE SANCTIONS on of Admissions:	02-Dissatisfaction W/ Reimbursene 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	of Full to Meet Fightenient
(L27) B. Rescind S	(L44) uspension Date: (L45)		00-Active
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	<b>03001</b> (L	31)	
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE		
(L32)	(L	33) DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245545

October 4, 2018

Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, MN 56540

Dear Administrator:

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 September 15, 2018 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 4, 2018

Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, MN 56540

RE: Project Number S5545027

Dear Administrator:

On August 27, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 1, 2018. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 13, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on August 13, 2018. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On September 26, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 12, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on August 13, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on August 13, 2018, as of September 15, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 15, 2018.

However, as we notified you in our letter of August 27, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 13, 2018., due to denial of payment for new admissions. Since your facility attained substantial compliance on September 15, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions:

Fair Meadow Nursing Home October 4, 2018 Page 2

- Mandatory denial of payment for new Medicare and Medicaid admissions effective be rescinded as of September 15, 2018. (42 CFR 488.417 (b))
- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 4, 2018

Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, MN 56540

Re: Reinspection Results - Project Number S5545027

Dear Administrator:

On September 26, 2018 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 September 26, 2018, with orders received by you on August 27, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT (	)F H	HEALTH	AND	HUMAN	SERVICES
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#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDIC	ARE/N	MEDICAL	D CER	TIFICAT	ION AN	D TRANS	MITTAL

ID: YBGW

PAR	I - TO BE COMPLETED BY THE STA	TE SURVEY AGENCY	Facility ID: 00460
<ol> <li>MEDICARE/MEDICAID PROVIDER NO. (L1) 245545</li> <li>2.STATE VENDOR OR MEDICAID NO.</li> </ol>	<ol> <li>NAME AND ADDRESS OF FACILITY</li> <li>(L3) FAIR MEADOW NURSING HOME</li> <li>(L4) BOX 8 300 GARFIELD AVENUE SO</li> </ol>	UTHEAST	4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW
(L2) <b>804740500</b>	(L5) FERTILE, MN	(L6) <b>56540</b>	3. Termination     4. CHOW       5. Validation     6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY       01 Hospital     05 HHA     09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	<ol> <li>On-Site Visit</li> <li>Other</li> <li>Full Survey After Complaint</li> </ol>
6. DATE OF SURVEY       08/13/2018       (L34)         8. ACCREDITATION STATUS:	02 SNF/NF/Dual06 PRTF10 NF03 SNF/NF/Distinct07 X-Ray11 ICF/III04 SNF08 OPT/SP12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b):	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF)	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds         42         (L18)           13.Total Certified Beds         42         (L17)	X B. Not in Compliance with Program	5. Life Safety Code	9. Beds/Room
	Requirements and/or Applied Waivers:	* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SN 42	F ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICA     17. SURVEYOR SIGNATURE     Theresa Gullingsrud, HFE - NE II	Date : 09/10/2018 (L19)	18. STATE SURVEY AGENCY A	
PART II - TO	BE COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE STA	
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Participate        2. Facility is not Eligible         (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	<ol> <li>Statement of Finan</li> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGRE	EMENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNI 02/01/1991	IG DATE ENDING DATE	VOLUNTARY <u>00</u> 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	nt 06-Fail to Meet Agreement
	TIVE SANCTIONS	04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(L27) B. Rescind	(L44) Suspension Date:		00-Active
28. TERMINATION DATE:	(L45) 29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	<b>03001</b> (L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE	1	
(L32)	(L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically Submitted August 27, 2018

Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, MN 56540

RE: Project Number S5545027

Dear Administrator:

On August 13, 2018, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> means one or more deficiencies related to participation requirements under 42 CFR 483.10, Residents Rights, 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm, 42 CFR 483.40 Behavioral Health Services, 42 CFR 483.45 Pharmacy Services, 42 CFR 483.70 Administration, or 42 CFR 483.80

Infection control;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

## REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 9, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

### DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: Iyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

# NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective September 1, 2018. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

# SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life, §483.25, Quality of Care, §483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control; has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Fair Meadow Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 13, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

# APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to

conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

# 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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 their respective deficiencies (if any) is acceptable.

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 13, 2018 (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 February 13, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

# INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

> 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

> 6 >

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245545	B. WING_			08/	13/2018
NAME OF F	PROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			OX 8 300 GARFIELD AVENUE SOUTHEAS ERTILE, MN 56540	Г	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00			
F 000	Emergency Prepare conducted on 8/6/1 recertification surve	iance with CMS Appendix Z edness Requirements was 8, through 8/13/18, during a ey. The facility is in compliance Z Emergency Preparedness	F 0(	00			
	survey was comple Minnesota Departm your facility was in o of 42 CFR Part 483	a 8/13/18, a recertification ted at your facility by the ment of Health to determine if compliance with requirements B, Subpart B, and ong Term Care Facilities.					
	The survey resulted (IJ) at F757 due to for and identify adve concurrent use of a medication in order The facility adminis (DON), and the ass (ADON) were notifie p.m. which began of prescribed an antib therapy without incr implemented. The	IJ was removed on 8/10/18, at er, non-compliance remained					
	allegation of compli enrolled in the elect (ePOC), a signatur	ion will serve as your facility's iance. Since your facility is tronic Plan of Correction re is not required at the bottom the CMS-2567 form.					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						09/04/2018

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

# PRINTED: 09/07/2018

		& MEDICAID SERVICES	(X2) MUU TU	PLE CONSTRUCTION		. 0938-039 TE SURVEY
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	G	08/13/2018		
		B. WING				
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTHE FERTILE, MN 56540	AST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ULD BE	(X5) COMPLETIC DATE
F 000	Continued From pa	ige 1	F 00	0		
F 580 SS=G	revisit of your facilit that substantial con has been attained i verification. Notify of Changes ( CFR(s): 483.10(g)( §483.10(g)(14) Not (i) A facility must im consult with the res consistent with his representative(s) w (A) An accident inv results in injury and physician interventi	ification of Changes. Imediately inform the resident; ident's physician; and notify, or her authority, the resident then there is- olving the resident which I has the potential for requiring on;	F 58	0		9/15/18
	mental, or psychos deterioration in hea status in either life- clinical complication (C) A need to alter a need to discontin treatment due to ac commence a new f	treatment significantly (that is, ue an existing form of lverse consequences, or to orm of treatment); or				
	resident from the fa §483.15(c)(1)(ii). (ii) When making n (14)(i) of this section all pertinent information	ansfer or discharge the acility as specified in otification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the				
	(iii) The facility mus resident and the re- when there is-	et also promptly notify the sident representative, if any, om or roommate assignment				

		& MEDICAID SERVICES				OMB NO.	
ATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING_			08/	13/2018	
IAME OF PROVIDER OR SUPPLIER				STREET	ADDRESS, CITY, STATE, ZIP CO	DE	
AIR ME	ADOW NURSING HO	ME			300 GARFIELD AVENUE SOUT LE, MN 56540	HEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 580	Continued From pa	age 2	F 58	30			
		3.10(e)(6); or ident rights under Federal or tions as specified in paragraph					
	(e)(10) of this secti (iv) The facility must update the address	on. st record and periodically s (mailing and email) and					
	phone number of the representative(s).	ne resident					
	that is a composite §483.5) must discle its physical configu locations that comp	nposite distinct part. A facility distinct part (as defined in ose in its admission agreement ration, including the various orise the composite distinct					
	room changes betw under §483.15(c)(9 This REQUIREME by:	NT is not met as evidenced					
	facility failed to enso of signs and sympt resident (R2) who e concurrent anticoas failure resulted in a	v and document review, the ure the physician was notified oms of bleeding for 1 of 1 experienced adverse effects of gulant and antibiotic use. This ictual harm for R2 due to the testinal bleed which required		on 8 moi is to rang	an: e anti-coagulation policy w 8/09/18 to include increase nitoring while on antibiotic o be notified if any reading ge. Dr. Ring, Medical Dire assist in updating this polic	ed s. Physician s are out of ector, present	
		blood transfusions.		PT/ resi the	INRs were checked on cu idents receiving anticoagu rapy on 8/09/18. Any non	Irrent Iation	
	4/27/18, indicated I had diagnoses whi	mum Data Set (MDS) dated R2 was cognitively intact and ch included urinary tract		Rin ord INR	rapeutic levels were repor g and orders received. S ers were changed regardi & every day while on antibi	tanding ng checking	
	thinner), therapeuti atrial fibrillation (an	use of anticoagulants (blood c drug level monitoring, and irregular heartbeat that		All 0 8/09	ned by Dr. Ring. charge nursing staff on the 9/18 were educated on the icoagulation Policy and Th	e updated	
	atrial fibrillation (an increases the risk of			8/09 Ant		e updated nerapeutic	

Facility ID: 00460

If continuation sheet Page 3 of 64

		X1) PROVIDER/SUPPLIER/CLIA	(V2) MILL T	יים			0938-039
	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING _			08/1	3/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 580	Continued From pa	age 3	F 58	0			
F 580	assistance with all eating and also rec medication daily. R2's Urinary Incom Catheter Care Area 7/11/18, indicated F of urinary tract infe increased confusion associated with UT R2's Falls CAA dath had a history of atr pacemaker, and hy antihypertensive m to orthostatic hypot CAA indicated R2's however Coumadin discontinued due to R2's care plan date atrial fibrillation and pacemaker. Coum after last hospital s for bleeding with us also indicated R2's risks/benefits of Co	activities of daily living except ceived anticoagulant tinence and Indwelling a Assessment (CAA) dated R2 had a longstanding history ctions (UTI) with history of on, hallucinations and delusions T1. ted 7/11/2018, indicated R2 ial fibrillation, use of ypertension with use of redication that could contribute tension and cause falls. The s atrial fibrillation was stable, n had recently been to a gastrointestinal (GI) bleed. ed 7/24/18, indicated R2 had d required the use of a adin currently discontinued tay related to GI bleed and risk se of Coumadin. The care plan a family would discuss bumadin and if it should be	F 58	:0	<ul> <li>were educated on this policy prior to working the floor.</li> <li>All other nursing staff on the floor 8/were educated on signs and sympton non-therapeutic INR including the list below. All nursing staff will be educe prior to working the floor.</li> <li>An emergency meeting was called a pm to educate nursing staff on this situation led by Nicole Johnson, DO Dr. Ring, Medical Director addresse at this time.</li> <li>Symptoms of active bleeding were reviewed, employees signed off understanding and took a post test of bleeding as a sign of Coumadin toxi." Bleeding from the gums after yo brush your teeth</li> <li>" Bleeding between menstrual pe</li> <li>" Diarrhea, vomiting or inability to for more than 24 hours</li> <li>" Fever</li> <li>" Severe bleeding, including heave than normal menstrual bleeding</li> <li>" Red or brown urine</li> <li>" Black or bloody stool</li> <li>" Severe headache or stomach pain, discomfort or swelling especially after an injury</li> </ul>	209/18 oms of st cated at 7:30 N. ed staff on icity. ou priods eat vier ain	
	8/13/18, revealed F to UTI with hallucin	ime dical record from 4/1/18, to R2 had ongoing issues related nations and confusion which ourses of antibiotic therapy.			<ul> <li>Vomiting of blood or material that looks like coffee grounds</li> <li>Coughing up blood</li> <li>Bruising that develops without at injury you remember</li> <li>Dizziness or weakness</li> </ul>		
	Concurrently, R2's modification and in	Coumadin regimen required creased monitoring due to outside of therapeutic levels.			" Vision changes RN involved was educated on impor of assessing residents herself when approached with concerns from		

Facility ID: 00460

		& MEDICAID SERVICES	() (O) 1 () () ()			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
	245545		B. WING		08/1	13/2018
NAME OF F	PROVIDER OR SUPPLIER					
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE FERTILE, MN 56540	SOUTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 580	Continued From pa	ge 4	F 580	0		
	of therapeutic rang doctor (MD)-A orde increased from 2.5 recheck in two wee			LPN/Charge Nurse. Edu her that she needs to no immediately when there symptoms of non-therap	tify Physician are signs or eutic INR. ff in-service was	
	R2's Progress note dated 6/18/18, indicated a ca had been received from MD-B's office with orders to start Bactrim DS 1 tab orally twice daily for 7 days. Check INR on 6/25/18, and send to MD-C The note did not include modification to R2's Coumadin order or increased INR monitoring with the addition of the antibiotic.			held on August 20th at 1 and scheduled for Augus and 2:15 pm to follow up well as training for LPNS PT/INR□s. Education in ordering of labs, timely d orders, acquisition of lab	st 28th at 1 pm o on this topic as o for conducting including proper lrawing of lab o orders and follow	
	licensed practical n had two loose stool R2's temperature w pain and stated "W bowels moved." LP monitor for fever, p note also indicated 2:30 p.m. and she R2 had also stated strain to have a bow	e dated 6/23/18, completed by urse (LPN)-C indicated R2 is that were maroon in color. vas 97. She denied abdominal ell it is better now that my N-C indicated he would ain and further stools. The LPN-C had spoken with R2 at had denied abdominal pain. two days ago she had to wel movement and was		ups was provided. Rep conditions addressed; h reported immediately to duty and DON. Educati Physician needs to be no immediately when there symptoms of non-therap Medical Director and Ph QAA on 8/22/18 and in a education provided. Fair Meadow nursing sta IDT meeting on every ho	ow they are to be charge nurse on on provided that otified are signs or beutic INR. armacy present at agreement with aff will institute an ospital admission.	
	straining. LPN-C in her checked in the LPN-C left a messa the nursing home a daughter-in-law car LPN-C informed the stools so family wa Daughter-in-law aw because she declin daughter-in-law pre	bod could be from the dicated he had offered to have ER but R2 had refused. age for R2's daughter to call and while doing so R2's me to pick her up for an outing. e daughter-in-law about the s aware and would watch also. vare R2 had declined ER led it again with esent. LPN-C indicated he nonitor when R2 returned and		Staff will look at all proce procedures and determin improvements could be Symptoms, all steps take hospital discharge, and a completed will be assess any problems or areas o Medical Director will be i and procedure improven to prevent any unnecess hospitalizations or medic adverse events to our re	ne if any made. en prior to any monitoring sed. If there are if concern, nvolved in policy nent. Our goal is sary cation related	

Facility ID: 00460

If continuation sheet Page 5 of 64

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDIC	CARE/MEDICAI	D CERTIFICATIO	ON AND TRANSMITTA
DIDET	TO DE GOL		

	CARE/MEDICAID CERTIFICATI I - TO BE COMPLETED BY THE S		ID: YBGW Facility ID: 00460
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245545     2.STATE VENDOR OR MEDICAID NO.     (L2) 804740500     5. EFFECTIVE DATE CHANGE OF OWNERSHIP	3. NAME AND ADDRESS OF FACILITY (L3) FAIR MEADOW NURSING HOI (L4) BOX 8 300 GARFIELD AVENUE (L5) FERTILE, MN	E SOUTHEAST (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
(L9)	7. PROVIDER/SUPPLIER CATEGORY       01 Hospital     05 HHA     09 E	<u>02</u> (L7) SRD 13 PTIP 22 CLIA	8. Full Survey After Complaint
6.     DATE OF SURVEY     09/26/2018     (L34)       8.     ACCREDITATION STATUS:     (L10)       0     Unaccredited     1       2     AOA     3	02 SNF/NF/Dual         06 PRTF         10 N           03 SNF/NF/Distinct         07 X-Ray         11 I           04 SNF         08 OPT/SP         12 R	CF/IID 15 ASC	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12.Total Facility Beds         42 (L18)         13.Total Certified Beds	10.THE FACILITY IS CERTIFIED AS:         X       A. In Compliance With         Program Requirements         Compliance Based On:        1.       Acceptable POC         B.       Not in Compliance with Program         Requirements and/or Applied Waivers:	And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code	6. Scope of Services Limit     7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 42	ICF IID	* Code: A 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICAE	(L42) (L43) LE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE Debra Vincent, HFE - NE II	Date : 10/08/2018	18. STATE SURVEY AGENCY A	
PART II - TO E	E COMPLETED BY HCFA REGIO	19)	• (L20)
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Participate        2. Facility is not Eligible         (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		l Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNIN 02/01/1991		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	05-Fail to Meet Health/Safety
	(L25) TVE SANCTIONS on of Admissions:	02-Dissatisfaction W/ Reimbursene 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	of Full to Meet Fightenient
(L27) B. Rescind S	(L44) uspension Date: (L45)		00-Active
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	<b>03001</b> (L	31)	
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE		
(L32)	(L	33) DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245545

October 4, 2018

Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, MN 56540

Dear Administrator:

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 September 15, 2018 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 4, 2018

Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, MN 56540

RE: Project Number S5545027

Dear Administrator:

On August 27, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 1, 2018. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 13, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on August 13, 2018. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On September 26, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 12, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on August 13, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on August 13, 2018, as of September 15, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 15, 2018.

However, as we notified you in our letter of August 27, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 13, 2018., due to denial of payment for new admissions. Since your facility attained substantial compliance on September 15, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions:

Fair Meadow Nursing Home October 4, 2018 Page 2

- Mandatory denial of payment for new Medicare and Medicaid admissions effective be rescinded as of September 15, 2018. (42 CFR 488.417 (b))
- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 4, 2018

Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, MN 56540

Re: Reinspection Results - Project Number S5545027

Dear Administrator:

On September 26, 2018 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 September 26, 2018, with orders received by you on August 27, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULT	IPI I	E CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	· ·				PLETED	
		245545	B. WING _			08/ <sup>,</sup>	13/2018	
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	DE		
FAIR ME	ADOW NURSING HO	ME		B F	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 580	Continued From pa	age 5	F 58	80				
		l lacked evidence of a	1 00		Audits of lab orders and results will	he		
	registered nurse as	maroon colored stool.			done monthly by DON or designee. Monitored by DON and QAA. Completed : 9/15/18			
	dated 6/1/18, to 6/3	dministration Record (MAR) 80/18, indicated R2 received n 6/23/18 per order.						
	R2's Progress Note following:	es dated 6/24/18 revealed the						
	R2 took scheduled R2 reported being The note indicated	completed by LPN-C indicated medications without difficulty. tired, denied abdominal pain. LPN-C would continue to a stool sample if able, to						
	of nursing (ADON) abdominal pain as	mpleted by assistant director indicated R2 denied well as tenderness with						
	quadrants. The not continue to monitor	ounds were present in all four ted indicated ADON would r and follow up with primary						
	status changed.	RN) and MD tomorrow unless						
	fatigue, and halluci	ave increased confusion, nations this afternoon as well ke appearance and more						
	maroon color to sto indicated R2 was a	ools this afternoon. The note also on Bactrim for a UTI and						
	antibiotics. Finger s indicated MD-E or	affected in the past by her stick INR 8.0 today. The note dered R2 be sent to the						
	hospital yesterday, agreed to have R2	2 not wanting to go to the the family was contacted and seen at the hospital. A stool						
		ed this afternoon and sent with en they departed the building at						

If continuation sheet Page 6 of 64

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
AND PLAN C	FCORRECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG		COIVI	FLETED
		245545	B. WING			08/	13/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HOI	ME			3OX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540	•	
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
F 580	Continued From pa	ge 6	F 58	80			
	3:25 p.m.	-					
	6/24/18, indicated F	epartment (ED) note dated R2 had been noted to have					
	the previous three of	n her stool over the course of days. She was on Coumadin					
	INR was checked a	history of atrial fibrillation. An and found to be significantly					
	hemorrhage). R2 w	al level which could result in a vas mildly tachycardic (heart					
	mildly pale. Anosco	al resting rate) and appeared opy (a scope used to examine					
	melanotic (having b	ealed black stool with black pigmentation) features.					
	R2's hemoglobin (p	ed and was greater than 10. protein responsible for					
	was given 10 mg of						
		and was admitted to the for further evaluation and					
	indicated an assess	ress Note dated 6/26/18, sment which included: trointestinal bleeding. The					
	cause was uncertai secondary to diverti	in. This could have been iculosis, hemorrhoids,					
	the supratherapeuti	ancer, most likely because of ic INR. s anemia. R2 dropped her					
	hemoglobin signific	of packed red blood cells.					
	3. Supratherapeuti	c INR on admission. It was sion. R2 was given vitamin K					
		n and 2.5 mg orally on					
		rate controlled status post ent.					
		gulation with Coumadin. Hold					

Facility ID: 00460

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PRINTED: 09/07/2018

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/ <sup>,</sup>	13/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			3OX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Bactrim, is most like INR. On 8/8/18, at 3:50 p facility had the capa testing for INR, how the testing was required INR testing was inco- orders. On 8/9/18, at 9:01 a effect monitoring for anticoagulant thera and stated the facility the testing. LPN-C monitored for symp bloody emesis, or b indicated the facility related to blood sto was 8 and the resid LPN-C stated the in Saturday and indica reported R2 had blood something R2 had blood stool was a "weird" the stool color was LPN-C did not reme had come down to stated he could not the time or if she ha however, confirmed UTI's. LPN-C state 6/23/18, that he record	ection. History of UTI. Was on ely the cause of her increased o.m. the ADON verified the acity to perform point of care vever, stated an MD order for uired and she was not sure if luded in the facility standing a.m. LPN-C indicated side r residents who received py included testing for INR ty had a machine to complete also stated the staff toms such as bloody stools, oruising easier. LPN-C r had an incident recently ols when the resident's INR lent had to go into the hospital. Incident happened on a ated a nursing assistant bod stools and he reported this stated it wasn't frank blood or d but looked more like eaten. LPN-C indicated the color and stated the next day darker than the day before. ember if the registered nurse look at R2 or not. LPN-C remember if R2 had a UTI at ad just been getting over one, d R2 became confused with d R2 was not confused on	F	580			

Facility ID: 00460

If continuation sheet Page 8 of 64

		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING	i		08/ <sup>,</sup>	13/2018
NAME OF F	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
FAIR ME	ADOW NURSING HO	МЕ			3OX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	and watching for sy bruises. LPN-B cor also be symptom the stated if any symptom notify the RN if it we contact the MD if it On 8/9/18, at 9:42 a confirmed she was stated the physiciar Coumadin and state (PRN) INR's were of made to Coumadin stated she would ex- signs or symptoms bleeding of cuts, bri- bleeding of cuts, bri- bleeding or any cha black, maroon or br the NAs were to rep charge nurse and the document any obse- note. RN-B stated se monitor symptoms doctor. R2's medical record verified the followin 6/23/18 progress is stools R2 received 4 mg Bactrim DS 800-1 6/18/18 and R2 cor through the morning R2's medical record documentation to in an RN on 6/23/18.	nitoring included checking INR mptoms such as bleeding or nfirmed bloody stools would hey would monitor. LPN-B oms were noted she would ere the day shift, or would was the evening shift. a.m. registered nurse (RN)-B R2's primary RN. RN-B ns managed the residents' ed monthly and as needed completed and adjustments orders as indicated. RN-B xpect staff to monitor for any of bleeding such as prolonged uises, bleeding to gums, rectal ange to stool such as stools right red in color. RN-B stated port any symptoms to the he charge nurse would erved symptoms in a progress she would expect the LPN's to and notify the RN and/or the d was reviewed with RN-B who g: note indicated R2 had maroon 1 Coumadin on 6/23/18. 60 mg was prescribed on ntinued to receive the antibiotic g of 6/24/18.	F	580			

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Facility ID: 00460
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If continuation sheet Page 9 of 64

-		IPLE CONSTRUCTION NG STREET ADDRESS, CITY, STATE, ZIP CODE	COM	E SURVEY IPLETED	
IOME	B. WING _	STREET ADDRESS. CITY, STATE, ZIP CODE	08/		
IOME		STREET ADDRESS, CITY, STATE, ZIP CODE		13/2018	
-					
FAIR MEADOW NURSING HOME         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES		BOX 8 300 GARFIELD AVENUE SOUTHE FERTILE, MN 56540	UE SOUTHEAST		
INTEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
would be contact RN-B and , 6/25/18, unless R2's status 29 a.m. the ADON stated the imadin were monitored for as bruising, blood in urine, color blood in stool. The ADON expect symptoms to be reported rese and the charge nurse/RN as and monitor to "see where the aded." The ADON verified on been receiving 4 mg of and had also been prescribed (18/18. The ADON stated R2's -A) had been out so it was MD-B, who prescribed the 1NR results were to have been C who covered for MD-A. The he had worked on 6/23/18, and C had reported R2's maroon her and so they went and looked the color was "weird." The ADON PN-C do a focused assessment they were in a "monitoring" state ON stated family had been at the P out for the day and R2 had and responsive with no signs of 2 had been offered the ER which ADON confirmed R2 had "left monitoring state at that time."	F 58	30			
	page 9 would be contact RN-B and y, 6/25/18, unless R2's status 29 a.m. the ADON stated the umadin were monitored for as bruising, blood in urine, color blood in stool. The ADON d expect symptoms to be reported rse and the charge nurse/RN ss and monitor to "see where the aded." The ADON verified on been receiving 4 mg of and had also been prescribed /18/18. The ADON stated R2's P-A) had been out so it was f, MD-B, who prescribed the e INR results were to have been C who covered for MD-A. The he had worked on 6/23/18, and C had reported R2's maroon her and so they went and looked he color was "weird." The ADON .PN-C do a focused assessment I they were in a "monitoring" state DON stated family had been at the 2 out for the day and R2 had nd responsive with no signs of 2 had been offered the ER which . ADON confirmed R2 had "left monitoring state at that time." ed she had not spoken with the stated LPN-C had done so. DON stated she was not sure if ained the risks and benefits of	would be contact RN-B and y, 6/25/18, unless R2's status 229 a.m. the ADON stated the umadin were monitored for as bruising, blood in urine, color blood in stool. The ADON d expect symptoms to be reported rse and the charge nurse/RN ss and monitor to "see where the aded." The ADON verified on been receiving 4 mg of and had also been prescribed /18/18. The ADON stated R2's -A) had been out so it was f, MD-B, who prescribed the e INR results were to have been C who covered for MD-A. The he had worked on 6/23/18, and C had reported R2's maroon her and so they went and looked he color was "weird." The ADON .PN-C do a focused assessment they were in a "monitoring" state OON stated family had been at the 2 out for the day and R2 had nd responsive with no signs of 2 had been offered the ER which . ADON confirmed R2 had "left monitoring state at that time." ed she had not spoken with the stated LPN-C had done so. OON stated she was not sure if	page 9       F 580         would be contact RN-B and       F 580         29 a.m. the ADON stated the       madin were monitored for         as bruising, blood in urine, color       blood in stool. The ADON         d expect symptoms to be reported       rse and the charge nurse/RN         ss and monitor to "see where the       add." The ADON verified on         been receiving 4 mg of       and had also been prescribed         /18/18. The ADON stated R2's       -A) had been out so it was         , MD-B, who prescribed the       Norescribed the         a INR results were to have been       C who covered for MD-A. The         he had worked on 6/23/18, and       C had reported R2's maroon         her and so they went and looked       he color was "weird." The ADON         P.N-C do a focused assessment       I they were in a "monitoring" state         OON stated family had been at the       2 out for the day and R2 had         nd responsive with no signs of       2 had been offered the ER which         . ADON confirmed R2 had "left       monitoring state at that time."         ed she had not spoken with the       stated LPN-C had done so.         ON stated she was not sure if       DON stated she was not sure if	page 9       F 580         would be contact RN-B and y, 6/25/18, unless R2's status       F 580         29 a.m. the ADON stated the imadin were monitored for as bruising, blood in urine, color blood in stool. The ADON d expect symptoms to be reported rse and the charge nurse/RN ss and monitor to "see where the aded." The ADON varified on been receiving 4 mg of and had also been prescribed /1/8/18. The ADON stated R2's I-A) had been out so it was , MD-B, who prescribed the e INR results were to have been C who covered for MD-A. The he had worked on 6/23/18, and C had reported R2's maroon ner and so they went and looked he color was "weird." The ADON .PN-C do a focused assessment I they were in a "monitoring" state ON stated family had been at the 2 out for the day and R2 had nd responsive with no signs of 2 had been offered the ER which . ADON confirmed R2 had 'left monitoring state at that time." ed she had not spoken with the stated LPN-C had done so. DON stated she was not sure if	

Facility ID: 00460

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		& MEDICAID SERVICES	(X2) MUIT	TIPLE CONSTRUCTION		. 0938-039 E SURVEY		
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	` '			IPLETED		
		245545	B. WING_		08/	08/13/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	IP CODE			
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE S FERTILE, MN 56540	SOUTHEAST	4ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE		
F 580	••••••	-	F 5	80				
	finished her shift. T had R2's dose of C contacted the phys the ADON stated si have done anything she knew now as F blood and R2 had r ADON stated she e menu to see if they the meal. The ADC experienced more appearance" later i lethargic which she outing the previous hallucinating which ADON stated just p an opportunity to ta when they had "put stated she contacte possible hospitalization would be testing R2 proceeded to check she again contacte would be willing to not comfortable with had obtained the fat the physician and r to the ER. Lastly, t R2's family to notify confirmed R2 had I bleed and received four day hospitalization she could have pro 6/23/18, as she wa	y further stools after she The ADON verified she had not coumadin held, nor had she ician at that point. In addition, he was not sure she would g differently knowing then what R2's stool did not have frank no other symptoms. The even went an checked the r had had beets served during DN verified on 6/24/18, R2 maroon stools with a "clotting n the day and was more a attributed the lethargy to R2's day. R2 had begun was attributed to a UTI. The prior to shift change, she had alk with the staff which was a ti all together." The ADON ed R2's family to discuss ation and to notify them she 2's INR. The ADON k R2's INR which was 8, so d the family to see if they send R2 to the ER as she was h R2's INR result. Once she amily's approval, she contacted eceived orders to transport R2 he ADON again contacted y them of the plan. The ADON been diagnosed with a GI two units of blood during a ation. The ADON confirmed ubably tested R2's INR on s aware of the interactions n and antibiotics and stated not						

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED
		245545	B. WING	;		08/1	13/2018
NAME OF	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			3OX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From pa	ige 11	F {	580			
	(DON) confirmed R flag" and stated she to assess the patien hold the Coumadin On 8/9/18, at 4:13 p and facility medical monitoring for resid anticoagulant who depended on the an stated usually if it w sulfamethoxazole ( the INR more often from 6/18/18, was n stated he would hav indicated physician nursing out. He sta prescribed the antik earlier INR testing, earlier INR testing, earlier INR testing a have also asked for confirmed a maroo a cause of concern signal to call somed have expected to b MD-A stated they h policy to include INI nursing discretions, stool, with or withou been an indication if the resident was of MD-A was unsure of nursing holding the indicated they shou physician prior to give	p.m. the director of nursing 82's maroon stool was a "red e would have expected ADON nt herself, checked an INR, and contact the physician director, MD-A indicated the dents who received were prescribed antibiotics ntibiotic prescribed. MD-D vas Cipro, Levaquin or Bactrim) staff needed to check b. R2's MD antibiotic order reviewed with MD-A who ve done that differently. MD-A s relied on pharmacy to help ated the physician who biotics should have ordered nursing should have asked for and/or the pharmacist should r earlier INR testing. MD-A n colored stool would indicate and should have been a one. MD-A indicated he would e notified when this occurred. ad been working on the facility R testing to be initiated per , however, a maroon colored ut policy changes would have to notify someone, particularly on anticoagulant medication. of the facility policy regarding Coumadin medication but ald have contacted the iving the medication.					

Facility ID: 00460

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A From page 12 the primary/on call physician f any medically unstable cor ected situations that warrant	ICIES BY FULL RMATION)	BOX 8 300 0 FERTILE,	DRESS, CITY, STATE, ZIP CODE	08/ ST	PLETED 13/2018 (X5) COMPLETIO DATE
R SUPPLIER RSING HOME JMMARY STATEMENT OF DEFICIEN I DEFICIENCY MUST BE PRECEDED ATORY OR LSC IDENTIFYING INFO d From page 12 the primary/on call physician f any medically unstable cor	ICIES I 9 BY FULL PRI RMATION) T7	STREET ADD BOX 8 300 ( FERTILE, ID REFIX (E/ AG CRO	GARFIELD AVENUE SOUTHEAS MN 56540 PROVIDER'S PLAN OF CORRECTIO ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO	ST ON .D BE	(X5) COMPLETIO
RSING HOME JMMARY STATEMENT OF DEFICIEN I DEFICIENCY MUST BE PRECEDED ATORY OR LSC IDENTIFYING INFO d From page 12 the primary/on call physician f any medically unstable cor	BY FULL PRI RMATION) T,	BOX 8 300 (FERTILE,	GARFIELD AVENUE SOUTHEAS MN 56540 PROVIDER'S PLAN OF CORRECTIO ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO	ON .D BE	COMPLETIO
JMMARY STATEMENT OF DEFICIEN I DEFICIENCY MUST BE PRECEDED ATORY OR LSC IDENTIFYING INFO d From page 12 the primary/on call physician f any medically unstable cor	BY FULL PRI RMATION) T,	FERTILE, ID REFIX (E/ AG CRO	MN 56540 PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO	ON .D BE	COMPLETIO
I DEFICIENCY MUST BE PRECEDED ATORY OR LSC IDENTIFYING INFO d From page 12 he primary/on call physician f any medically unstable cor	BY FULL PRI RMATION) T,	EFIX (E/ AG CRO	ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPRO	D BE	COMPLETIO
he primary/on call physician f any medically unstable cor		E 580			
f any medically unstable cor	n would be	1 300			
	ted				
	ing, notifications				
-	-	F 582			8/28/18
each Medicaid-eligible resid t the time of admission to th d when the resident become of-	e nursing es eligible for				
acility services under the Sta the resident may not be cha e other items and services th fers and for which the reside	ate plan and arged; hat the ent may be				
n each Medicaid-eligible resi are made to the items and s	services				
before, or at the time of adm lly during the resident's stay in the facility and of charges including any charges for so under Medicare/ Medicaid of ber diem rate.	nission, and y, of services s for those ervices not r by the				
	the policy did not address r are not concerning lab or dia //Medicare Coverage/Liability 483.10(g)(17)(18)(i)-(v) g)(17) The facility must each Medicaid-eligible resident the time of admission to the d when the resident becom of- tems and services that are in acility services under the State the resident may not be char e other items and services the fers and for which the resident and the amount of charges and n each Medicaid-eligible resident are made to the items and services in §483.10(g)(17)(i)(A) and g)(18) The facility must inform before, or at the time of admini- ing the resident's stay in the facility and of charges including any charges for so under Medicare/ Medicaid of oper diem rate. e changes in coverage are mini- tices covered by Medicare are	the policy did not address notifications are not concerning lab or diagnostic test //Medicare Coverage/Liability Notice 483.10(g)(17)(18)(i)-(v) g)(17) The facility must each Medicaid-eligible resident, in t the time of admission to the nursing nd when the resident becomes eligible for of- tems and services that are included in acility services under the State plan and the resident may not be charged; e other items and services that the fers and for which the resident may be and the amount of charges for those and n each Medicaid-eligible resident when are made to the items and services in §483.10(g)(17)(i)(A) and (B) of this g)(18) The facility must inform each before, or at the time of admission, and ally during the resident's stay, of services in the facility and of charges for those including any charges for services not under Medicare/ Medicaid or by the	the policy did not address notifications ber not concerning lab or diagnostic test//Medicare Coverage/Liability Notice 483.10(g)(17)(18)(i)-(v)F 582g)(17) The facility must each Medicaid-eligible resident, in t the time of admission to the nursing nd when the resident becomes eligible for of- tems and services that are included in acility services under the State plan and the resident may not be charged; e other items and services that the fers and for which the resident may be and the amount of charges for those and n each Medicaid-eligible resident when are made to the items and services in §483.10(g)(17)(i)(A) and (B) of thisg)(18) The facility must inform each before, or at the time of admission, and ally during the resident's stay, of services in the facility and of charges for those including any charges for services not under Medicare/ Medicaid or by the ber diem rate. e changes in coverage are made to items ices covered by Medicare and/or by the	, the policy did not address notifications         re not concerning lab or diagnostic test         //Medicare Coverage/Liability Notice         483.10(g)(17)(18)(i)-(v)         g)(17) The facility must         each Medicaid-eligible resident, in         t the time of admission to the nursing         d when the resident becomes eligible for         of-         terms and services that are included in         acility services under the State plan and         the resident may not be charged;         e other items and services that the         fers and for which the resident may be         and the amount of charges for those         and         n each Medicaid-eligible resident when         are made to the items and services         in §483.10(g)(17)(i)(A) and (B) of this         g)(18) The facility must inform each         before, or at the time of admission, and         lly during the resident's stay, of services         in the facility and of charges for those         including any charges for services not         under Medicaied metade to items         teer diem rate.         a changes in coverage are made to items         teer diem rate.         a changes in coverage are made to items         teer diem rate. <td>, the policy did not address notifications         re not concerning lab or diagnostic test         //Medicare Coverage/Liability Notice         483.10(g)(17)(18)(i)-(v)         g)(17) The facility must         each Medicaid-eligible resident, in         t the time of admission to the nursing         id when the resident becomes eligible for         of-         terms and services that are included in         acility services under the State plan and         the resident may not be charged;         e other items and services for those         and         n each Medicaid-eligible resident when         are made to the items and services         in §483.10(g)(17)(i)(A) and (B) of this         g)(18) The facility must inform each         before, or at the time of admission, and         lly during the resident's stay, of services         in the facility and of charges for those         including any charges for services not         under Medicaid- Medicaid or by the         ber of em rate.         e changes in coverage are made to items         e changes in coverage are made to items</td>	, the policy did not address notifications         re not concerning lab or diagnostic test         //Medicare Coverage/Liability Notice         483.10(g)(17)(18)(i)-(v)         g)(17) The facility must         each Medicaid-eligible resident, in         t the time of admission to the nursing         id when the resident becomes eligible for         of-         terms and services that are included in         acility services under the State plan and         the resident may not be charged;         e other items and services for those         and         n each Medicaid-eligible resident when         are made to the items and services         in §483.10(g)(17)(i)(A) and (B) of this         g)(18) The facility must inform each         before, or at the time of admission, and         lly during the resident's stay, of services         in the facility and of charges for those         including any charges for services not         under Medicaid- Medicaid or by the         ber of em rate.         e changes in coverage are made to items         e changes in coverage are made to items

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TATENAENIT			(V2) MILLI TI			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY PLETED
		245545	B. WING _		08/	13/2018
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTH FERTILE, MN 56540	EAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 582	Continued From pa	age 13	F 58	2		
	notice to residents	of the change as soon as is				
	reasonably possible (ii) Where changes	are made to charges for other				
		that the facility offers, the				
	facility must inform	the resident in writing at least				
		plementation of the change.				
		s or is hospitalized or is				
		es not return to the facility, the to the resident, resident				
		estate, as applicable, any				
		already paid, less the facility's				
		he days the resident actually				
		d or retained a bed in the				
		of any minimum stay or				
	discharge notice re					
		st refund to the resident or ative any and all refunds due				
		30 days from the resident's				
	date of discharge fi					
		admission contract by or on				
		ual seeking admission to the				
		nflict with the requirements of				
	these regulations.					
		NT is not met as evidenced				
	by: Based on interview	v and document review, the		Correct Form #CMS-10055 S	NFARN was	
		vide the Skilled Nursing Facility		obtained online and business		
		ry Notice of Non-coverage		use this form along with the M		
	(SNFABN) (CMS 1	0055) to 3 of 3 residents (R38,		Notice for residents coming of		
		discontinuation of Medicare		stay.		
	Part A benefits, as	required		Effective 8/14/18 the new form		
	Findings include:			for any residents coming off M A CMS Form 10055 was filled provided to R38□s family on 8	out and	
	R38's SNF [skilled	nursing facility] Beneficiary		Administrator to monitor for co		
		ion Review (CMS-20052),		QAA was made aware of defic		
	completed by the fa	acility, revealed R38's		meeting on 8/22/18 and will m		
	Medicare Part A se	rvices started 6/15/18, and the		compliance.		
		$^{\circ}$ Part A service was 7/23/18.		Completed 8/28/18.		

Facility ID: 00460

		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245545	B. WING	i		08/	13/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 582	The form indicated the discharge from when benefit days of remained in the fact record review reveat NOMNC [Notice of (CMS 10123); howe Advance Beneficiar (SNFABN) (CMS 10 R142's CMS-20052 revealed R142's Me 6/4/18, and the last was 7/2/18. The fo "facility/provider init Medicare Part A set not exhausted." R1 on 7/3/18, with bene record review reveat NOMNC (CMS 101 (CMS 10055) was r R143's CMS-20052 revealed R142's Me 3/29/18, and the last service was 7/3/18. "facility/provider init Medicare Part A set not exhausted." R1 after 7/3/18. Further facility/provider init Medicare Part A set not exhausted." R1 after 7/3/18. Further facility had provided however, an SNFAI provided On 8/13/18, at 10:1 manager (BOM) ind been aware of the op protection notification	the "facility/provider initiated Medicare Part A services were not exhausted." R38 iility after 7/23/18. Further aled the facility had provided a Medicare Non-Coverage] ever, a Skilled Nursing Facility ry Notice of Non-coverage 0055) was not provided. 2, completed by the facility, edicare Part A services started covered day of Part A service im indicated the tiated the discharge from rvices when benefit days were 142 discharged from the facility efit days remaining. Further aled the facility had provided a 23), however, an SNFABN	F	582	2		

Facility ID: 00460

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245545	B. WING			08/	13/2018
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR MEADOW NURSING HOME			BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 582	had not given the no	otices as required. nd Bill policy directed when/if	F 5	582			
	social worker's resp resident/representa "Appeal Rights" pap information with QIC organization].	tive with the process of berwork and contacting D [quality improvement m Physical Restraints	F€	604			9/6/18
	§483.10(e) Respect The resident has a and dignity, includin	right to be treated with respect					
	physical or chemica purposes of disciplin	ight to be free from any al restraints imposed for ne or convenience, and not resident's medical symptoms, 3.12(a)(2).					
	neglect, misappropri and exploitation as includes but is not li corporal punishmen	e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from it, involuntary seclusion and mical restraint not required to medical symptoms.					
	§483.12(a) The faci	lity must-					
	from physical or che purposes of disciplinare not required to t	re that the resident is free emical restraints imposed for ne or convenience and that treat the resident's medical ne use of restraints is					

Facility ID: 00460

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X2) MULTIPLE CONSTRUCTION			
IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WING _		08/13/2018			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	E		
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTI FERTILE, MN 56540	IEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 604	Continued From pa	age 16	F 60	04			
		ty must use the least restrictive					
		east amount of time and					
		re-evaluation of the need for					
	restraints.						
		NT is not met as evidenced					
	by:						
	Based on observation, interview and document			8/14/18 Resident⊡s primary			
	review, the facility failed to ensure 1 of 2 residents (R40) were free from the use of physical			Administrator met with daught and it was explained that it is			
	restraints.			mother s right to be free from			
				physical restraint not required			
	Findings include:				xplained to		
				daughter that there is still a ris			
		ed 8/10/18 indicated R40 had		potential falls. Daughter agree	ed to		
		uded, but were not limited to		remove the seat belt.			
	hallucinations, and	e, repeated falls, weakness,		On 8/09/18 RN⊡s met with D			
	naliucinations, anu	disorientation.		discussed the appropriate use restraints and the need for me			
	R40's quarterly mir	nimum data set (MDS) dated		symptoms to warrant the restr			
		R40 had severe cognitive		other residents with restraints			
		extensive assistance of two		reviewed to make sure approp			
	persons for bed mobility and required extensive			symptoms warranted their use	e. No other		
		person for transfers and		changes were made at that tir			
		DS indicated R40 had bowel		R 40⊡s restraint removed on			
		inence and required extensive		8/20/18. Interventions put in p			
		ting. The MDS also indicated use daily which included a chair		Monitoring resident every 15 r room for one week. Monitor			
		ng, and a restraint marked as		minutes while in room for one			
		R40 was in bed Additionally,		Monitor every hour while in ro			
		R40 had personal alarm's		week. Toileting to be done ir			
	used while in bed a	and in the wheelchair.		after meals in an attempt to m			
		· · · <b>-</b> · · · <b>-</b> · · ·		needs prior to her attempts to	get out of		
		completed Physical Restraint		chair independently.	:11 i.e I.e. I.e		
		ment dated 7/18/18, indicated		Communication board used w			
		d with an alarmed seat belt in especific reason for the		specific words that resident ca make her needs known. Cop			
		dentified as poor safety		communication sheet are in th			
		f-transfers with falls. The		department, dietary departme			
		ted R40's daughter requested		therapy department as well as			

Facility ID: 00460

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY	
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		B. WING _		08/	08/13/2018		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	ODE		
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SO FERTILE, MN 56540	UTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
F 604	Continued From pa	age 17	F 60	)4			
	Continued From page 17 to have the restraint used for safety to prevent injury from falls. The assessment indicated R40 was fitted for a new wheelchair that had footrests and R40 was better positioned in that wheelchair. Although the assessment indicated R40 was a candidate for a restraint reduction, a reduction had not been attempted. The assessment lacked a specific medical symptom R40 displayed to warrant the use of a restraint. R40's care plan for falls dated as last revised on 7/18/18, indicated the following related to the use of the seat belt with alarm: A seat belt with alarm wads used and the alarm part was placed at the back of the wheelchair out of the reach of R40 because she attempted to remove the alarms and fall. Alarm with seatbelt used on wheelchair to alert staff of self transfers. Staff to fill out restraint release form every shift daily. Discuss and record with me/my family the risks and benefits of the restraint, when the restraint should be applied, routines while restrained, and any concerns or issues regarding restraint use. Reviewed ongoing use of restraint with family and restraint release forms. Ensure proper positioning in wheelchair while restrained. Ensure opportunities for restraint-free time and physical activity during restorative program, meals, toileting, walking, and while in bed. Document restraint release form daily. Restraint applied when up in wheelchair and released during meals, activities, during family visits, ADL's, and one on one. Report any negative or adverse effects of restraint use including a decline in mood, change in behavior, decrease in ADL self performance, decline in cognitive ability or communication, contracture formation, skin breakdown, signs of delirium,			room. Care plan and care sheet winclude use of the commun SPT to do education on colboard with nursing staff on Education will include commended in the sheet of the sheet set in the sheet set is the sheet set set is the sheet set is the sheet set is the sheet s	ication board. mmunication Sept. 6, 2018. munication with nmunication performed on emonitoring imely by results to be eficiencies at		

If continuation sheet Page 18 of 64
		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		E SURVEY PLETED
		245545	B. WING			08/ <sup>,</sup>	13/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FAIR ME	ADOW NURSING HO	ME			OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540	ſ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	Continued From pa	ge 18	F 6	04			
	8/7/18, at 7:30 p.m. used the alarmed s escape her wheelch like the restraint be have it on. FM-A sta fitted for a new whe better seated in. FM be open to a restrain R40 was interviewe indicated she liked hide the belt by reach R40 was observed at the dining room to alarmed seat belt w although R40's care the seatbelt while d During an interviewe register nurse (RN) primary nurse and w health care. RN-A s was used for fall pro RN-A was not awar request the use of a	ed on 8/7/18, at 7:35 p.m. and the restraint belt and tried to djusting her shirt. on 8/8/18, at 7:06 a.m. seated table in her wheelchair. R40's vas still on in the dining room e plan directed staff to remove					
F 676 SS=D	the restraint use. R specific medical syn use of a restraint. Activities Daily Livin CFR(s): 483.24(a)( §483.24(a) Based of	RN-A could not identify a mptom that would warrant the ng (ADLs)/Mntn Abilities	F 6	76			9/6/18
		id choices, the facility must					

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/*	13/2018
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	provide the necessi ensure that a reside daily living do not d of the individual's ci- that such diminution includes the facility §483.24(a)(1) A res- treatment and servi- or her ability to carr living, including tho- of this section §483.24(b) Activitie The facility must pra- accordance with pa- activities of daily liv §483.24(b)(1) Hygie grooming, and oral §483.24(b)(2) Mobi including walking, §483.24(b)(2) Mobi including walking, §483.24(b)(3) Elimi §483.24(b)(4) Dinin snacks, §483.24(b)(5) Com- (i) Speech, (ii) Language, (iii) Other functiona This REQUIREMEN by: Based on observat review, the facility fa- assistance was pro-	ary care and services to ent's abilities in activities of iminish unless circumstances linical condition demonstrate n was unavoidable. This ensuring that: sident is given the appropriate ices to maintain or improve his y out the activities of daily se specified in paragraph (b) es of daily living. ovide care and services in aragraph (a) for the following ing: ene -bathing, dressing, care, ility-transfer and ambulation,	F	376	R 40 is placed on the assisted side dining room. Dietary staff have bee instructed on 8/28/18 to cut food int size pieces prior to serving her tray.	en o bite	

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245545 MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) 20 of daily living.	E	08 STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO
MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX	FERTILE, MN 56540 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO
JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIC
		,	
d 8/10/18 indicated R40 cluded, but were not limited a, repeated falls, weakness, sorientation. um data set (MDS) dated b had severe cognitive ensive assistance of one to ity, and supervision with set ng. The MDS indicated R40 which included a chair that tionally, the MDS indicated m's used while in bed and A was interviewed on uring which she stated R40 the dining room to a table ld be provided. FM-A also 0 was supposed to be n device developed by the hologist (SLP) but had not ed on 7/18/18, revealed R40 g related to holding or th and cheeks and had n-edible items like napkins blan indicated R40 required to sit in the upright nd chew each bit o eat on the assisted side supervision with meals.	F 676	<ul> <li>Nursing staff are to monitor and cue resident to drink between bites as directed by her care sheet.</li> <li>Communication board will include specific words that resident can point to make her needs known. Copies of the communication sheet are in the activity department, dietary department, and therapy department as well as in her room.</li> <li>Care plan and care sheet were updated to include use of the communication board. Staff was re-educated on the importance of following care sheets at the nursing staff meetings on 8/20 and 8/28/18.</li> <li>SPT to do education on communication board with nursing staff on Sept. 6, 2018. Education will include communication with R25 as well, who has a communication board she uses at times.</li> <li>R 40 and R25 will have increased quality of life by being able to express needs and receive asst when needed.</li> <li>Rn s and DON will do random walk throughs at meal time and other shifts to assure asst is given when needed and</li> </ul>	2 2 1
	g. The MDS indicated R40 which included a chair that onally, the MDS indicated m's used while in bed and was interviewed on ring which she stated R40 the dining room to a table d be provided. FM-A also 0 was supposed to be a device developed by the ologist (SLP) but had not d on 7/18/18, revealed R40 related to holding or h and cheeks and had edible items like napkins an indicated R40 required to sit in the upright d chew each bit o eat on the assisted side	g. The MDS indicated R40 which included a chair that onally, the MDS indicated m's used while in bed and was interviewed on ring which she stated R40 the dining room to a table d be provided. FM-A also 0 was supposed to be a device developed by the blogist (SLP) but had not d on 7/18/18, revealed R40 related to holding or h and cheeks and had edible items like napkins an indicated R40 required to sit in the upright d chew each bit	g. The MDS indicated R40 which included a chair that onally, the MDS indicated m's used while in bed and a was interviewed on ring which she stated R40 the dining room to a table d be provided. FM-A also 0 was supposed to be n device developed by the ologist (SLP) but had not d on 7/18/18, revealed R40 related to holding or h and cheeks and had edible items like napkins an indicated R40 required to sit in the upright d chew each bit

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/ <sup>,</sup>	13/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540	ſ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	at a dining room tak which included frem a difficult time eatin had not been cut fo cut the meal into bir finished the meal ar were staff observed with cutting the mea between bites of for R40 was observed 3:30 p.m. and 8/9/1 no time was a comu- implemented to ent Nursing assistant (I 8/9/18, at 9:12 a.m. aware of any comm developed for R40. -At 9:41 a.m. NA-G R40 had a commun- through R40's room board in a dresser of stated they were not board and had never Review of the SLP 6/5/18, revealed R4 communication and express her wants social interaction to goal of the SLP for of life and quality of express needs and SLP notes indicated communication boar personalized vocab and their function was	ble. R40 was served the meal ich toast and bacon. R40 had ig because the french toast or her and R40 was unable to te size pieces herself. R40 t 8:20 a.m. and at no time d seated by R40 to assist her al or cueing her to drink od. on 8/8/18, from 7:06 a.m. to 8, from 8:15-11:00 a.m. and at munication device hance communication. NA)-H was interviewed on and stated she was not hunication device or board e stated she was not aware hication board however, looked in and found a communication drawer. Both NA-H and NA-G ot aware of the communication er used it. Evaluation and Plan dated	F	576			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(V2) MUUTIC		O. 0938-039 ATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:			OMPLETED	
		245545	B. WING	0	8/13/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540	_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 676	Continued From pa	ge 22	F 676	3		
	care plan for using in R40's current car	the board had not been found e plan.				
F 677 SS=D	registered nurse (R have had supervision the breakfast meal choking. RN-A furth been encouraged to board during activith her communication ADL Care Provided	for Dependent Residents	F 677	7	8/28/18	
	out activities of dail services to maintain personal and oral h This REQUIREMEN by:	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview and document		The care sheet contained instructions to		
	review, the facility fa assistance with inco	ailed to provide timely ontinence cares for 1 of 1 was totally dependent on staff		toilet every 2-3 hours. Education given employees by RN on the floor on 8/08/18 regarding toileting not being not timely. Education provided to all nursing staff by DON regarding the importance of	to 3	
	Findings include:	imum Data Sat (MDS) dated		following the care plan given at nursing staff meeting on 8/20 and 8/28/18. Bladder assessment done on R12 on		
	5/23/18 identified R impairment and dia disease, and deme required extensive daily living and was	imum Data Set (MDS) dated 12 with severe cognitive gnoses including Alzheimer's ntia. The MDS indicated R12 assistance with all activities of totally incontinent of bowel		<ul><li>8/28/18, care sheet and care plan changed to q2h.</li><li>Charge nurse on each shift is responsibl to check the toileting schedules to be su they have been followed. This was</li></ul>	re	
	and bladder. The Urinary Inconti	nence Care Area Assessment		reinforced at the nursing meeting on 8/2 and 8/28/18. Random audits will be done weekly on	U	

Facility ID: 00460

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STATEMENT	OF DEFICIENCIES	KOMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
	ST CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G		
		245545	B. WING			/13/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
FAIR ME	ADOW NURSING HO	DME		BOX 8 300 GARFIELD AVENUE SOUT	IHEASI	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 677	incontinent of blad to check and chan needed.	age 23 der and required assist of staff ge every two hours and as essment Form dated 3/17/18	F 67	7 incontinent cares are done ti Audit results will be presente least quarterly, more often if increased issues. QAA was made aware of def	d to QAA at there are	
	totally incontinent of physical impairment would be inapprop	functional incontinence, was of bowel and bladder due to nts and cognitive deficits. R12 riate for bladder retraining and of change with toileting needs.		meeting on 8/22/18 and will r compliance. Completed: 8/28/18	nonitor	
	to assist R12 with	ated 5/30/18, directed the staff a check and change of t schedule of every two hours				
	observations from	l on 8/8/18, during continuous 7:05 a.m. to 10:23 a.m. R12 to be assisted with a during this time.				
	-At 7:05 a.m. R12 wheelchair (WC) in	was observed seated in a n the dining room.				
	wheeled R12 from	sed practical nurse (LPN)-C the dining room to the desk ntrance and positioned her by				
	therapy room. R12	nerapy aide wheeled R12 to the 2 was observed to fold towels oper and lower range of motion				
	the therapy room,	nerapy aide wheeled R12 out of returned her to the desk area ce and positioned her by the				

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		AND HUMAN SERVICES				FORM	D: 09/07/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245545	B. WING			08	8/13/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEA	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	<ul> <li>-At 9:01 a.m. the active front door and r by the front entrance the wall.</li> <li>-At 9:05 a.m. licens wheeled R12 into the on the television an -At 9:12 a.m. LSW-R12 continued to be her WC.</li> <li>-At 9:43 a.m. activitiactivity room and in 10:00 a.m.</li> <li>-At 10:00 a.m. AA-A and positioned her resident for Bible steres and positioned her resident for Bible steres and positioned her with activity room and in 10:00 a.m. AA-A and positioned her resident for Bible steres and positioned her resident</li></ul>	dministrator wheeled R12 to eturned her to the desk area are and positioned her next to ed social worker (LSW)-A ne activity room. LSW-A turned d sat next to R12. A left the activity room and e seated in the activity room in and the activity room in and the activity room and e seated in the activity room in and the activity room and e seated in the activity room in and the activity room and a seated in the activity room in a	F	677			

Facility ID: 00460

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	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY IPLETED
		IDENTIFICATION NOMBER.	A. BUILDING	3		
		245545	B. WING		08/	13/2018
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTHEA FERTILE, MN 56540	SI	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 677	Continued From pa earlier).	ge 25	F 677			
	confirmed R12 was	a.m. registered nurse (RN)-B to be assisted with every two hours as directed				
	(DON) confirmed s	o.m. the director of nursing taff was expected to provide and incontinence cares.				
	incontinence care v provided.	ted to timely provision of vas requested, however not				
F 686 SS=D	Treatment/Svcs to CFR(s): 483.25(b)(	Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 686			8/28/18
	resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmen with professional st promote healing, pu new ulcers from de	sure ulcers. brehensive assessment of a must ensure that- res care, consistent with ards of practice, to prevent d does not develop pressure idividual's clinical condition they were unavoidable; and bressure ulcers receives and services, consistent andards of practice, to revent infection and prevent				
	Based on observat review, the facility f repositioning servic R5) who were ident	tion, interview and document ailed to provide timely ses for 2 of 2 residents (R12, ified at risk for pressure ulcers assistance to reposition.		Education given to nursing staff floor by RN on 8/08/18 regarding repositioning not being not timely R12's care sheet said to reposition resident every 1 1 /2 hours to pre	n	

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TATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED	
		245545	B. WING _		08/	13/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
FAIR ME	ADOW NURSING HC	ME		BOX 8 300 GARFIELD AVENUE FERTILE, MN 56540	E SOUTHEAST	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 686	Continued From pa	age 26	F 68	6			
	Findings include:			pressure ulcers. Bladde done on R12 on 8/28/18 care plan changed to q	8, care sheet and		
	5/23/18, indicated impairment and dia Alzheimer's diseas	nimum Data Set (MDS) dated R12 had severe cognitive agnoses which included e and a coccyx region		receive toileting and rep as directed by updated R12 expired on 9/03/18 areas.	oositioning needs care plan. 8 with no open		
	extensive assist of mobility, transfers indicated R12 had	e MDS indicated R12 required two persons for toilet use, bed and dressing. The MDS also one unhealed, stage 1 act skin with blanchable		A bladder assessment dated 9/07/18. Care pla changed to toilet q2h. I toileting and repositioni directed by the updated	an and care sheet R5 will receive ng needs as		
	redness of a localiz prominence), was further pressure ul reducing device for	zed area usually over a bony at risk for the development of cers, and required a pressure r bed and chair, a turning and am, and nutrition/hydration		All residents who requir toileting needs will be re their care plans accurat needs.	e assistance with eviewed to ensure		
	interventions to ma	anage skin problems. ance dated 3/7/18 indicated		Education provided to a DON regarding the imp following the care plan	ortance of		
	R12 was at high ris development.	sk for pressure ulcer		staff meeting on 8/20 a Charge nurse on each to check the repositioni	shift is responsible		
	indicated R12 was ulcers, received m	assessment dated 3/7/18, at high risk for pressure echanical soft diet with Boost t three times daily, air mattress		ensure they have been was reinforced at the ne 8/20 and 8/28/18. Shift audits will be com	followed. This ursing meeting on		
		ng every two hours and check two hours to address		the next 90 days by DO assure incontinent care Compliance monitored DON.	s are done timely.		
	was at risk for pres decreased mobility	ovided 8/18/18, indicated R12 soure ulcers related to r, need for assistance with bed and repositioning, bowel		QAA was made aware meeting on 8/22/18. A brought to QAA for inpu increase, decrease or c	udit results will be It on need to		
	incontinence, histo recent superficial c above the knee an	ry of pressure ulcers, history of open area on coccyx, and a left oputation with no prosthesis. cted the staff to assist with		based on the findings. Completed : 9/15/18			

		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		245545	B. WING	i		08/	13/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAS1 FERTILE, MN 56540	Ī	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	hygiene and genera on bony prominence every two hours, ar change every two h On 8/8/18, during c 7:05 a.m. to 10:23 a be assisted with rep -At 7:05 a.m. R12 v wheelchair (WC) in -At 8:24 a.m. licens wheeled R12 from area by the front er the wall. -At 8:29 a.m. the th therapy room. R12 provided provided to motion activity. -At 8:51 a.m. the th the therapy room, r by the front entrance wall. -At 9:01 a.m. the ac the front door and r by the front entrance the wall. -At 9:05 a.m. licens wheeled R12 into th on the television an a.m. LSW-A left the remained seated in	al skin care, minimize pressure ses, reposition with two staff and assist with check and nours for incontinence care. continuous observations from a.m. R12 was not observed to positioning.	F	586			

If continuation sheet Page 28 of 64

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/ <sup>.</sup>	13/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			3OX 8 300 GARFIELD AVENUE SOUTHEAS ERTILE, MN 56540	Г	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 686	Continued From paractivity room and in 10:00 a.m. -At 10:00 a.m. AA-/ and positioned her resident for Bible st -At 10:15 a.m. nurs resident from the ad- -At 10:21 a.m. NA-/ transfer from the wildow body mechanical life changed R12's incon- noted to have been coccyx and buttock areas observed. At R12 was incontinent buttock area was re- not provided R12 was re- r:00 a.m. (a total of earlier). On 8/8/18, at 11:24 confirmed R12 was	age 28 Iformed R12 of Bible study at A offered R12 a glass of water at a table with another female	1	586	DEFICIENCY)	RATE	DATE
	On 8/8/18, at 2:00 g (DON) confirmed th provide timely repordirected by the care R5's annual MDS d	ed by the care plan. p.m. the director of nursing ne staff was expected to sitioning every two hours as e plan. lated 5/2/18, indicated R5 assistance of two staff for bed					

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245545	B. WING	i		08/	13/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540	Г	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	mobility, transfers, personal hygiene al pressure ulcers. The upper and lower ex- sides of body. R5's diagnosis repo- included diagnoses results from damag- are responsible for- sclerosis (a progress disease that affects the spinal cord), an neuropathy (loss of feet, and in organs- and eyes). R5's skin review as indicated R5 was to hours and had no co- R5's care plan prov- staff to turn and rep- hours when in bed. R5 had a recent op opened and healed as of 8/2/18. R5's nursing assista on 8/10/18, directed reposition every 1.5 as she requested. On 8/8/18, during c 7:16 a.m. until 10:2 assistance to turn of -At 10:20 a.m. NA-I	dressing, toileting and and was at risk for developing be MDS identified R5 had stremity impairment on both ort provided on 8/10/18, s of aphasia (disorder that ge to portions of the brain that language), amyotrophic lateral ssive neurodegenerative is nerve cells in the brain and ad hereditary and idiopathic f sensitivity in the hands and such as the kidneys, heart, essessment dated 5/1/18, to be repositioned every two current skin issues. <i>v</i> ided on 8/10/18, directed the bosition R5 every 1.5 to two . The care plan also indicated ben sore on the coccyx which d and was most recently open ant (NA) care sheet provided d the staff to turn and 5 to two hours when in bed, or continuous observation from 20 a.m. R5 was not provided	F	686			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/ <sup>,</sup>	13/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR MEA	DOW NURSING HOM	ИЕ			SOX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688 I SS=D (	provided care for R at 6 a.m. a total of 4 earlier. On 8/9/18, at 9:19 a assisting R5 with re R5 had not been rep when she started he 19 minutes earlier. On 8/13/18, at 10:30 be provided assistance of pressure ulcers e resident request. On 8/13/18, at 1:14 would expect the re repositioned accord DON stated three ho was not acceptable A facility policy relat repositioning was re provided. Increase/Prevent Do CFR(s): 483.25(c)(1 §483.25(c) Mobility. §483.25(c) Mobility. §483.25(c)(1) The faresident who enters range of motion doe range of motion united the faciliant of the total of the total of the total was not acceptable of the total of the total of the total of the total of the total of the total of the total of the total of the total of total of the total of th	both confirmed they had not 5 since the start of their shift 4 hours and 20 minutes a.m. NA-E was observed positioning. NA-E confirmed positioned since 6:00 a,m. er shift, a total of 3 hours and 6 a.m. RN-B stated R5 was to nce with turning and er to prevent the development every 1.5 to two hours, and per p.m. the DON stated she sidents' to be turned and ling to their care plan. The ours in between repositioning care. eed to timely provision of equested, however was not ecrease in ROM/Mobility 1)-(3) acility must ensure that a a the facility without limited es not experience reduction in ess the resident's clinical ates that a reduction in range		586			9/15/18

Facility ID: 00460

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 09/07/2018 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) D	ATE SURVEY DMPLETED
		245545	B. WING			8/13/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
FAIR ME	ADOW NURSING HO	ME			OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	<ul> <li>§483.25(c)(2) A res motion receives ap services to increase prevent further deci- §483.25(c)(3) A res receives appropriat assistance to maint the maximum pract reduction in mobility This REQUIREMEN by:</li> <li>Based on observat review the facility fa a knee brace as dir 1 resident (R19) ob knee brace on.</li> <li>Findings include:</li> <li>R19's quarterly min 5/29/18, indicated F impaired and requir two staff for bed mo toileting and person</li> <li>R19's admission re indicated diagnoses disorder of bone, un</li> <li>R19's care plan pro R19 had degenerat knee and directed s right knee when up</li> <li>R19's nursing assis 8/10/18, directed st</li> </ul>	ident with limited range of propriate treatment and a range of motion and/or to rease in range of motion. ident with limited mobility e services, equipment, and ain or improve mobility with icable independence unless a <i>y</i> is demonstrably unavoidable. NT is not met as evidenced ion, interview and document iled to ensure the removal of ected by the care plan for 1 of served lying in bed with the imum data set (MDS) dated R19 was severely cognitively ed extensive assistance from obility, transfers, dressing, nal hygiene. cord provided 8/10/18, s of osteoarthritis of knee and	Fé	588	R19's care sheet contained instructions to remove leg brace while in bed. Education provided to nursing staff by DON regarding the importance of following the care plan discussed at nursing staff meetings on 8/20 and 8/28/18. Dr. Ring asked for updated order related to brace on 8/29/18. R19 has no skin breakdown due to use of the brace. Car sheet will be updated to include physicia order. Instructions for brace will be updated to include when the brace shou be on and off. This will be laminated and placed in resident s room. Random audits will be completed by DO or designee 3xwk for 1 month/ 2xwk for weeks/ 1xwk for 1 week to ensure that brace is being removed when resident in bed. Compliance monitored by primary RN ar DON. QAA was made aware of deficiencies at meeting on 8/22/18. Audit results will be brought to QAA for input on need to increase, decrease or discontinue audits based on findings.	e n d J N 2

Facility ID: 00460

		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/ <sup>,</sup>	13/2018
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			X 8 300 GARFIELD AVENUE SOUTHEAST RTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	Continued From pa	ge 32	F 68	38	Completed: 9/15/18		
	included directions the brace. The inst	tions provided by the facility for how to apply and remove tructions did not indicate at ce should not be worn.					
	nurse's station, sea knee brace on. The	o.m. R19 was observed by the ited in wheelchair, with a right e brace was noted to have ocated on each side of the					
	room, seated in a w brace on. -At 12:02 p.m. R19 the right side with th	a.m. R19 was observed in her wheelchair, with the right knee was observed lying in bed on he brace on the right knee. be was uncomfortable to have					
	stated it was the ex assistants followed	p.m. register nurse (RN)-A pectation that the nursing R19's care sheets/care plan, knee brace to be removed ed.					
		7 a.m. NA-B stated R19 ee brace removed when in					
		0 a.m. registered occupational 9 should have had the brace is in bed.					
	(DON) stated she w	p.m. the director of nursing vould expect R19's knee brace n bed, if nothing else, for r resident.					

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			FORM OMB NO	. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245545	B. WING _		08/	13/2018
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HOI	ME		BOX 8 300 GARFIELD AVENUE SOUTHE	AST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	ge 33	F 68	39		
	Free of Accident Ha CFR(s): 483.25(d)(	azards/Supervision/Devices 1)(2)	F 68	9		9/15/18
Ę						
	§483.25(d)(2)Each resident receives an supervision and assistance devices to accidents. This REQUIREMENT is not met as ev by: Based on observation, interview and d review the facility failed to ensure footro in place on a wheelchair for 1 of 1 resid	sistance devices to prevent NT is not met as evidenced tion, interview and document, illed to ensure footrests were chair for 1 of 1 resident (R19)		Foot rests were applied to R19's wheelchair on 8/10/18 and are to when resident is being pushed to	o be used o/from	
		neir foot become lodged neelchair during transport.		locations. Footrests are to ren when resident is self-propeling w feet and put on when resident is pushed for transport.	/ith her being	
	5/29/18, indicated F impaired, required e staff for transfers, u	imum Data Set (MDS) dated R19 was severely cognitively extensive assistance from two used a wheelchair and required are of one staff for locomotion		Care sheet updated to instruct o footrests. QAA addressed this issue on 8/2 Footrest storage bags have bee to hang on the back of resident wheelchairs. Those residents th propel will have footrests off unle pushed to/from location.	22/18. n ordered at self	
	Area Assessment (	ily Living/Functional Care CAA) dated 10/10/17, at times, propel self with lots of		Therapy screened all residents f need for footrests. Care sheets plans will be updated based on t information. Those residents wh the need for footrests will have a	and care his no have	
	R19's care plan pro R19 used a wheelc	vide on 8/10/18, indicated hair for locomotion.		the footrests on the back of their ensure they are always available needed.	chair to	
		tant care sheet indicated R19 r with bilateral leg rests.		DON provided education to nurs at staff meeting on 8/20 and 8/22 regarding safe wheelchair transp	3/18	

Facility ID: 00460

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES	-		OŅ		APPROVEI 0938-039
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
		245545	B. WING	WING		08/13/2018	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 689	During observation 7:32 p.m.; 8/8/18, a again from 9:27 a.r until 11:57 a.m.; an 9:53 a.m., R19 was without footrests in R19's Nurse progre indicated a staff me wheelchair, stoppe break for resident's room R19 yelled, "I proceeded to lift fe wheelchair while st the writer stating, " Staff explained the in locomotion and r injured. On 8/8/18, at 11:57 was observed push when R19 yelled of entangled under th R19, "You need to continued to push f room. At 12:02 p.m foot became entan On 8/9/18, at 2:06 stated the foot ped on R19's wheelchai and verified she wa R19's foot had bee wheelchair when b the leg rests in place On 8/13/18, at 1:13 (DON) stated she wa	A son 8/7/18, at 6:45 p.m. until at 7:17 a.m. until 7:24 a.m. and m. to 9:35 a.m. and 9:47 a.m. ad on 8/9/18, at 9:36 a.m. until s observed in the wheelchair place on the wheelchair. ess note (PN) dated 8/7/18, ember was pushing R19's ad at the dining room for a rest s legs. Once in the activity I'm mad" at writer, then et and tuck them under till in motion. R19 hollered at Look what you have done!" risks of planting feet while still made sure resident was not Y a.m. nursing assistant (NA)-E hing R19 in the wheelchair ut when her left foot became e wheelchair. NA-E stated to keep your feet up" and the wheelchair towards R19's n. R19 stated it hurt when her gled under the wheelchair. p.m. registered nurse (RN)-A als should have been placed air when going long distance, as aware of instances where en caught underneath the eing pushed by staff without	F6	89	the need for foot rests. Random audits will be completed by or designee 3xwk for 1 month/ 2xwk weeks/ 1xwk for 1 week to assure s using footrests at appropriate times ensure safety of the resident and the will not be lodged underneath the wheelchair during transport. Compliance monitored by primary R DON. QAA was made aware of deficiencie meeting on 8/22/18. Audit results w brought to QAA for input on need to increase, decrease or discontinue a based on findings. Completed: 9/15	k for 2 taff is to at feet RN and es at <i>r</i> ill be	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY
				NG		
		245545	B. WING _	STREET ADDRESS, CITY, STATE, ZIP (		8/13/2018
	PROVIDER OR SUPPLIER	ME		BOX 8 300 GARFIELD AVENUE SO FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLETIC DATE
F 689	Continued From pa	ge 35	F 68	39		
F 690 SS=D		ntinence, Catheter, UTI 1)-(3)	F 69	90		9/15/18
	resident who is con admission receives maintain continenc	facility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical mes such that continence is				
	incontinence, base comprehensive ass ensure that- (i) A resident who e indwelling catheter resident's clinical co	essment, the facility must nters the facility without an is not catheterized unless the ondition demonstrates that				
	indwelling catheter is assessed for rem as possible unless	necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary;				
	(iii) A resident who receives appropriat	is incontinent of bladder e treatment and services to t infections and to restore xtent possible.				
	incontinence, base comprehensive ass ensure that a reside receives appropriat	a resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel e treatment and services to ormal bowel function as				

If continuation sheet Page 36 of 64

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		E SURVEY		
IND PLAN (	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED		
		245545	B. WING		08/	13/2018		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
FAIR ME	ADOW NURSING HO	DME	BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETIO DATE		
F 690	by: Based on observa	NT is not met as evidenced ation, interview and document	F 69	A bladder assessment was done	-			
	assistance with inc residents (R5) who for incontinent care	failed to provide timely continence cares of 1 of 3 o required extensive assistance es.		dated 9/07/18. Care plan and ca changed to toilet q2h. R5 will red toileting needs as directed by the care plan. All residents who require assista	eive updated nce with			
5/2/18, indicated R5 assistance of two sta dressing, toileting and at risk for developing		staff for bed mobility, transfers, and personal hygiene and was ng pressure ulcers. The MDS upper and lower extremity		toileting needs will be reviewed to their care plans accurately reflect needs. Education provided to all nursing DON regarding the importance of following the care plan provided staff meetings on 8/20 and 8/28/ Charge nurse on each shift is rest to check the that toileting schedu been followed. This was reinfor	t their g staff by f at nursing 18. sponsible iles have			
	included diagnoses results from damagare responsible for sclerosis (ALS) (a disease that affect the spinal cord), ar neuropathy (loss o feet, and in organs and eyes).	ort provided on 8/10/18, s of aphasia (disorder that ge to portions of the brain that language), amyotrophic lateral progressive neurodegenerative s nerve cells in the brain and hereditary and idiopathic f sensitivity in the hands and s such as the kidneys, heart,		nursing meetings on 8/20 and 8/ Policy relating to toileting was re- and updated to ensure timely can residents who are continent and incontinent. Shift audits are being completed the 90 days by DON or designee assure timely toileting on all shift QAA was made aware of deficien meeting on 8/22/18. Audit result brought to QAA for input on need	viewed res to 3x/wk for to s. ncies at s will be I to			
	5/14/18, indicated of bladder, had diff to ALS, mostly use changing of incont as needed (PRN).	Area Assessment (CAA) dated R5 was frequently incontinent ficulty using commode related d bedpan or staff checking and inent brief every 2-3 hours and R5 had stress/urge functional ce related to neuromuscular		increase, decrease or discontinu based on findings. Compliance by primary RN and DON. Completed: 9/15/18	e audits			

		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/ <sup>,</sup>	13/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
FAIR ME	ADOW NURSING HO	МЕ			3OX 8 300 GARFIELD AVENUE SOUTHEAS <sup>-</sup> FERTILE, MN 56540	Г	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	to provide extensive check and change, every 2-3 hours and R5's nursing assista 8/10/18, directed st commode or bedpa On 8/8/18, during c 7:16 a.m. until 10:2 care for urinary inco nursing assistant (N observed to provide having been inconti both confirmed they since the start of th 4 hours and 20 min assistance. On 8/9/18, at 9:19 a assisting R5 with re- incontinence care/to been provided to R 6:00 a.m. for a total earlier. On 8/13/18, at 10:3 (RN)-B stated the s incontinence care of prn. On 8/13/18, at 1:14 stated she would ex- checked and change care plan and over assistance, was not	e assistance of two persons to use commode, or bedpan d prn. ant care sheet provided on aff to check and change, use an every 2-3 hours and prn. continuous observation from 0 a.m. R5 was not provided ontinence. At 10:20 a.m. NA)-D and NA-E were e R5 incontinence care due R5 inent of urine. NA-D & NA-E y had not provided care for R5 eir shift at 6 a.m. for a total of nutes without incontinence care a.m. NA-E was observed epositioning. NA-E confirmed oileting assistance had not 5 since the start of her shift at I of 3 hours and 19 minutes aff were expected to provide or toileting every 2-3 hours and epom. the director of nursing xpect that residents would be ged/toileted according to the three hours without	F	590			

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						0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245545	B. WING		08/ <sup>,</sup>	13/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540	HEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 690	Continued From pa	ge 38	F 690	0		
	not provided.					
F 697 SS=D	Pain Management CFR(s): 483.25(k)		F 69	7		9/15/18
	consistent with prof the comprehensive and the residents' of This REQUIREMEN by: Based on observat review, the facility fa assess pain, and id interventions for 1 of complaints of pain. The findings include R38's face sheet da had diagnoses inclu and muscle weakne Review of the 30-da system (PPS) Minir 7/13/18, indicated F cognitive impairmen rated at a 6 on a sc lowest amount of pain. The made sleep difficult R38's day-to-day ac Review of R38's ph indicated R38 had b	ated 8/10/18, indicated R38 uding atrial fibrillation, anemia, ess. ay prospective payment num Data Set (MDS) dated R38 had moderately impaired nt, and had occasional pain vale of 1-10 with one being the ain and 10 being the most e MDS indicated pain had not at night and had not limited		A Comprehensive Assessment was on R38 on 9/04/18 to include the loc of the pain, a description of the pain aggravating factors, alleviating factor and both pharmacological and non-pharmacological interventions to alleviated the pain. Pain assessments were done on R3 9/03 and 9/04 by primary RN. Tyler increased to 325 mg 3x/day on 9/04 Xanax was ordered on 9/04/18 relat anxiety associated with pain. PT evaluation was ordered with PT to fe indicated. 7 day monitoring sheet was started 9/06 to monitor R38's pain on every Monitoring includes: non pharmacol interventions, activity levels, pain ra location of pain, medication given of side effects, level of consciousness Care plan was updated to include p aggravating factors, alleviating factor non -pharm interventions on 8/10/18 Rehab nursing initiated neck range motion, heat and massage to resid	cation a, brs, that 38 on hol was 1/18. ted to ollow if on shift. logical ting, r not, ain: ors, 3. of	

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ATEMENT	OF DEFICIENCIES OF CORRECTION	KANNERS      KANNERS			E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
		245545	B. WING _			08/*	13/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AIR ME	ADOW NURSING HO	ME		B F	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 697	pain. R38's Medication A 7/1/18-8/10/18, rev 325 mg one tablet a exception of four da rated the pain betw R38 was interviewe stated she frequent back area which wa the night time hours described the pain rated the pain at a 0 stated aggravating included the bed/m which was uncomfor and strenuous activ use, and a warm no neck/back pain. Review of R38's co provided by the fac The assessment in occasional pain in t not limited R38's da rated the pain at a 0 assessment failed the was located, a desc aggravating factors pharmacological ar interventions that a assessed.	y four hours as needed for administration Record from ealed R38 received Tylenol at least once a day with the ays in that time frame. R38 reen 3 and 7 on a 1-10 scale. ed on 8/8/18, at 8:46 a.m. and tly had pain in her neck and as more pronounced during s (after midnight). R38 as a dull ongoing ache and 6 on the 1-10 scale. R38 factors of the neck pain attress supplied by the facility ortable, cold air/environment, <i>vity.</i> R38 stated regular Tylenol eck roll alleviated the emprehensive pain assessment ility was section J of the MDS. dicated R38 had experienced the last five days, the pain had ay-to-day activity, and R38 6 on a scale of 1-10. The ot comprehensive, as the to identify where R38's pain cription of the pain, a, alleviating factors, and both nd non-pharmacological lleviated the pain had not been	F 69	97	non-pharmacological intervention. new pillow was ordered 8/29/18 to to alleviate resident □s pain at nigh Three mattresses have been tried fit for comfort. Warm blankets and packs continue to be offered to alle pain. Pain management policy was upda list what the pain assessment shou include on 8/29/18. Comprehensive pain assessments done for all residents on admission with new or worsening onset of pai Residents that are on a current pai management program will been re-assessed and care plans will be updated as appropriate. Charge nurses and primary RN to continue to monitor R38 for compla pain. Random audits will also be 3x/wk for 3 weeks, then 1xwk for 3 QAA was made aware of deficienc meeting on 8/22/18. Audit results brought to QAA for input on need to increase, decrease or discontinue on the findings. Completed: 9/15/1	attempt t. to best heat eviate ated to ild will be and n. n aints of done weeks. ies at will be o based	
		omprehensive care plan lan had been developed which ain symptoms.					

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING		08/ <sup>,</sup>	13/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
FAIR ME	ADOW NURSING HOI	ME		BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	Continued From pa	ge 40	F 69	7		
	(RN)-A confirmed R comprehensively as plan had not been o	7 a.m. registered nurse 38 had not been ssessed for pain, and a care developed to identify nd non-pharmacological				
F 757	prevention (undated would complete a p admission, following and upon determina not identified what t include.	or Pain management/pain d) indicated the staff nurse pain assessment at the time of g a hospitalization, quarterly, ation of pain. The policy had the assessment should ree from Unnecessary Drugs	F 75	7		9/15/18
SS=J	CFR(s): 483.45(d)( §483.45(d) Unnece Each resident's dru					
	§483.45(d)(1) In ex duplicate drug thera	cessive dose (including apy); or				
	§483.45(d)(2) For e	excessive duration; or				
	§483.45(d)(3) With	out adequate monitoring; or				
	§483.45(d)(4) Withouse; or	out adequate indications for its				
		e presence of adverse ch indicate the dose should be nued; or				
	§483.45(d)(6) Any o	combinations of the reasons				

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT			<u>IO. 0938-03</u> DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		245545	B. WING			08/13/2018	
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME	BOX 8 300 GARFIELD AVENUE SOUTHEA FERTILE, MN 56540			ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
F 757	Continued From pa	age 41	F 75	57			
	•	ns (d)(1) through (5) of this	1.10				
	section.						
		NT is not met as evidenced					
	by: Based observation	n, interview and document			Plan:		
		failed to implement increased			The anti-coagulation policy was updated	t	
		ntify symptoms of bleeding			on 8/09/18 to include increased		
		gastrointestinal bleed and			nonitoring while on antibiotics. Physicia		
		ation and subsequent blood			s to be notified if any readings are out o		
		of 1 resident (R2) who received			ange. Dr. Ring, Medical Director, pres	ent	
		on Coumadin therapy. R2			o assist in updating this policy. PT/INRs were checked on current		
		y stool without the identification the physician and was found to			esidents receiving anticoagulation		
		evated INR (lab test which			herapy on 8/09/18. Any non		
		ng ability of the blood). This			herapeutic levels were reported to Dr.		
		in immediate jeopardy situation		F	Ring and orders received. Standing		
		he facility's failure to evaluate			orders were changed regarding checkin	g	
		licies and procedures in order			NR every day while on antibiotic and		
		r improvement and/or			signed by Dr. Ring.		
		aff education to prevent or currences resulted in the			All charge nursing staff on the floor B/09/18 were educated on the updated		
		hat was not immediate			Anticoagulation Policy and Therapeutic		
	•	residents (R19, R13, R29) who			Monitoring of INR Policy. All charge sta	aff	
	also received Cour				vere educated on this policy prior to		
				v	working the floor.		
		pardy began on 6/18/18, when			All other nursing staff on the floor 8/09/1		
	•	Bactrim DS (an antibiotic) for			vere educated on signs and symptoms	of	
		urinary tract infection and did			non-therapeutic INR including the list	Ч	
		ed monitoring for signs and rse reaction to the combination			below. All nursing staff will be educate prior to working the floor.	u	
		ticoagulant use. The			An emergency meeting was called at 7:	30	
		y was identified on 8/9/18, at			om to educate nursing staff on this		
	4:25 p.m. at which	time the administrator, director			situation led by Nicole Johnson, DON.		
	of nursing (DON) a	ind assistant director of nursing			Dr. Ring, Medical Director addressed st	aff	
		ied. The immediate jeopardy			at this time.		
		/10/18, at 11:00 a.m. but			Symptoms of active bleeding were		
	noncompliance ren	nained at the lower scope and		r	eviewed, employees signed off		
		- isolated scope and severity			understanding and took a post test on		

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		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	PLE CONSTRUCTION G		E SURVEY PLETED	
		245545	B. WING _		08/	13/2018	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DE		
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUT FERTILE, MN 56540	SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 757	Continued From pa	age 42	F 75	7			
	immediate jeopard	•		" Bleeding from the gums a	after you		
	Findings include:	, ,		brush your teeth "Bleeding between menstr "Diarrhea, vomiting or inal	rual periods		
	7/11/18, indicated F had diagnoses which infection, and atrial heartbeat that incre- heart disease). The required extensive daily living except ea anticoagulant medi R2's Urinary Incont Catheter Care Area 7/11/18, indicated F of urinary tract infe- increased confusion associated with a U R2's Falls CAA date history of atrial fibri hypertension with u medication that cou- hypotension and ca R2's atrial fibrillatio	tinence and Indwelling a Assessment (CAA) dated R2 had a longstanding history ctions (UTI) with history of n, hallucinations and delusions JTI. ed 7/11/18, indicated R2 had a llation, a pacemaker, and use of antihypertensive uld contribute to orthostatic ause falls. The CAA indicated n was stable, however,		for more than 24 hours "Fever "Severe bleeding, includin than normal menstrual bleedi "Red or brown urine "Black or bloody stool "Severe headache or ston "Joint pain, discomfort or sespecially after an injury "Vomiting of blood or mate looks like coffee grounds "Coughing up blood "Bruising that develops within injury you remember "Dizziness or weakness "Vision changes RN involved was educated or of assessing residents hersel approached with concerns from LPN/Charge Nurse. Education her that she needs to notify P immediately when there are ses symptoms of non-therapeutic	g heavier ng nach pain swelling, erial that thout an n importance f when om n provided to hysician signs or		
	discontinued due to R2's care plan date atrial fibrillation and pacemaker. Count after last hospital s for bleeding. Review of R2's clin 4/10/18, medical do	gulant) had recently been o a gastrointestinal bleed (GI). ed 7/24/18, indicated R2 had d required the use of a adin currently discontinued tay related to GI bleed and risk ical record revealed on octor (MD)-A started R2 on a s (Bactrim DS) due to urinary		A mandatory nursing staff in-sheld on August 20th at 1 pm a and scheduled for August 28t and 2:15 pm to follow up on t well as training for LPNS for of PT/INR s. Education includi ordering of labs, timely drawin orders, acquisition of lab order ups was provided. Reporting conditions addressed; how the reported immediately to charge	and 2:15pm th at 1 pm his topic as conducting ng proper ng of lab ers and follow g of resident ney are to be		

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STATEMEN	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	· í		E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245545	B. WING _	-		08/1	13/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0/2010
FAIR ME	ADOW NURSING HO	ME		В	OX 8 300 GARFIELD AVENUE SOUTHEAS ERTILE, MN 56540	r	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 757	tract infection (UTI Coumadin orders ( when an antibiotic concurrently) which Coumadin for two doses every other resume the regular daily and check INI the effects of antice 4/16/18. The INR elevated at 3.8 (Fa indicated normal IN 3.0). R2 was seen for UTI due to a pe confusional state a admitted to the hos R2's Nursing Home MD-A dated 6/1/18 hospitalizations for had been sent hom suppression with c mg daily. However recurrence of UTI s cephalexin use. Th discontinued and C with modifications section of the note on the Cipro and th course of the Cipro On 6/2/18, R2's IN MD-A ordered R2's 6/2/18, then resum ordered a recheck INR dated 6/6/18, v ordered R2's Count then resumed at 2.	<ul> <li>) with adjustments made of her increased risk of bleeding and Coumadin are used in directed the staff to hold the days and then give scheduled day for four days then to to dose of Coumadin 2.5 mg R (laboratory test that monitors bagulant treatment) Monday, results dated 4/16/18, were ir Meadow Lab Flow Sheet NR range to be between 2.0 - by physician assistant (PA)-A rsistent and worsening nd R2 was subsequently spital.</li> <li>e Progress Note (NHPN) by , indicated R2 had had several UTIs. After hospitalization, R2 he on chronic urinary tract ephalexin (an antibiotic) 250 r, in the past week R2 had a symptoms despite the herefore, the cephalexin was Cipro (an antibiotic) was started for her INR. The assessment indicated R2 was doing well he plan was to complete the</li> </ul>	F 7	57	duty and DON. Education provide Physician needs to be notified immediately when there are signs of symptoms of non-therapeutic INR. Medical Director and Pharmacy pre QAA on 8/22/18 and in agreement education provided. Audits of lab orders and results will done periodically by DON per Con Pharmacist recommendations. Fair Meadow nursing staff will instit IDT meeting on every hospital adm Staff will look at all processes and procedures and determine if any improvements could be made. Symptoms, all steps taken prior to hospital discharge, and any monito completed will be assessed. If there any problems or areas of concern, Medical Director will be involved in and procedure improvement. Our to prevent any unnecessary hospitalizations or medication relate adverse events to our residents by providing early detection and preve measures. Audits of lab orders and results will done monthly by DON or designee Monitored by DON and QAA. Completed: 9/15/18	or esent at with be sultant tute an ission. ring re are policy goal is ed entative be	

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING	;		08/	13/2018
NAME OF F	PROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	Г	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 757	course of Cipro. R2's Fair Meadow I communication date was 1.6. MD-A resp increase R2's Cour and to recheck in tw Concurrently, R2's dated 6/13/18, indic hallucinations and I further indicated an MD-A to culture R2 increased weakness hallucinations she r room.	Nursing Home (FMNH) fax ed 6/13/18, indicated R2's INR bonded with an order to madin to 4 mg, 1 tablet daily wo weeks. nursing Progress Notes (PN) cated R2 experienced ethargy/sleepiness. The note order had been received from 's urine and if R2 experienced	F	757	7		
	had called the facili 1 tab orally, twice a recheck the INR on However, neither the identified any modified dose or the need for following the initiative history of abnormal antibiotic. R2's PN dated 6/23 practical nurse (LPI loose stools that we temperature was 97 and , "Well it is bett moved." LPN-C ind fever, pain and furth indicated LPN-C ha and she had denied stated two days ago bowel movement a	Alternative and the second sec					

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245545	B. WING	;		08/	13/2018
NAME OF F	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 757	had offered to have emergency room (E left a message for F nursing home and y daughter-in-law car LPN-C informed the stools so family way because she decline daughter-in-law pre- would continue to n treat as necessary R2's clinical record registered nurse as notification of the m Administration Recor- revealed on 6/23/18 4 mg as ordered. R2's PN dated 6/24 increased confusion well as increased c maroon color to hear received Bactrim for affected in the past checked today and significant risk for m sample was obtained the ambulance whe follow up NP noted admitted to the hos R2's Emergency De 6/24/18, indicated F intermittent blood in the previous 3 days chronically due to a INR was checked a	her checked in the ER) but R2 refused. LPN-C R2's daughter to call the while doing so, R2's me to pick her up for an outing. e daughter-in-law about the s aware and would watch also. vare R2 had declined ER red it again with esent. LPN-C indicated he nonitor when R2 returned and and as R2 and family desired. lacked evidence of a esessment or physician haroon stool. R2's Medication ord (MAR) for June 2018, 8, R2 had received Coumadin 4/18, indicated R2 had n, fatigue and hallucinations as lot like appearance and more r stools. R2 continues to or a UTI and her INR had been by antibiotic use. INR was found to be 8.0 (at najor hemorrhage). A stool ed this afternoon and sent with en they departed at 3:25 p.m. A indicated R2 had been	F	757	7		

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/ <sup>,</sup>	13/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FAIR ME	ADOW NURSING HO	ME			SOX 8 300 GARFIELD AVENUE SOUTHEAS ERTILE, MN 56540	r	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757	complaints. R2 ware exceeds normal respale. Anoscopy (a anal canal) revealed (having black pigme was repeated and w hemoglobin (protein oxygen in the blood mg of vitamin K (hei intravenously and w service for further e R2's Hospital Cons- indicated R2 was et (blood in the stool). some bright red bloo occasion on Saturd R2's son reported h previously after she Assessment: diagr greater than would a medical condition acute kidney injury. INR. R2's Hospital Progr indicated an assess 1. Acute lower gas cause was uncertait secondary to diverted digestive tract), her (vascular malformar most likely because 2. Acute blood loss hemoglobin signific	and had not offered any acute is mildly tachycardic (heart rate sting rate) and appeared mildly scope used to examine the d black stool with melanotic entation) features. An INR was greater than 10. R2's in responsible for transporting d) was 8.9 R2 was given 10 elps the blood clot) vas admitted to the hospitalist evaluation and treatment. Fultation Note dated 6/25/18, valuated for hematochezia R2 reported she had passed bod per rectum on one lay. Found to have INR >10. Ther INR had become elevated e had been treated for UTIs. nosis supratherapeutic (levels be used in actual treatment of d) INR, rectal bleeding and thematochezia with elevated ress Note dated 6/26/18, sment which included: trointestinal bleeding. The in. This could have been iculosis (pockets in the morrhoids, angiodysplasia ation of the gut) or cancer, e of the supratherapeutic INR. s anemia. R2 dropped her cantly from 8.9 to 7.4.	F 7	757	DEFICIENCY)		
		f packed red blood cells. ic INR on admission. It was					

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STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	· · /	TE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	CO	MPLETED		
		245545	B. WING		08	/13/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE		
F 757	Continued From pa	-	F 7	57				
	10 mg on admissio 6/25/18.	ssion. R2 was given vitamin K on and 2.5 mg orally on						
	pacemaker placem	, rate controlled, status post nent. gulation with Coumadin. Hold						
	Coumadin for now 6. Urinary tract inf							
	observed seated in	oximately 3:15 p.m. R2 was a recliner, in her room. R2 omed and oriented to person						
	nursing (ADON) ve capacity to perform testing for INR, how testing was require	p.m. the assistant director of erified the facility had the n point of care/finger stick wever, an MD order for the ed and she was not sure if INR ed in the facility standing						
	monitoring for resident anticoagulant thera and the facility also perform the testing	a.m. LPN-C stated side effect dents who received apy included testing for INR b had a machine in house to c. LPN-C stated the staff						
	bloody emesis, or l had experienced a required hospitaliza incident happened	otoms such as bloody stools, bruising. LPN-C confirmed R2 n elevated INR of 8 which ation. LPN-C stated the on a Saturday and verified a						
	bloody stools and f registered nurse (F frank or coffee gro	NA) had reported that R2 had ne had reported this to the RN). LPN-C stated it was not und blood and was a "weird" ed the next day, R2's stool color						

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING	i		08/ <sup>.</sup>	13/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	r	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 757	was darker than the remember if the RN 6/23/18, when the r reported. LPN-C all had a UTI at the tim getting over one. R 6/23/18 was review R2 was offered the On 8/9/18, at 9:33 a anticoagulation mor resident's INR and as bleeding or bruis stools would be a s monitor. LPN-B sta noted she would no shift, or would conta evening shift. On 8/9/18, at 9:42 a R2's primary RN. R specific identified th INR, however, indic reference range ide sheets. RN-B verifi the residents' Coun as needed (PRN) II adjustments made according to the INI would expect staff t symptoms of bleed bleeding or any cha that were black, ma RN-B stated the NA symptoms of bleed any observed symp a progress note. RN	e day before. LPN-C could not N had evaluated R2 or not on maroon colored stool was Iso could not remember if R2 ne or if she had just been R2's Progress Note dated red with LPN-C who confirmed ER and refused.	F	757			

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/	13/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	МЕ			OX 8 300 GARFIELD AVENUE SOUTHEAS <sup>-</sup> ERTILE, MN 56540	r	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757	bleeding and notify RN-B stated she ha 6/23/18, or 6/24/18, maroon stool had b the RN had assess R2's medical record verified the followin 6/23/18, progress maroon stools. R2 received 4 mg Bactrim DS 800-1 on 6/18/18, and R2 antibiotic through th R2's clinical record to indicate R2 had 8 6/23/18. Progress note dat indicated the ADON MD-A on Monday, 6 changed. On 8/9/18, at 11:29 residents on Counts symptoms such as of skin, lethargy, an expect any symptor charge nurse so the monitor to "see whe The ADON stated the them individual INR stated she would re INR parameters. In INR results were re ADON verified on 6 was for 4 mg daily a prescribed Bactrim	the RN and/or the doctor. ad not been working on , so she was not sure if R2's been reported to the RN or if ed R2 once reported to her. d was reviewed with RN-B who	F 7	57			

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/1	3/2018
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			3OX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757	the antibiotic and the been reported to M The ADON verified and confirmed LPN colored stool to her The ADON stated to The ADON stated to The ADON stated st assessment of R2 a monitoring state at family had been at to the day and R2 had responsive with no ADON confirmed R evaluated at the ER therefore, when R2 she had "left in a m The ADON stated st family, however, LP sure if LPN-C had a benefits of R2 refus The ADON stated," trying to determine passed the informa ADON stated she w further stools after s addition, the ADON observation of the r not had R2's dose of contacted the physis was not sure if she differently knowing ADON stated the st and R2 had no other	rovider, MD-B, who prescribed the INR results were to have D-C, who covered for MD-A. she had worked on 6/23/18, -C had reported R2's maroon and they had looked at it. the stool was a weird color. the had LPN-C do a focused and that they [staff] were in a that point. The ADON stated the facility to take R2 out for 8 been coherent and signs of confusion. The 22 had been offered to be 8 for which she had refused had left the facility with family, onitoring state at that time." the had not spoken with the PN-C had done so and was not explained the risks and sing to be evaluated in the ER. "I guess at that point we were what the stool was and tion on [to the next shift]." The vas not aware if R2 had any she had left the facility. In confirmed that following the naroon colored stool, she had of Coumadin held, nor had she totan. The ADON stated she would have done anything then what she knew now. The tool did not have frank blood er symptoms. ADON stated checked the menu to see if een served beets.	F	757			

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING	i		08/	13/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR MEA	ADOW NURSING HOI	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	appearance" and n staff had attributed previous day. R2 th they attributed to a before shift change discuss R2 with sta together" so the firs R2's family to discu to notify them she w The ADON perform revealed the INR le contacted the family was not comfortable ask if they would be for an evaluation. Of the ADON contacte orders to transport verified at the ER, F bleed and subseque blood during a four ADON stated she c R2's INR on 6/23/18 adverse interactions antibiotics, however she was not R2's pr not know her histor stated following R2' formal discussion w regarding R2's hosp however, she had ta about the incident. had not made any of monitoring system I done what they sho since had her order	ge 51 maroon stools with a "clotting nore lethargy, however, the the lethargy to R2's outing the en began hallucinating which UTI. The ADON stated just is she had the opportunity to off and was able to "put it all st thing she did was contact iss possible hospitalization and would be testing R2's INR. He the INR test which wel was 8. The ADON y again to inform them she e with R2's INR results and e willing to send R2 to the ER Once the family had approved, d the physician and received R2 to the ER. The ADON R2 was diagnosed with a GI ently had received two units of day hospitalization. The could have probably tested 8, as she was aware of the s between Coumadin and r, not to make excuses, but rimary RN and probably did y as well as RN-B. The ADON 's adverse medication event, a with the interdisciplinary team pitalization was not conducted, alked with RN-B and LPN-C The ADON stated the facility changes to the anticoagulant because they felt they had or f coumadin discontinued. a.m. the unit clerk (UC) three residents in house who	F 7	757			

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT OF DEFICI AND PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		245545	B. WING	·		08/	13/2018
NAME OF PROVIDER	OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR MEADOW N	URSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	Г	
PREFIX (EAG	CH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Currentl R29. On 8/9/ (DON) of flag and ADON to checked contacts she felt in order improve On 8/9/ and fac monitor anticoa prescrite yrescrite was Cip (Bactrin often. F reviewed done th relied o stated t antibioti testing, testing a asked f maroon and sho	18, at 12:01 confirmed R I stated she to have assed d an INR, he ed the physic the situation to identify a ement. 18, at 4:13 p ility medical ing for resid gulant medi bed antibiotion bed antibiotion d with MD-A at differently n the pharm he physician cs should h nursing sho and/or the p or earlier IN colored sto build have be tated he wo when R2 ha AD-A indicat acility policy per nursing	ge 52 Coumadin, R13, R19, and p.m. the director of nursing 2's maroon stool was a red would have expected the essed the patient herself, eld the Coumadin, and ician. The DON also stated in should have been reviewed areas for facility process o.m. R2's primary physician director, MD-A indicated the lents who received cation who were also cs depended on the antibiotic stated usually if the antibiotic stated usually if the antibiotic is order from 6/18/18, was A who stated he would have y. MD-A stated the physicians nacy to help nursing out. He n who prescribed the ave ordered earlier INR build have asked for earlier INR harmacist should have also R testing. MA-D confirmed a bol was a cause for concern een a signal to call someone. uld have expected to be ad the first maroon colored ted the staff had been working y to include INR testing to be g discretion, however, stated a or without policy changes	F	757			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/07/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245545	B. WING			08/1	13/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			3OX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757	particularly if the re- medication. MD-A policy regarding nur Coumadin medicati indicated they shou physician prior to gi The undated Thera directed staff to enso obtained per standi The policy also dire warfarin (Coumadir bleeding (i.e. bruisin bleeding, signs of b etc.) nursing discre a finger stick INR in The undated Antico indicated the physic serious medication example: concurrer amiodarone and ma also indicated the p change medications or monitor PT/INR individual received stabilized. The poli physician would mo complications in ind anticoagulated and problems. If an ind therapy showed sig hematuria (blood in up blood), or other nurse would discus physician before giv of anticoagulant.	sident was on anticoagulant was unsure of the facility rsing staff holding the ion without an order but ald have contacted the iving the medication. Appeutic Monitoring of INR policy sure a physician order was ing orders or physician order. Eacted if a resident was on n) therapy and had signs of ng, bleeding gums, rectal blood in stool, blood in urine, etion could be used to complete n house. Dagulation Management policy cian would identify potentially interactions with warfarin for nt use with digoxin, Dilantin, any antibiotics. The policy ohysician would stop, taper, or s that interacted with warfarin, very closely while the warfarin to ensure the PT/INR icy also indicated the staff and	F 7	757			

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CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545	· ·	S	E CONSTRUCTION	FC OMB (X3	TED: 09/07/2018 DRM APPROVED NO. 0938-0391 ) DATE SURVEY COMPLETED 08/13/2018
FAIR ME	ADOW NURSING HO	ME		F	ERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 757	facility implemented -checked the curren currently received O -updated the facility INR testing -updated their antice increased monitorin -educated all nursin policies including th non-therapeutic INF -developed a plan t ensure education w of their next shift. -updated their proce interdisciplinary tea hospital admission	10/18, at 11:00 a.m. when the d the following actions: Int INR levels of residents who Coumadin y standing orders regarding coagulation policy to include ing while on antibiotics ing staff regarding the updated ine signs and symptoms of a R to educate staff not working to was received prior to the start edures to include im review of each resident for measures to prevent talizations or medication	F	757			
	R19's diagnoses in behavioral disturba thrombosis (blood o anticoagulant use. R19's 14 day MDS	eport dated 8/10/18, indicated cluded dementia with nces, chronic embolism and clot), edema, and long term dated 6/5/18, indicated R19					
	ambulate, and required one to two staff for R18 received anticed during the MDS reference R19's Order Summarevealed an order for the statement of the statement	paired cognition, did not nired extensive assistance of ADLs. The MDS also indicated pagulant medication daily erence period. nary Report dated 8/10/18, or Aspirin 81 mg daily, and ily for chronic embolism and					

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		AND HUMAN SERVICES				FORM	09/07/2018 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY PLETED
		245545	B. WING	i		08/	13/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	т	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 757	thrombosis. The ph INR checks. The re antibiotic medicatio R19's FMNH fax re indicated R19's mo physician response dose of coumadin a weeks then monthly R13's quarterly MD R13's diagnoses into of a UTI. The MDS moderately impaire assist of one to two living (ADL) except anticoagulant media reference period. R13's FMNH fax re R13's INR was 1.5 with an order to inci- daily and to rechect R29's quarterly MD R29's diagnoses ind diabetes, Parkinsor dementia. The MDS cognition, required all ADLs except for independent, requir and received antico during the MDS refe R29's INR was 1.5 drop since the 8/1/1 responded with an	and recheck the INR in two staff for activities of daily for eating, and received cation daily during the MDS and the physician responded rease the Coumadin to 2 mg k the INR in two weeks. So dated 8/9/18, indicated cluded diabetes, and a history also indicated R13 had do cognition, required extensive o staff for activities of daily for eating, and received cation daily during the MDS and the physician responded rease the Coumadin to 2 mg k the INR in two weeks. So dated 6/27/8, indicated cluded anemia, heart failure, n's, a seizure disorder and So also indicated R29 had intact extensive staff assistance for eating in which R29 was red supervision for transfers, pagulant medicaiton daily		757			

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TATEMENT	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		0. 0938-039 TE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		3		MPLETED		
		245545	B. WING		08	8/13/2018		
NAME OF I	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CO	DE			
FAIR ME	ADOW NURSING HO	ME	BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 757	Continued From pa	age 56	F 757	,				
	two weeks and 4 w	eeks.						
F 880 SS=F			F 880	)		9/30/18		
	infection prevention designed to provide comfortable enviro development and t diseases and infect §483.80(a) Infection program. The facility must est and control program a minimum, the fol §483.80(a)(1) A sy reporting, investigat and communicable staff, volunteers, vi providing services arrangement based conducted accordin accepted national st	stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable tions. n prevention and control stablish an infection prevention m (IPCP) that must include, at lowing elements: stem for preventing, identifying, ting, and controlling infections e diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards;						
	procedures for the but are not limited (i) A system of surv possible communic infections before th persons in the facil (ii) When and to we communicable dise reported;	veillance designed to identify cable diseases or ney can spread to other						

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY	
ND PLAN C	F CORRECTION	DENTIFICATION NUMBER:		ING	COMPLETED		
		245545	B. WING		08/	13/2018	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP (	CODE		
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SO FERTILE, MN 56540	UTHEAST	ST	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD BE	(X5) COMPLETIO DATE	
F 880	Continued From pa	ige 57	F 8	80			
	<ul> <li>(iv)When and how resident; including</li> <li>(A) The type and dedeending upon the involved, and</li> <li>(B) A requirement to least restrictive posicircumstances.</li> <li>(v) The circumstan must prohibit emploid disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in §483.80(a)(4) A system in the system of the system of</li></ul>	uration of the isolation, e infectious agent or organism hat the isolation should be the ssible for the resident under the ces under which the facility byees with a communicable skin lesions from direct nts or their food, if direct t the disease; and ne procedures to be followed direct resident contact.					
		ndle, store, process, and as to prevent the spread of					
	IPCP and update the	review. duct an annual review of its neir program, as necessary. NT is not met as evidenced					
	Based on interview facility failed to esta program which incl for the care and tre infections. In addit develop and mainta program, which wa	v and document review, the ablish an infection control uded policies and procedures atment of residents with ion, the facility failed to ain an infection surveillance s completed timely in order to and/or potential infectious		Infection control deficiency QAA 8/22/18. This topic is priority. Infection and preve will include a system for pre- identifying, reporting, inves controlling infections and co- diseases for all staff and re QAA Committee has assign	a QAA □s top ention program eventing, tigating, and pmmunicable sidents. The		

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				ייסו		NO. 0938-03
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
		245545	B. WING_			08/13/2018
NAME OF	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
FAIR ME	ADOW NURSING HO	ME			OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
F 880	Continued From pa	age 58	F 88	80		
	to have oxygen and equipment stored i Findings include: On 8/13/18, at 11:3 program was review	I of 1 resident (R19) observed d nebulizer treatment n the bathroom, uncovered. 35 a.m. the infection control wed with the director of nurses ninistrator. The administrator			February 2018. The QAPI team and QAA are monitoring progress. New surveillance reporting policy discusses who should receive resulting information after surveillance has been completed. Infection control log initiated on each resident wing to be tracked by charge nurses as illnesses/symptoms/infection	
	stated the current I less than one week former DON had le When the infection reviewed by the fac the facility lacked p monitoring informa program. The adm policies had been r	DON had started at the facility or prior to the survey. The set the facility in May 2018. control information was cility, they had identified that policies, procedures and tion for the infection control inistrator stated the facility missing since May 2018. The cility had started collecting			occur. All new infections and antibiotics be logged with symptoms and isolation precautions to be initiated by primary charge nurse. Symptoms are to be tracked until they resolve per policy. Compliance will be monitored by antibio stewardship RN. DON will assess infection patterns among residents and employees. Isolation precautions will be discontinued per policy depending on	s to otic
	infection control po throughout the faci and had placed the Review of the infect policies and proceed follow up of infection surveillance report grid related to whice equipment was reco organism. At 11:45 policies and proceed and did not give clea	licies as they were located lity including the DON's office em into a three ring binder. Attion control binder, included dures for the identification and ons, hand washing, ing, contact precautions and a th type of personal protective quired for an identified a.m. the DON confirmed the dures were not comprehensive ear facility guidance for the			infectious organism/agent. New policies written for Use and Storag of Blood Glucose Monitors, Obtaining a UA from an Indwelling Urinary Catheter Performing a Blood Glucose Test, Associate Illness, Shingles, Antibiotic Stewardship, Surveillance, Infection Identification, Environmental Culturing, Environmental Rounds, High Level Disinfection, Intermediate Level Disinfection, Low-level Disinfection, Resident Care Equipment, Sterilization Critical Devices, Cleaning of	of
					CPAP/Bi-Level Equipment, Cleaning o Nebulizer Equipment, Cleaning of Oxyg Equipment, Linen Handling, Multi-drug Resistant Organisms, Guidelines for MRSA, Guidelines for VRE, C-Diff,	gen

Facility ID: 00460

		(X2) MULTI	PLE			E SURVEY
	IDENTIFICATION NUMBER:					PLETED
	245545	B. WING _		08/13/2018		
VIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
OW NURSING HO	ME					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE
ontinued From pa	age 59	F 88	80			
At 11:50 a.m. the f as reviewed with dministrator. The cility had been ur fection surveilland dministrator state ompleted surveilland arrent DON started dministrator state of reviewing the re- entified concern s illness or antibio g. At 11:55 a.m. the f l progress notes of cords on a daily f pe of signs and s fection control log e only staff memily mptoms of infect of responsible for e infection control fections/signs or corded in real time sident developed quire isolation teo ave approved poli- uide the staff. At 1:15 p.m. the ac- nowledge, the fac- pe of infectious o me Facility Assess e facility would had	Facility infection surveillance the DON and the administrator stated the nable to locate any type of ce prior to May 2018. The d the interim DON had ance from 5/9/18, until the d on 8/1/18. The d the DON's were responsible cords and placing any such as signs and symptoms tic use on the infection control DON confirmed she reviewed entered into the computer basis and documented any ymptoms of illness on an g. The DON confirmed she was ber reviewing the records for ion as the staff nurses were documenting information onto d logs. The DON confirmed the symptoms of illness were not he. The DON indicated if a an illness, which would chniques, the facility did not cies or procedures in which to dministrator stated to her ility had not experienced any utbreak in the past 12 months.			and Cleaning, Disinfection and Sterilization. Employee illnesses are to be record DON to ensure resident safety and prevent the spread of illness. Association their duration depending on infection Staff symptoms will be logged to see any patterns exist. The sick slips employees fill out on return from an include the symptoms of illness. The relevance of this was reiterated to see the nursing staff meetings on 8/20 a 8/28/18. Other department heads direction on 8/31/18 to remind their departmental employees to include nature of their illness on the sick slip return to work. A facility map will be used monthly show locations of infections/ illness show 'at a glance' any patterns. Antibiotic Stewardship RN/DON to monitor log daily to look for patterns. Command hooks were hung on resist walls 8/10/18 for O2 tubing to be hund Oxygen concentrators and tubing we be stored in resident bathrooms. Oxygen tubing safety policy update include safe storage including tubing Care sheets updated regarding tub placement and using command how Closed three bin storage system in for all residents with nebulizers for a storage outside of resident bathrooms	ded by to ciate s and n type. e if a illness beatff at and given the p upon to es to s. ident ung on. <i>i</i> ll not d to g. ing pks. itiated safe m	
	FOR MEDICARE DEFICIENCIES CORRECTION OVIDER OR SUPPLIER OW NURSING HO SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ONTINUED FROM DA AL 11:50 a.m. the f as reviewed with dministrator. The actility had been ur fection surveilland dministrator state ompleted surveilland dministrator state ompleted surveilland dministrator state of reviewing the re- entified concern s fillness or antibio g. At 11:55 a.m. the f appendix staff memily pe of signs and s fection control log to responsible for the infection control for responsible for the infection control fections/signs or ecorded in real time esident developed ave approved polition to the staff. At 1:15 p.m. the ar- nowledge, the fac pe of infectious o the Facility Assess the facility would har- ogram in which the period and the staff.	CORRECTION       IDENTIFICATION NUMBER:         245545         VIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ontinued From page 59         At 11:50 a.m. the facility infection surveillance as reviewed with the DON and the dministrator. The administrator stated the icility had been unable to locate any type of fection surveillance prior to May 2018. The dministrator stated the interim DON had ompleted surveillance from 5/9/18, until the urrent DON started on 8/1/18. The dministrator stated the DON's were responsible or reviewing the records and placing any entified concern such as signs and symptoms f illness or antibiotic use on the infection control g.         At 11:55 a.m. the DON confirmed she reviewed I progress notes entered into the computer secords on a daily basis and documented any pe of signs and symptoms of illness on an fection control log. The DON confirmed she was ee only staff member reviewing the records for //mptoms of infection as the staff nurses were of responsible for documenting information onto ee infection control logs. The DON confirmed the fectorded in real time. The DON indicated if a esident developed an illness, which would equire isolation techniques, the facility did not ave approved policies or procedures in which to	FOR MEDICARE & MEDICAID SERVICES         IDEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         ABUILDIN 245545         DWINCE         OW NURSING HOME         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ON THE ACTION TO A DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ON THE ACTION TO BE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ON THE ACTION TO A DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ON THE ACTION TO A DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ON THE ACTION TO A DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ON THE ACTION TO A DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ATT 11:50 a.m. the facility information otho BY THEOR CONCENT STATED TO MAY 2018. The dministrator stated the DON'S were responsible or reviewing the records for ymptoms of infection as the staff nurses were to responsible for documenting information onto the infection control logs. The DON confirmed the faction control logs. The DON confirmed the faction techniques, the facility did not ave approved policies or procedure	FOR MEDICARE & MEDICAID SERVICES         DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245545         B WING	FOR MEDICARE & MEDICAID SERVICES         OI           DEFICIENCIES ORRECTION         (x1) PROVIDERSUPPLIERCLIA DENTIFICATION NUMBER: 245545         (x2) MULTIPLE CONSTRUCTION A BUILDING 245545         (x2) MULTIPLE CONSTRUCTION A BUILDING EDITIFICATION NUMBER: 245545         (x2) MULTIPLE CONSTRUCTION A BUILDING EDITIFICATION NUMBER: 245545           OW NURSING HOME         STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540           OW NURSING HOME         STREET ADDRESS, CITY, STATE, ZIP CODE BOX 8300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540           Outside Construction of DEFICIENCIES (EACH DERICENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX FRESTILE, MN 56540           Ontimued From page 59 ontinued From page 59 ont thinistrator. The administrator stated the icitity had been unable to locate any type of fection surveillance prior to May 2018. The diministrator stated the DON and the imministrator stated the DON swere responsible inflects surveillance from 5/9/18, until the irrelevion glain bere rocive and placing any entified concern such as signs and symptoms illness on antibiotic use on the infection control g.         F 880           11 155 a.m. the DON confirmed she reviewed progress notes entered into the computer fection sorking the records for mptoms of infection as the staff nurses were not coorded in real time. The DON indicated if a sident developed an illness, which would aguire isolatin techniques, the facility did not ave approved policies or procedures in which to ide the staff.         A facility map will be used monthy is show locations of infections infection sufficience and lagence' any patterns. Antibiotic Stewardship RN/DON to monontoro	FOR MEDICARE & MEDICAID SERVICES         OND NO.           DEFICIENCIES         (X2) MULTIPLE CONSTRUCTION         (X3) DATA           DERFECTION         245545         8. WING         (X3) DATA           OW NURSING HOME         STREET ADDRESS, CITY, STATE, ZIP CODE         BX VING         08/           OW NURSING HOME         STREET ADDRESS, CITY, STATE, ZIP CODE         BX VING         08/           OW NURSING HOME         STREET ADDRESS, CITY, STATE, ZIP CODE         BX VING         08/           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DEVIFUTION INFORMATION)         PRECENT TAG         PROVIDERS PLAN OF CORRECTION (EACH OORRECTIVE ACTION SINGLID BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         PROVIDERS PLAN OF CORRECTION (EACH OORRECTIVE ACTION SINGLID BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           ONTINE         DEFICIENCY (EACH CORRECTIVE ACTION SINGLID BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F8 800           Influenza Vaccine for Residents, Influenza Vaccine for Residents, Influenza Vaccine for Residents, Influenza Vaccine for Residents, Influenza Vaccine for Resident S, Prevention of Catheter-Associated UTI-S and Cleaning, Disinfection and Sterilization.         F8 800           Influenza Vaccine for Resident S, Influenza Vaccine for Resident S, Influenza Vaccine for Resident S, Prevention of Catheter-Associated UTI-S and Cleaning, Disinfection and Sterilization.         Statission Signal Signal Signand Symptoms of liness and symptoms of illness and peof signs a

Facility ID: 00460

If continuation sheet Page 60 of 64

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED		
		IDENTIFICATION NOMBER.	A. BUILDII	NG _		COM			
		245545	B. WING			08/1	3/2018		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE				
FAIR ME	ADOW NURSING HO	DME			OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE		
F 880	required complex of Infections such as infection, influenza disease could be to facility assessmen control program in management of th the facility assess monitoring of the in in a timely manner On 8/7/18, at 7:32 equipment (mask, was observed on a shelf located to the uncovered. R19's cannula were coile Velcro on R19's co bathroom. -At 7:46 p.m. R19 nebulizer treatmen On 8/8/18, at 9:05 equipment (mask, were observed on shelf located to the uncovered. R19's cannula were observed on shelf located to the uncovered. R19's cannula were observed on	care and care management. skin, respiratory, urinary and other common infectious reated in the facility. The t indicated the facility infection cluded monitoring and e identified diagnoses. Lastly, nent indicated surveillance and infections was to be completed	F 8	80	for main entry area. Gloves are to be moved out of reside bathrooms and placed upon entran- resident room along with hand sanifie each resident room by 9/30/18. Infe- control education provided at all sta- meeting on 8/20/18 and 8/28/18. Skills fair upon employee hire and annually to cover infection control, handwashing, standard precautions isolation. Safe transport of linen is addressed hire and annually at our skills fair. O2 training for nursing employees of and annually to include safe storage infection control. DON is scheduled to visit neighbori Nursing Home on 8/23/18 to gain knowledge on their infection control program and their antibiotic steward program. Oxygen, neb treatment, and crash of education by Northwest Respiratory scheduled for Sept. 2018. Random audits will be done on all s check for appropriate infection control practices by RNs and DON. Audits will be given to QAA, which w made aware of deficiencies at meet	ce into tizer in ection off s, and d on bon hire e r/t ng dship cart / chifts to rol was			
	concentrator was o uncovered nasal c bar located to the r	a.m. R19's oxygen observed in bathroom with an annula draped over the towel right of the sink. ders provided on 8/10/18,			compliance. Completed: 9/30/2018.				

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY		
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:		NG	CON	IPLETED		
		245545	B. WING_		08/	13/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
AIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE		
F 880	Continued From pa	ge 61	F 88	30				
		urations to keep >90% every 8						
		PRN) for complaints of						
		, /DuoNeb solution 0.5-2.5 nilliliters (ml) administer one						
		o times daily and every 6						
	hours prn for comp	laints of shortness of breath.						
	On 8/9/18 at 2:06 r	o.m. registered nurse (RN)-A						
		nnula and nebulizer equipment						
		d, uncovered, in a resident's						
	bathroom. RN-A co during the night hou	onfirmed R19 required oxygen urs.						
	would not expect to	p.m. the DON stated she find oxygen & nebulizer a resident's bathroom.						
	indicated that oxyge	Safety policy dated 4/6/18 en tubing was to be stored in a in use. This policy did not equipment						
F 881 SS=F	Antibiotic Stewards	hip Program	F 88	31		9/15/18		
	program.	n prevention and control						
		tablish an infection prevention n (IPCP) that must include, at owing elements:						
	that includes antibio system to monitor a This REQUIREMEN	ntibiotic stewardship program otic use protocols and a antibiotic use. NT is not met as evidenced						
		v and document review, the elop an antibiotic stewardship		Antibiotic Stewardship discusse 8/22/18. This topic is one of Q/ priorities.				

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	& MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-
	IDENTIFICATION NUMBER:			COMPLETED
	245545	B. WING		08/13/201
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ADOW NURSING HO	ME			AST
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	ILD BE COMPLI
protocols and a syst to include how the implemented and a deficient practice h residents who resid Findings include: On 8/13/18, at 11:3 control program wa nursing (DON) and infection control pro facility-wide system antibiotics which in appropriate prescri before antibiotic us antibiotic use by ph lacked protocols for symptoms, labs, de antibiotic use and r identified. -At 11:40 a.m. the a DON had left the fa infection control pro place prior to May 3 located. To the adu facility did not have program and they o policies or procedu stewardship was bo facility. The admin followed the orders	estem to monitor antibiotic use, program would be antibiotic use monitored. This ad the potential to affect all 40 ded in the facility's infection as reviewed with the director of the administrator. The ogram lacked protocols for a n to monitor the use of cludes (but not limited to) bing of antibiotics, criteria are and periodic review of hysicians. The program also or review of signs and etermination of appropriate reporting of any patterns administrator stated the former acility in May 2018 and any actices, which had been in 2018, were unable to be ministrator's knowledge, the e any antibiotic stewardship did not have any type of ures to ensure antibiotic eing implemented at the istrator stated the facility staff as prescribed by the attending	F 88	<ul> <li>New policy written for Antibiotic Stewardship to include protocols systems to monitor antibiotic use improve the safety and quality of care.</li> <li>DON is scheduled to visit neight Nursing Home on 8/23/18 to gain knowledge on their infection com- program and their antibiotic stew program.</li> <li>Infection control log will include s monitoring during antibiotic use a Staff symptoms will be logged to any patterns exist.</li> <li>A facility map will be used month show locations of infections/ illnes show 'at a glance' any patterns.</li> <li>Charge nurses working the floor infection control log as illnesses/ symptoms occur.</li> <li>Primary RN's/DON to monitor log look for patterns.</li> <li>New surveillance reporting policy discusses who should receive re information after surveillance has completed.</li> <li>Employee illnesses are to be rece charge nurse upon call-in and gin DON to ensure resident safety a prevent the spread of illness.</li> <li>New policies written for Associatt Shingles, Antibiotic Stewardship,</li> </ul>	e to resident poring trol ardship symptom and after. see if ly to esses to will fill out g daily to y sulting s been orded by yen to nd to e Illness,
	PROVIDER OR SUPPLIER ADOW NURSING HO SUMMARY ST/ (EACH DEFICIENC REGULATORY OR I Continued From pa protocols and a syst to include how the implemented and a deficient practice h residents who resid Findings include: On 8/13/18, at 11:3 control program wa nursing (DON) and infection control pro- facility-wide system antibiotics which in appropriate prescri before antibiotic us antibiotic use by pr lacked protocols for symptoms, labs, de antibiotic use and r identified. -At 11:40 a.m. the a DON had left the fa infection control pro- place prior to May 1 located. To the add facility did not have program and they of policies or procedu stewardship was b facility. The admin followed the orders physicians. The admin	OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         DEF CORRECTION       10ENTIFICATION NUMBER:         245545         PROVIDER OR SUPPLIER         ADOW NURSING HOME         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 62 protocols and a system to monitor antibiotic use, to include how the program would be implemented and antibiotic use monitored. This deficient practice had the potential to affect all 40 residents who resided in the facility.         Findings include:         On 8/13/18, at 11:35 a.m. the facility's infection control program was reviewed with the director of nursing (DON) and the administrator. The infection control program lacked protocols for a facility-wide system to monitor the use of antibiotics which includes (but not limited to) appropriate prescribing of antibiotics, criteria before antibiotic use and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns	COP DEFICIENCIES FORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIF A. BUILDING         245545       B. WING	OF DEFICIENCIES       (X1) PROVIDERSUPPLIENCLIA       (X2) MULTIPLE CONSTRUCTION         DF CORRECTION       245545       B. WING         ADOW NURSING HOME       STREET ADDRESS, CITY, STATE, ZIP CODE         BADOW NURSING HOME       STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MEST PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREVIX       PROVIDERS PLANO OF CORRECT (EACH DEFICIENCY)         Continued From page 62 protocols and a system to monitor antibiotic use, to include how the program would be implemented and antibiotic use monitored. This deficient practice had the potential to affect all 40 residents who resided in the facility's infection control program mas reviewed with the director of nursing (DON) and the administrator. The infection control program lacked protocols for a facility-wide system to monitor the use of antibiotic use by physicians. The program allo tacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and periodic review of antibiotic use by physicians. The program allo tacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and periodic review of antibiotic use and periodic stawardship program and they did not have any type of policies or procedures to ensure antibiotic stewardship was being implemented at the facility. The administrator stated the facility staff followed the orders as prescribed by the attending physicians. The administrator stated the facility staff

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		AND HUMAN SERVICES				FORM /	09/07/2018 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				E SURVEY PLETED
		245545	B. WING	i		08/1	3/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			OX 8 300 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 881	Continued From pa	nge 63	F	381	tested for infections agents/organisr Infection control log initiated on each resident wing to be tracked by charge nurses as illnesses/symptoms/infect occur. All new infections and antibio be logged with symptoms and isolat be initiated by primary charge nurse Symptoms to be tracked until resolv policy. Compliance will be monitored Antibiotic Stewardship RN. DON will assess infection patterns among res and employees. Antibiotic Usage Report log includes resident, antibiotic, dose, length of treatment, date of culture, organism sensitivity to antibiotic, clinical signs infection, physician involved, and wh the infection was resolved. Criteria for initiating antibiotics for ar indication of urinary tract infection education from the State Operations Manual provided to RN Unit Coordin and added to infection control log. Primary RN's/DON to monitor log da look for patterns. Education provided to CNA□s/Nursi staff at all staff meeting held on 8/20 and 8/28/18. Staff members were educated on the importance of preve and early detection and reporting of symptoms of infection. QAA was made aware of deficiencies meeting on 8/22/18 and will monitor compliance. Completed: 9/15/2018	h ge tions otics to tion to e ved per d by l sidents s of nen n s nators aily to ing D/18 rention	

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The second line is a second second		AND HUMAN SERVICES & MEDICAID SERVICES	-	F5545027	FORM	: 09/10/2018 APPROVEL 0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245545	B, WING			/08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUT FERTILE, MN 56540	HEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 00	00		
	FIRE SAFETY					
	ALLEGATION OF O					
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOU VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio Fair Meadow Nursin compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, ng Home was found not in a requirements for participation hid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), Health Care and the 2012 Health Care Facilities Code.				
	copy of the plan of o PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY TAGS) TO:		EPO	C	
	HEALTH CARE FIR					
		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	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.

a second s		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	09/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE COMF	E SURVEY PLETED
		245545	B, WING			08/0	8/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	_	
FAIR ME	ADOW NURSING HO	ME			BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/o responsible for corr prevent a reoccurre Fair Meadow Nursi without a basement different times. The constructed in 1967 Type II(111) constru- was added to the o determined to be of The south wing is a fire barrier from an facility is divided int 30 minute fire barrier The facility has a find detection throughout	ET, SUITE 145 01-5145, or tate.mn.us @ state.mn.us @ state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. ng Home is a 1-story building, t, and constructed at 2 e original building was 7 and was determined to be of uction. In 1972 the south wing riginal building and was f Type II (111) construction. separated with at least a 2 hour apartment building. The to 4 separate smoke zones by ers. re alarm system with smoke ut the corridor system and in	K	000			
	NFPA 72 "The National International Internat	nstalled in accordance with onal Fire Alarm Code" 1999 Itic fire department notification.					

Facility ID: 00460

If continuation sheet Page 2 of 5

	Non-othersteinte statue auto-oscure vature of each	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	09/10/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245545	B. WING		08/	08/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	_	
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTHEAS FERTILE, MN 56540	а <b>т</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
K 000 K 353 SS=E	automatic fire sprin accordance with NF Installation of Autor quick response hea automatic fire detect system. The facility smoke detectors in The facility has a ca census of 40 at the The requirement at NOT MET as evide Sprinkler System - CFR(s): NFPA 101 Sprinkler System - CFR(s): NFPA 101 Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspe maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMARI any non-required or system. 9.7.5, 9.7.7, 9.7.8, a	<ul> <li>pletely protected by an kkler system installed in FPA 13 Standard for the natic Sprinkler Systems with ads. Hazardous areas have be toon that is on the fire alarm also has battery operated all resident sleeping rooms.</li> <li>apacity of 42 beds and had a time of the survey.</li> <li>42 CFR, Subpart 483.70(a) is need by:</li> <li>Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, an ining of Water-based Fire too and testing are sure location and readily.</li> <li>Apstern last checked apstern test upply source</li> <li>KS information on coverage for partial automatic sprinkler</li> </ul>	К 0	000		8/23/18

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		& MEDICAID SERVICES			MB NO.	E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		6 01 - MAIN BUILDING 01		PLETED
		245545	B. WING	r	08/	08/2018
AME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AIR ME	ADOW NURSING HO	ME	BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 353	Continued From pa	age 3	K 353	3		
	by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of residents, staff and visitors.			Sprinkler head was replaced on 0 by Simplex Grinnell. Monitoring to done by Maintenance Supervisor completion of any painting or rend	o be upon	
	Findings include:					
		between 9:00 am to 12:30 pm servations revealed a sprinkler om 14 full of paint.				
		ition was confirmed by the or and the Maintenance				
K 920 SS=D	Electrical Equipme CFR(s): NFPA 101	nt - Power Cords and Extens	K 920	0		8/16/18
	Extension Cords Power strips in a pa used for componer patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power st may not be used for electronics), excep rooms that do not u PCREE meet UL 1 strips for non-PCR	nt - Power Cords and atient care vicinity are only its of movable d electrical equipment es that have been assembled nel and meet the conditions of rips in the patient care vicinity or non-PCREE (e.g., personal t in long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient				

Facility ID: 00460

If continuation sheet Page 4 of 5

and the second second second		AND HUMAN SERVICES & MEDICAID SERVICES		FO OMB	ED: 09/10/2018 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245545	B. WING		08/08/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FAIR ME	ADOW NURSING HO	ME		BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
К 920	care rooms, power standards. All pow precautions. Exten substitute for fixed Extension cords us immediately upon of which it was installed 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3 (D This REQUIREMENT by: Based on observation facility failed to ens and multiple outlet with the 2012 edition 10.24.2.1. This de and an undetermined and visitors. Findings include: On the facility tour for on 08/08/2018 observation extension cord, ser multiplug adapter a station.	ge 4 strips meet other UL er strips are used with general sion cords are not used as a wiring of a structure. ed temporarily are removed completion of the purpose for ed and meets the conditions of , 10.2.4 (NFPA 99), 400-8 0) (NFPA 70), TIA 12-5 NT is not met as evidenced tion and staff interview the ure the use of extension cords adapters are in accordance of NFPA 99 section eficient practice could affect ed amount of residents, staff between 9:00 am to 12:30 pm ervations revealed an ving a light, plugged into a across from the main nurses ation was confirmed by the bor and the Maintenance	К 920	Multiple plug in adapter and extension cords were removed. Down's Electric relocated an additional outlet in this are by nurses station on 08/16/2018. Facility wide inspection done by Maintenance Supervisor on 8/16/18 to make sure compliance is being followe Random monthly audits done by Maintenance Staff added to maintenar checklist.	ea

Facility ID: 00460

If continuation sheet Page 5 of 5



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 27, 2018

Administrator Fair Meadow Nursing Home Box 8 300 Garfield Avenue Southeast Fertile, MN 56540

Re: State Nursing Home Licensing Orders - Project Number S5545027

Dear Administrator:

The above facility was surveyed on August 6, 2018 through August 13, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Fair Meadow Nursing Home August 27, 2018 Page 2 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, Unit Supervisor at (218) 308-2104 or lyla.burkman@state.mn.us.

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE S COMPL	
		00460	B. WING		08/1	3/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	) GARFIELD MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this corre- pursuant to a surver found that the defice herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of wit corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The State delineated on the a	o participate in the electronic insure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ttached Minnesota		NH LICENSING CORRECTION O In accordance with Minnesota Stat section 144A.10, this correction or been issued pursuant to a survey. reinspection, it is found that the de or deficiencies cited herein are not	ute, der has If, upon ficiency	
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

Electronically Signed

STATE FORM

If continuation sheet 1 of 56

09/04/18

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00460	B. WING		08/13/2018	
	PROVIDER OR SUPPLIER	ME BOX 8 30	0 GARFIELI	STATE, ZIP CODE D AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	MN 56540 ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "corr text. You must then State licensure pro- completion date, th corrected prior to el Minnesota Department's staff the following correct Please indicate in y correction that you and identify the data Minnesota Department's staff the following correct Please indicate in y correction that you and identify the data Minnesota Department the State Licensing federal software. Ta assigned to Minness Nursing Homes. The assigned tag n column entitled " II statute/rule out of c "Summary Statement and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow are the Suggested Time period for Corr PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 8/13/18, surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed. The tof Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and trection. ARD THE HEADING OF THE	2 000	corrected, a fine for each violat corrected shall be assessed in accordance with a schedule of promulgated by rule of the Min Department of Health. Determination of whether a vio been corrected requires compl all requirements of the rule pro tag number and MN Rule numl indicated below. When a rule of several items, failure to comply the items will be considered lac compliance. Lack of compliant re-inspection with any item of r rule will result in the assessme even if the item that was violate the initial inspection was correct You may request a hearing on assessments that may result fr non-compliance with these ord provided that a written request the Department within 15 days of a notice of assessment for non-compliance. INITIAL COMMENTS:	fines nesota lation has iance with vided at the per contains with any of ck of ce upon nulti-part nt of a fine ed during cted. any om ers is made to	

Minneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	SURVEY PLETED
		00460	B. WING		08/1	3/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	0 GARFIELD , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	age 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 265	MN Rule 4658.008 Resident Health St	5 Notification of Chg in atus	2 265			9/1/18
	A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:					
		involving the resident which has the potential for requiring ion;				
	physical, mental, c example, a deterio	t change in the resident's or psychosocial status, for ration in health, mental, or s in either life-threatening al complications;				
	example, a need to	Iter treatment significantly, for discontinue an existing form adverse consequences, or to of treatment;				
	D. a decision resident from the n	to transfer or discharge the ursing home; or				
Minnosota D	epartment of Health					

Minnesc	Minnesota Department of Health							
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLE			
		00460	B. WING		08/13	/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
FAIR ME	ADOW NURSING HO		0 GARFIELD MN 56540	AVENUE SOUTHEAST				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE		
2 265	Continued From pa	ge 3	2 265					
	E. expected an	d unexpected resident deaths.						
	This MN Requireme	ent is not met as evidenced						
	Based on interview facility failed to ensi- of signs and sympto- resident (R2) who e concurrent anticoag failure resulted in a	and document review, the ure the physician was notified oms of bleeding for 1 of 1 experienced adverse effects of gulant and antibiotic use. This ctual harm for R2 due to the estinal bleed which required blood transfusions.		Corrected.				
	Findings included:							
	4/27/18, indicated F had diagnoses whic infection, long term thinner), therapeutic atrial fibrillation (an increases the risk o The MDS also indic assistance with all a	num Data Set (MDS) dated R2 was cognitively intact and ch included urinary tract use of anticoagulants (blood c drug level monitoring, and irregular heartbeat that of stroke and heart disease). cated R2 required extensive activities of daily living except eived anticoagulant						
	Catheter Care Area 7/11/18, indicated F of urinary tract infec	inence and Indwelling Assessment (CAA) dated 2 had a longstanding history ctions (UTI) with history of n, hallucinations and delusions I.						
Minnesota D	had a history of atri pacemaker, and hy antihypertensive mo	ed 7/11/2018, indicated R2 al fibrillation, use of pertension with use of edication that could contribute ension and cause falls. The						

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURV COMPLETED		
		00460	B. WING	B. WING		08/13/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FAIR ME	ADOW NURSING HO	MF	00 GARFIELD / E, MN 56540	AVENUE SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
2 265	Continued From pa	age 4	2 265				
	however Coumadir	CAA indicated R2's atrial fibrillation was stable, however Coumadin had recently been discontinued due to a gastrointestinal (GI) bleed.					
	atrial fibrillation and pacemaker. Coum after last hospital s for bleeding with us also indicated R2's risks/benefits of Co restarted, and were	his medication and in					
	8/13/18, revealed F to UTI with hallucin required multiple c Concurrently, R2's modification and in	dical record from 4/1/18, to R2 had ongoing issues related actions and confusion which ourses of antibiotic therapy. Coumadin regimen required creased monitoring due to outside of therapeutic levels.					
	of therapeutic rang doctor (MD)-A orde	perienced INR results outside e at 1.6 for which medical ered R2's Coumadin be mg to 4 mg 1 tablet daily with eks.					
	had been received to start Bactrim DS days. Check INR o The note did not in	e dated 6/18/18, indicated a cal from MD-B's office with orders 1 tab orally twice daily for 7 on 6/25/18, and send to MD-C. clude modification to R2's increased INR monitoring with antibiotic.	3				
	licensed practical r	e dated 6/23/18, completed by nurse (LPN)-C indicated R2 Is that were maroon in color.					

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00460	B. WING		08/	08/13/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
AIR ME	ADOW NURSING HO	MF	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLET DATE	
2 265	R2's temperature w pain and stated "W bowels moved." LP monitor for fever, p note also indicated 2:30 p.m. and she R2 had also stated strain to have a bow wondering if the blo straining. LPN-C in her checked in the LPN-C left a messa the nursing home a daughter-in-law can LPN-C informed the stools so family wa Daughter-in-law aw because she declin daughter-in-law pre- would continue to r treat as necessary R2's clinical record registered nurse as notification of R2's R2's Medication Ad dated 6/1/18, to 6/3 Coumadin 4 mg on	vas 97. She denied abdominal ell it is better now that my N-C indicated he would ain and further stools. The LPN-C had spoken with R2 at had denied abdominal pain. two days ago she had to wel movement and was bod could be from the dicated he had offered to have ER but R2 had refused. age for R2's daughter to call and while doing so R2's me to pick her up for an outing e daughter-in-law about the s aware and would watch also vare R2 had declined ER led it again with esent. LPN-C indicated he nonitor when R2 returned and and as R2 and family desired. lacked evidence of a sessment or physician maroon colored stool. ministration Record (MAR) 60/18, indicated R2 received					
	R2 took scheduled R2 reported being The note indicated monitor and obtain check for blood.	ompleted by LPN-C indicated medications without difficulty. ired, denied abdominal pain. LPN-C would continue to a stool sample if able, to mpleted by assistant director					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
AIR ME	ADOW NURSING HO	MF	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265	abdominal pain as palpation. Bowel so quadrants. The not continue to monitor registered nurse (R status changed. 3:03 p.m. note co R2 was noted to ha fatigue, and halluci as increased clot lil maroon color to sto indicated R2 was a her INR had been a antibiotics. Finger s indicated MD-E orc hospital. Due to R2 hospital yesterday, agreed to have R2 sample was obtain the ambulance whe 3:25 p.m.	indicated R2 denied well as tenderness with bunds were present in all four red indicated ADON would r and follow up with primary RN) and MD tomorrow unless mpleted by ADON indicated ave increased confusion, nations this afternoon as well ke appearance and more bols this afternoon. The note lso on Bactrim for a UTI and affected in the past by her stick INR 8.0 today. The note lered R2 be sent to the 2 not wanting to go to the the family was contacted and seen at the hospital. A stool ed this afternoon and sent with en they departed the building ar				
	intermittent blood in the previous three chronically due to a INR was checked a elevated at 8 (critic hemorrhage). R2 v	R2 had been noted to have h her stool over the course of days. She was on Coumadin a history of atrial fibrillation. An and found to be significantly al level which could result in a was mildly tachycardic (heart				
	mildly pale. Anosc the anal canal) reve melanotic (having b An INR was repeat R2's hemoglobin (p transporting oxyger was given 10 mg o	al resting rate) and appeared opy (a scope used to examine ealed black stool with black pigmentation) features. ed and was greater than 10. protein responsible for n in the blood) was 8.9. R2 f vitamin K (clots y and was admitted to the				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING		08/13/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	0 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTI			
2 265		ge 7 or further evaluation and	2 265			
	<ul> <li>indicated an assess</li> <li>1. Acute lower gas cause was uncertain secondary to divert angiodysplasia or or the supratherapeuti</li> <li>2. Acute blood loss hemoglobin signific Received two units</li> <li>3. Supratherapeuti above 10 on admission 6/25/18.</li> <li>4. Atrial fibrillation, pacemaker placem</li> <li>5. Chronic anticoage Coumadin for now.</li> <li>6. Urinary tract inference</li> </ul>	s anemia. R2 dropped her antly from 8.9 to 7.4. of packed red blood cells. c INR on admission. It was sion. R2 was given vitamin K n and 2.5 mg orally on rate controlled status post ent. gulation with Coumadin. Hold				
	facility had the capa testing for INR, how the testing was requ	o.m. the ADON verified the acity to perform point of care vever, stated an MD order for uired and she was not sure if luded in the facility standing				
	effect monitoring fo anticoagulant thera and stated the facili the testing. LPN-C monitored for symp bloody emesis, or b	a.m. LPN-C indicated side r residents who received py included testing for INR ity had a machine to complete also stated the staff toms such as bloody stools, pruising easier. LPN-C y had an incident recently				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00460	B. WING			08/13/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
FAIR ME	ADOW NURSING HO	ME	0 GARFIELD / MN 56540	AVENUE SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
2 265	related to blood sto was 8 and the resic LPN-C stated the in Saturday and indica reported R2 had blood to the RN. LPN-C coffee ground blood something R2 had stool was a "weird" the stool color was LPN-C did not remo- had come down to stated he could not the time or if she ha however, confirmed UTI's. LPN-C state 6/23/18, that he red On 8/9/18, at 9:33 a anticoagulation mo and watching for sy bruises. LPN-B co also be symptom th stated if any sympto notify the RN if it we contact the MD if it On 8/9/18, at 9:42 a	ols when the resident's INR dent had to go into the hospital. neident happened on a ated a nursing assistant ood stools and he reported this stated it wasn't frank blood or d but looked more like eaten. LPN-C indicated the color and stated the next day darker than the day before. ember if the registered nurse look at R2 or not. LPN-C remember if R2 had a UTI at ad just been getting over one, d R2 became confused with ed R2 was not confused on called. a.m. LPN-B indicated nitoring included checking INR /mptoms such as bleeding or nfirmed bloody stools would hey would monitor. LPN-B oms were noted she would ere the day shift, or would was the evening shift. a.m. registered nurse (RN)-B	2 265	DEFICIENCY			
	stated the physician Coumadin and stat (PRN) INR's were of made to Coumadin stated she would ex	R2's primary RN. RN-B ns managed the residents' ed monthly and as needed completed and adjustments orders as indicated. RN-B xpect staff to monitor for any of bleeding such as prolonged					
	bleeding or any cha black, maroon or b the NAs were to re	uises, bleeding to gums, rectal ange to stool such as stools right red in color. RN-B stated port any symptoms to the he charge nurse would					

ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
00460		B. WING		08/*	13/2018
PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
ADOW NURSING HO	MF		AVENUE SOUTHEAST		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 9	2 265			
note. RN-B stated s	she would expect the LPN's to				
R2's medical record was reviewed with RN-B who verified the following:					
stools R2 received 4 mg Bactrim DS 800-1 6/18/18 and R2 cor through the morning R2's medical reco documentation to ir an RN on 6/23/18. Progress note dat indicated ADON wo MD-A on Monday, 6 changed.	Coumadin on 6/23/18. 60 mg was prescribed on ntinued to receive the antibiotic g of 6/24/18. and contained no ndicate R2 was assessed by red 6/24/18, at 1:30 p.m. build be contact RN-B and 6/25/18, unless R2's status				
residents on Count symptoms such as of skin, lethargy, blo stated she would ex to the charge nurse would then assess situation was heade 6/23/18, R2 had be Coumadin daily and Bactrim DS on 6/18 primary MD (MD-A) another provider, M antibiotic and the IN	adin were monitored for bruising, blood in urine, color bod in stool. The ADON expect symptoms to be reported and the charge nurse/RN and monitor to "see where the ed." The ADON verified on en receiving 4 mg of d had also been prescribed B/18. The ADON stated R2's had been out so it was ID-B, who prescribed the IR results were to have been				
	OF CORRECTION PROVIDER OR SUPPLIER ADOW NURSING HOI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par document any obset note. RN-B stated s monitor symptoms doctor. R2's medical record verified the followin 6/23/18 progress stools R2 received 4 mg Bactrim DS 800-1 6/18/18 and R2 cord through the morning R2's medical record documentation to ir an RN on 6/23/18. Progress note dat indicated ADON wo MD-A on Monday, 6 changed. On 8/9/18, at 11:29 residents on Coum- symptoms such as of skin, lethargy, block stated she would ex- to the charge nursed would then assess situation was headed 6/23/18, R2 had be Coumadin daily and Bactrim DS on 6/18 primary MD (MD-A) another provider, N antibiotic and the IN	OF CORRECTION         IDENTIFICATION NUMBER:           00460         00460           PROVIDER OR SUPPLIER         STREET AL BOX 8 30 FERTILLE           ADOW NURSING HOME         BOX 8 30 FERTILLE           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 9           document any observed symptoms in a progress note. RN-B stated she would expect the LPN's to monitor symptoms and notify the RN and/or the doctor.         Progress note indicated R2 had maroon stools          6/23/18 progress note indicated R2 had maroon stools        R2's medical record was reviewed with RN-B who verified the following:          R2's medical record was reviewed no 6/18/18 and R2 continued to receive the antibiotic through the morning of 6/24/18.        R2's medical record contained no documentation to indicate R2 was assessed by an RN on 6/23/18.        Progress note dated 6/24/18, at 1:30 p.m. indicated ADON would be contact RN-B and MD-A on Monday, 6/25/18, unless R2's status changed.           On 8/9/18, at 11:29 a.m. the ADON stated the residents on Coumadin were monitored for symptoms such as bruising, blood in urine, color of skin, lethargy, blood in stool. The ADON stated she would expect symptoms to be reported to the charge nurse and the charge nurse/RN would then assess and monitor to "see where the situation was headed." The ADON verified on 6/23/18, R2 had been receiving 4 mg of Coumadin daily and had also been prescribed Bactrim DS on 6/18/18. The ADON stated R2's primary MD (MD-A) had been out so it was another provider, MD-B, who prescribed the antibiotic and the INR results were to have been	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00460       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST         BOX 8 300       GARFIELD / FERTILE, MN 56540         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 9       2 265         document any observed symptoms in a progress note. RN-B stated she would expect the LPN's to monitor symptoms and notify the RN and/or the doctor.       2         R2's medical record was reviewed with RN-B who verified the following:      6/23/18, Bactrim DS 800-160 mg was prescribed on 6/18/18 and R2 continued to receive the antibiotic through the morning of 6/24/18, R2's medical record contained no documentation to indicate R2 was assessed by an RN on 6/23/18. Progress note dated 6/24/18, at 1:30 p.m. indicated ADON would be contact RN-B and MD-A on Monday, 6/25/18, unless R2's status changed.         On 8/9/18, at 11:29 a.m. the ADON stated the residents on Coumadin were monitored for symptoms such as bruising, blood in urine, color of skin, lethargy, blood in stool. The ADON stated she would expect symptoms to be reported to the charge nurse and the charge nurse/RN would then assess and monitor to "see where the situation was headed." The ADON verified on 6/23/18, R2 had been receiving 4 mg of Coumadin daily and had also been prescribed Bactrim DS on 6/18/18. The ADON stated R2's primary MD (MD-A) had been out so it was another provider, MD-B, who prescribed the antibiotic and the INR results were to have been	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       00460     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       BOW NURSING HOME     BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540       VERNING FICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D       PREFIX     PROVIDERS PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D       Continued From page 9     2 265       document any observed symptoms in a progress note. RN-B stated she would expect the LPN's to monitor symptoms and notify the RN and/or the doctor.     Continued record was reviewed with RN-B who verified the following:      6/23/18 progress note indicated R2 had maroon stools    82 received 4 mg Cournadin on 6/23/18.      R2's medical record contained no documentation to indicate R2 was assessed by an RN on 6/23/18.    R2's medical record contained no documentation to indicate R2 was assessed by an RN on 6/23/18.      Progress note dated 6/24/18, at 1:30 p.m. indicated ADON would be contact RN-B and MD-A on Monday, 6/25/18, unless R2's status changed.       On 8/9/18, at 11:29 a.m. the ADON stated the residents on Cournadin were monitored for symptoms such as bruising, blood in urine, color of skin, lethargy, blood in stool. The ADON stated she would expect symptoms to be reported to the charge nurse and the charge nurse/RN would then assess and monitor to 'see where the situation was headed." The ADON stated R2's primary MD (MD-A) had been outs oi twas another provider, MD-B, who prescribed the sitwasion was headed." The ADON stated R2's primary	OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:     COM       00460     B. WING     08/   PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE   BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540       SUMMARY STATEMENT OF DEFICIENCES     ID       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX       REQUATORY OR LSC DENTIFYING INFORMATION)     PREFIX       TAG     PREVIDER'S PLAN OF CORRECTION SHOULD BE       Continued From page 9     2 265       document any observed symptoms in a progress     CROSS-REFERENCE TO THE APPROPRIATE       DEFICIENCY     DEFICIENCY       Continued From page 9     2 265       document any observed symptoms in a progress     CROSS-REFERENCE TO THE APPROPRIATE       DEFICIENCY     DEFICIENCY       Continued From page 9     2 265       document any observed symptoms in a progress     CROSS-REFERENCE TO THE APPROPRIATE       DEFICIENCY     Continued Concerve the LPN's to      6/23/18 progress note indicated R2 had maroon     Stools      R2 received 4 mg Countain on 6/23/18.

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED			
		00460	B. WING		08/	13/2018			
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BOX 8 300 GARFIELD AVENUE SOUTHEAST									
AIR ME	ADOW NURSING HO	MF	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST					
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)			
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>\</sup>	HE APPROPRIATE	COMPLET DATE			
2 265	Continued From pa	ige 10	2 265						
	at it and stated the	color was "weird." The ADON							
	stated she had LPN	I-C do a focused assessment							
	of R2 and stated th	ey were in a "monitoring" state							
	at that point. ADO	N stated family had been at the	•						
	facility to take R2 o	ut for the day and R2 had							
		responsive with no signs of							
		ad been offered the ER which							
		DON confirmed R2 had "left							
		nitoring state at that time."							
	The ADON verified she had not spoken with the								
		ated LPN-C had done so.							
	-	N stated she was not sure if							
		ed the risks and benefits of							
		uated in the ER. The ADON							
		nat point we were trying to							
		stool was" and passed the							
	-	he next shift] and was not							
		y further stools after she he ADON verified she had not							
		oumadin held, nor had she							
		ician at that point. In addition, he was not sure she would							
		differently knowing then what							
		2's stool did not have frank							
		to other symptoms. The							
		even went an checked the							
		had had beets served during							
		ON verified on 6/24/18, R2							
		maroon stools with a "clotting							
		n the day and was more							
		attributed the lethargy to R2's							
		day. R2 had begun							
		was attributed to a UTI. The							
	ADON stated just p	prior to shift change, she had							
		lk with the staff which was							
		it all together." The ADON							
		ed R2's family to discuss							
		ation and to notify them she							
		2's INR. The ADON							
		k R2's INR which was 8, so	1			1			

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
00460		B. WING		08/	13/2018	
NAME OF I	PROVIDER OR SUPPLIER		10/2010			
	ADOW NURSING HO	BOX 8 3(	DDRESS, CITY, ST 10 GARFIELD	AVENUE SOUTHEAST		
		FERTILE	, MN 56540			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	age 11	2 265			
	would be willing to not comfortable with had obtained the far the physician and r to the ER. Lastly, t R2's family to notify confirmed R2 had b bleed and received four day hospitalizat she could have pro 6/23/18, as she wa between Coumadir to make excuses, b RN and probably di well as RN-B had. On 8/9/18, at 12:01	d the family to see if they send R2 to the ER as she was th R2's INR result. Once she amily's approval, she contacted eceived orders to transport R2 the ADON again contacted y them of the plan. The ADON been diagnosed with a GI two units of blood during a ation. The ADON confirmed bably tested R2's INR on s aware of the interactions in and antibiotics and stated not but she was not R2's primary id not know R2's history as				
	flag" and stated she to assess the patie hold the Coumadin	82's maroon stool was a "red e would have expected ADON nt herself, checked an INR, and contact the physician.				
	and facility medical monitoring for resid anticoagulant who depended on the al stated usually if it w sulfamethoxazole ( the INR more often from 6/18/18, was u	were prescribed antibiotics ntibiotic prescribed. MD-D vas Cipro, Levaquin or Bactrim) staff needed to check n. R2's MD antibiotic order reviewed with MD-A who				
	indicated physician nursing out. He sta prescribed the antil earlier INR testing, earlier INR testing a have also asked fo	ve done that differently. MD-A s relied on pharmacy to help ated the physician who biotics should have ordered nursing should have asked for and/or the pharmacist should r earlier INR testing. MD-A n colored stool would indicate				

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMP	SURVEY LETED
		00460	B. WING		08/1	3/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	) GARFIELD MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	signal to call some have expected to be MD-A stated they he policy to include INH nursing discretions, stool, with or without been an indication to if the resident was of MD-A was unsure of nursing holding the indicated they shou physician prior to gi The undated Notified directed the primary notified of any med policy directed situation immediate notification clinical status was of however, the policy which were not con- results. SUGGESTED MET The director of nurs- update policies and staff on examples of be notified. The DO audits of medical residuant	ge 12 and should have been a one. MD-A indicated he would e notified when this occurred. ad been working on the facility R testing to be initiated per however, a maroon colored at policy changes would have to notify someone, particularly on anticoagulant medication. of the facility policy regarding Coumadin medication but Id have contacted the ving the medication. cation of Physician policy y/on call physician would be ically unstable condition. The ations that warranted ion included if the resident's unclear or worsening, did not address notifications cerning lab or diagnostic test CHOD OF CORRECTION: sing (DON) or designee could procedures and then educate on when the physician should DN or designee could perform ecords to determine if the notified appropriately.	2 265			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
2 510	MN Rule 4658.0300	) Subp. 2 Use of Restraints	2 510			9/1/18
/linnesota D	epartment of Health		u			

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Minnesota Department	of Health				0120
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
	00460	B. WING		08/13/201	18
NAME OF PROVIDER OR SUPI	LIER STREET A	DDRESS, CITY,	STATE, ZIP CODE		
FAIR MEADOW NURSING	i HOME	00 GARFIELI 5, MN 56540	OAVENUE SOUTHEAST		
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COM	X5) IPLETE ATE
2 510 Continued Fro		2 510			
must be free f restraints impo convenience,	dom from restraints. Residents om any physical or chemical sed for purposes of discipline or and not required to treat the ical symptoms.				
by: Based on obs review, the fac	rement is not met as evidenced ervation, interview and document ility failed to ensure 1 of 2 resident e from the use of physical	5	Corrected.		
Findings inclue	le:				
diagnoses tha Parkinson's di	a dated 8/10/18 indicated R40 had included, but were not limited to sease, repeated falls, weakness, and disorientation.				
7/18/18, indica impaired, requ persons for be assistance of ambulation. Th and bladder in assistance for R40 had restra that prevented "other" used w the MDS indic	minimum data set (MDS) dated ted R40 had severe cognitive red extensive assistance of two d mobility and required extensive one person for transfers and the MDS indicated R40 had bowel continence and required extensive toileting. The MDS also indicated int use daily which included a chai rising, and a restraint marked as hen R40 was in bed Additionally ated R40 had personal alarm's ed and in the wheelchair.				
Elimination As R40 was restr the wheelchair	ast completed Physical Restraint sessment dated 7/18/18, indicated ained with an alarmed seat belt in . The specific reason for the as identified as poor safety				

	<u>ta Department of Herror Department of Herror Department of Department of Herror Departmen</u>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
			A. BUILDING:					
	00460		B. WING		08/	13/2018		
NAME OF	PROVIDER OR SUPPLIER							
FAIR MEADOW NURSING HOME BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540								
(X4) ID	_	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE		
2 510	Continued From pa	age 14	2 510					
	judgement and self	f-transfers with falls. The						
		ted R40's daughter requested						
		nt used for safety to prevent						
		e assessment indicated R40						
		wheelchair that had footrests						
		r positioned in that wheelchair.						
		sment indicated R40 was a						
		traint reduction, a reduction pted. The assessment lacked						
		symptom R40 displayed to						
	warrant the use of							
	R40's care plan for falls dated as last revised on							
		he following related to the use						
		alarm: A seat belt with alarm						
		alarm part was placed at the						
		hair out of the reach of R40						
		pted to remove the alarms and						
		d would then self transfer and tbelt used on wheelchair to						
		ansfers. Staff to fill out restraint						
		shift daily. Discuss and record						
		the risks and benefits of the	•					
		restraint should be applied,						
		ained, and any concerns or						
		estraint use. Reviewed ongoing	1					
	use of restraint with	n family and restraint release						
		er positioning in wheelchair						
		nsure opportunities for						
		and physical activity during						
		n, meals, toileting, walking, and						
		ment restraint release form						
		lied when up in wheelchair g meals, activities, during						
		, and one on one. Report any						
		e effects of restraint use						
		in mood, change in behavior,						
		elf performance, decline in						
		communication, contracture						
	formation, skin bre					1		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00460		B. WING		08/	13/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AIR ME	ADOW NURSING HO	MF	00 GARFIELD / 5, MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 510	Continued From pa	age 15	2 510			
	agitation, and weak	ness.				
	8/7/18, at 7:30 p.m used the alarmed s escape her wheelc like the restraint be have it on. FM-A st fitted for a new whe	M-A) was interviewed on . during which she stated R40 seat belt so she would not hair. FM-A stated R40 did not ated R40 had recently been selchair in which R40 was M-A confirmed she would now int reduction.				
		ed on 8/7/18, at 7:35 p.m. and the restraint belt and tried to djusting her shirt.				
	at the dining room alarmed seat belt v	on 8/8/18, at 7:06 a.m. seated table in her wheelchair. R40's vas still on in the dining room e plan directed staff to remove linning.				
	register nurse (RN) primary nurse and health care. RN-A s was used for fall pr RN-A was not awar request the use of resident had a spec the restraint use.	on 8/9/18, at 11:30 a.m. )-A stated she was R40's was responsible for R40's stated the alarmed seat belt evention and family request. re family members could not a restraint device unless a cific medical symptom to justify RN-A could not identify a mptom that would warrant the	/			
	The Director of Nur develop/review and	THOD OF CORRECTION: rsing or her designee could l or revise policies and appropriate use of physical				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
	00460		B. WING		08/13/2018				
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE					
FAIR MEADOW NURSING HOME       BOX 8 300 GARFIELD AVENUE SOUTHEAST         FERTILE, MN 56540									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE			
2 510	Continued From pa	ige 16	2 510						
	on the process of a restraints. The Dire designee could dev ensure ongoing cor	opriate staff could be educated oppropriate use of physical actor of Nursing or her velop a monitoring system to mpliance. R CORRECTION: Twenty-one							
2 830		0 Subp. 1 Adequate and re; General	2 830			9/1/18			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident n bed.							
	by: Based on observat review, the facility f assess pain, and id	ent is not met as evidenced ion, interview and document ailed to comprehensively lentify non-pharmacological of 1 resident (R38) who voiced		Corrected.					
		e: ated 8/10/18, indicated R38 uding atrial fibrillation, anemia,							

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
0046					00/40/0040
		00460		08/13/2018	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE AVENUE SOUTHEAST	
FAIR ME	ADOW NURSING HO	)MF	, MN 56540	AVENUE SOUTHEAST	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLE THE APPROPRIATE DATE
2 830	Continued From pa	age 17	2 830		
	and muscle weakn	less.			
	system (PPS) Mini 7/13/18, indicated cognitive impairme rated at a 6 on a so lowest amount of p amount of pain. Th made sleep difficul R38's day-to-day a				
	indicated R38 had mg one tab every r prior to 8/6/18, R38	hysician order's dated 8/6/18, been prescribed Tylenol 325 hight at bedtime on 8/6/18, and 8 had an order for Tylenol 325 by four hours as needed for			
	7/1/18-8/10/18, rev 325 mg one tablet exception of four d	Administration Record from vealed R38 received Tylenol at least once a day with the lays in that time frame. R38 veen 3 and 7 on a 1-10 scale.			
	stated she frequen back area which w the night time hour described the pain rated the pain at a stated aggravating included the bed/m which was uncomf and strenuous acti	ed on 8/8/18, at 8:46 a.m. and tly had pain in her neck and as more pronounced during rs (after midnight). R38 as a dull ongoing ache and 6 on the 1-10 scale. R38 factors of the neck pain nattress supplied by the facility ortable, cold air/environment, vity. R38 stated regular Tylenol eck roll alleviated the			
inesota D		omprehensive pain assessmen cility was section J of the MDS.			

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	00460		B. WING		08/13/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	00 GARFIELD / ., MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 18	2 830			
	occasional pain in t not limited R38's da rated the pain at a d assessment was no assessment failed t was located, a desc aggravating factors pharmacological ar interventions that a assessed. Review of R38's co revealed no care pl addressed R38's pain On 8/10/18, at 11:3 (RN)-A confirmed F comprehensively as plan had not been of pharmacological ar interventions. The facility policy for prevention (undated would complete a p	a, alleviating factors, and both ad non-pharmacological lleviated the pain had not beer amprehensive care plan an had been developed which ain symptoms. 7 a.m. registered nurse				
	not identified what t include.	ation of pain. The policy had the assessment should THOD FOR CORRECTION:				
	review and revise a procedures regardi assessment of and interventions for pa	sing (DON) could develop, is necessary the policies and ng the comprehensive non-pharmacological in management. The DON ng for all appropriate staff on				
	ta Department of He				()(0) DAT	
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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		00460	B. WING		08/	13/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
AIR ME	ADOW NURSING HO	MF	0 GARFIELD MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
		procedures. The quality surance committee could do nsure compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				
2 840	MN Rule 4658.0520 Proper Nursing Car	) Subp. 2 B Adequate and e; Clean skin	2 840			8/28/18
		r determining adequate and criteria for determining er care include:				
	odors. A bathing pl resident's plan of ca condition requires th must be given a con other day and more incontinent resident every two hours, an	and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every often as indicated. An t must be checked at least id must receive perineal care ode of incontinence.				
	checked according written in the reside attending physician interval longer than if competent, or a fa appointed conserva agent of a resident					
	determining this inte documented in the	erval, and this waiver is resident's care plan. ] hing must be provided				
		ning musi be provided				
nesota De	epartment of Health M		6899 VE	3GW11	If continuat	ion sheet 20

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00460	B. WING		08/13/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	,	
AIR ME	ADOW NURSING HO	MF	00 GARFIELI 5, MN 56540	O AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
2 840	Continued From pa	age 20	2 840			
	Perineal care inclue the perineal area. to keep the bed dry comfort. Special a skin to prevent irrita types of protectors completely covered contact with the res	the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be d, and not come in direct sident. Soiled linen and moved immediately from revent odors.				
	by: Based on observat review, the facility f assistance with inc	ent is not met as evidenced ion, interview and document failed to provide timely ontinence cares for 1 of 1 was totally dependent on staff res.	F	Corrected.		
	Findings include:					
	5/23/18 identified F impairment and dia disease, and deme required extensive	nimum Data Set (MDS) dated R12 with severe cognitive agnoses including Alzheimer's antia. The MDS indicated R12 assistance with all activities of totally incontinent of bowel				
	(CAA) print date 8/8 incontinent of blade	nence Care Area Assessment 8/18, indicated R12 was der and required assist of staff ge every two hours and as				
		essment Form dated 3/17/18 functional incontinence, was				

ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00460	B. WING		08/13/2018	
DER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	• • • •	
W NURSING HO	MF		AVENUE SOUTHEAST		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Illy incontinent of sical impairment and be inappropriate a sist mathematical be check and a sist mathematical be check and a sist mathematical be check and a sist mathematical be a not observed to a since cares 7:05 a.m. R12 to be cares a by the front er wall. 8:29 a.m. the the rapy room. R12 be provided up vity. 8:51 a.m. the the therapy room, r he front entrance 1. 9:01 a.m. the and front door and r he front entrance	of bowel and bladder due to hts and cognitive deficits. R12 riate for bladder retraining and d change with toileting needs. ted 5/30/18, directed the staff a check and change of schedule of every two hours on 8/8/18, during continuous 7:05 a.m. to 10:23 a.m. R12 o be assisted with during this time. was observed seated in a the dining room. Sed practical nurse (LPN)-C the dining room to the desk ntrance and positioned her by herapy aide wheeled R12 to the was observed to fold towels oper and lower range of motion herapy aide wheeled R12 out o returned her to the desk area ce and positioned her by the		DEFICIENCY		
	W NURSING HO SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Itinued From pa Ily incontinent of sical impairmer ild be inappropri- ild be inappropri- ild be check an 2's care plan da ssist R12 with a pontinent product as needed. 2' was observed to a not observed a not observed to a not observed a not obser	DER OR SUPPLIER         STREET AL           W NURSING HOME         BOX 8 30 FERTILE           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Image: Comparison of the compar	00460       B. WING         DER OR SUPPLIER       STREET ADDRESS, CITY, ST         W NURSING HOME       BOX 8 300 GARFIELD of FERTILE, MN 56540         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Itinued From page 21       2 840         Ity incontinent of bowel and bladder due to sical impairments and cognitive deficits. R12 IId be inappropriate for bladder retraining and IId be check and change with toileting needs.       2 840         It's care plan dated 5/30/18, directed the staff ssist R12 with a check and change of ontinent product schedule of every two hours as needed.       2 840         It was observed on 8/8/18, during continuous ervations from 7:05 a.m. to 10:23 a.m. R12 is not observed to be assisted with ontinence cares during this time.       7:05 a.m. R12 was observed seated in a selchair (WC) in the dining room.         8:24 a.m. licensed practical nurse (LPN)-C seled R12 from the dining room to the desk a by the front entrance and positioned her by wall.       8:29 a.m. the therapy aide wheeled R12 to the rapy room. R12 was observed to fold towels be provided upper and lower range of motion vity.         8:51 a.m. the therapy aide wheeled R12 to front entrance and positioned her by the .       9:01 a.m. the administrator wheeled R12 to front door and returned her to the desk area he front entrance and positioned her next to wall.       9:05 a.m. licensed social worker (LSW)-A	Deer OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           BOW NURSING HOME         BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED to T DEFICIENCY MUST BE PRECEDED BY FULL TAG         ID PREFIX         PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED to T DEFICIENCY MUST BE PRECEDED BY FULL TAG           Itinued From page 21         2 840         2 840           Up incontinent of bowel and bladder due to sical impairments and cognitive deficits. R12 (ab cinappropriate for bladder retraining and ld be check and change with toileting needs.         2 840           2's care plan dated 5/30/18, directed the staff ssist R12 with a check and change of notinent product schedule of every two hours as needed.         2 840           2'was observed to 8/8/18, during continuous ervations from 7:05 a.m. to 10:23 a.m. R12 on observed to be assisted with notinence cares during this time.	Image: Construction of the staff         Image: Construction of the staff         Image: Construction of the staff           Image: Construction of the staff         2840         2840           Image: Construction of the staff

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If continuation sheet 22 of 56

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING		08/13/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
	ADOW NURSING HO	MF	0 GARFIELD A MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pa	ge 22	2 840			
		d sat next to R12. A left the activity room and e seated in the activity room in				
		y aide (AA)-A entered the formed R12 of Bible study at				
		A offered R12 a glass of water at a table with another female udy.				
		ing assistant (NA)-A wheeled ty room to her room.				
	transfer from the w body mechanical lif changed R12's inco observed to be inco coccyx and buttock areas observed. -At 10:22 a.m., NA- incontinent of urine area was red. NA- provided R12 with i morning. -At 10:23 a.m. NA-l assisted with incom prior to going to the	A and NA-C assisted R12 to heelchair to the bed via a full t. Once in bed, NA-C ontinence brief. R12 was ontinent of urine and the area was red, with no open C confirmed R12 was and her coccyx and buttock C confirmed she had not ncontinence care that B confirmed R2 had last been tinence cares at 6:45 a.m. e dining room for breakfast at 5 hours and 30 minutes				
	earlier). On 8/8/18, at 11:24 confirmed R12 was	a.m. registered nurse (RN)-B to be assisted with				
	incontinence cares by the care plan.	every two hours as directed				
	On 8/8/18, at 2:00 pepartment of Health	o.m. the director of nursing				

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00460	B. WING	B. WING		13/2018
NAME OF PROVIDER OR SUPPLI		ADDRESS, CITY, ST	TATE, ZIP CODE		10/2010
FAIR MEADOW NURSING	HOME	300 GARFIELD / .E, MN 56540	AVENUE SOUTHEAST		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 840 Continued From	page 23	2 840			
	d staff was expected to provide ing and incontinence cares.				
required extensi mobility, transfer personal hygiene pressure ulcers.	S dated 5/2/18, indicated R5 ve assistance of two staff for be- rs, dressing, toileting and e and was at risk for developing The MDS identified R5 had extremity impairment on both	d			
included diagnos results from dan are responsible sclerosis (a prog disease that affe the spinal cord), neuropathy (loss	eport provided on 8/10/18, ses of aphasia (disorder that hage to portions of the brain that for language), amyotrophic later gressive neurodegenerative ects nerve cells in the brain and and hereditary and idiopathic s of sensitivity in the hands and ns such as the kidneys, heart,				
indicated R5 was	assessment dated 5/1/18, s to be repositioned every two o current skin issues.				
staff to turn and hours when in b R5 had a recent	rovided on 8/10/18, directed the reposition R5 every 1.5 to two ed. The care plan also indicated open sore on the coccyx which led and was most recently open	t			
on 8/10/18, direc	sistant (NA) care sheet provided cted the staff to turn and 1.5 to two hours when in bed, or d.				
On 8/8/18, durin	g continuous observation from				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			B. WING			00/40/0040	
		00460			08/	13/2018	
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE AVENUE SOUTHEAST			
AIR ME	ADOW NURSING HO	MF	E, MN 56540				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 840	Continued From pa	age 24	2 840				
	7:16 a.m. until 10:2 assistance to turn o	20 a.m. R5 was not provided or reposition.					
	incontinence care a R5. NA-D & NA-E provided care for F	D and NA-E provided and turned and repositioned both confirmed they had not S since the start of their shift 4 hours and 20 minutes					
	assisting R5 with re R5 had not been re	a.m. NA-E was observed epositioning. NA-E confirmed epositioned since 6:00 a,m. her shift, a total of 3 hours and					
	be provided assista repositioning in ord	36 a.m. RN-B stated R5 was to ance with turning and ler to prevent the development every 1.5 to two hours, and pe					
	would expect the re repositioned accore	I p.m. the DON stated she esidents' to be turned and ding to their care plan. The nours in between repositioning e care.					
		ted to timely provision of equested, however was not					
	The director of nurs review and revise p to ensuring incontin	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related nence care is provided for eacl . The director of nursing or					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (2	(3) DATE SURVEY COMPLETED	
		00460	B. WING		08/13/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	0 GARFIELE , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	
2 840	designee could dev and develop a mon are providing care a of care.	ge 25 relop a system to educate staff itoring system to ensure staff as directed by the written plan R CORRECTION: Twenty-one	2 840			
2 905	MN Rule 4658.0528 Subp. 4. Positionin positioned in good of residents unable must be changed a including periods of been put to bed for has documented th hours during this tir	5 Subp. 4 Rehab - Positioning ag. Residents must be body alignment. The position to change their own position t least every two hours, f time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval.	2 905		8/28/18	
	by: Based on observati review, the facility f repositioning servic R5) who were ident	ent is not met as evidenced ion, interview and document ailed to provide timely ses for 2 of 2 residents (R12, iffied at risk for pressure ulcers assistance to reposition.		Corrected.		
	R12's quarterly Min 5/23/18, indicated F impairment and dia Alzheimer's disease pressure ulcer. The extensive assist of	imum Data Set (MDS) dated R12 had severe cognitive gnoses which included e and a coccyx region e MDS indicated R12 required two persons for toilet use, bed and dressing. The MDS also				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00460	B. WING		08/	13/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	• • •	
AIR ME	ADOW NURSING HO	ME	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 905	indicated R12 had pressure ulcer (inta redness of a localiz prominence), was a further pressure ulc reducing device for repositioning progra interventions to ma R12's Tissue Tolera R12 was at high ris development. R12's Skin Review indicated R12 was ulcers, received me breeze supplement on bed, repositionin and change every to incontinence care. R12's care plan pro- was at risk for pres- decreased mobility mobility/offloading a incontinence, histo recent superficial o above the knee arr The care plan direc	age 26 one unhealed, stage 1 act skin with blanchable zed area usually over a bony at risk for the development of cers, and required a pressure r bed and chair, a turning and am, and nutrition/hydration anage skin problems. ance dated 3/7/18 indicated sk for pressure ulcer r assessment dated 3/7/18, at high risk for pressure echanical soft diet with Boost t three times daily, air mattress ng every two hours and check two hours to address byided 8/18/18, indicated R12 soure ulcers related to r, need for assistance with bed and repositioning, bowel ry of pressure ulcers, history of open area on coccyx, and a left putation with no prosthesis. cted the staff to assist with al skin care, minimize pressure	F			
	every two hours, ar change every two h On 8/8/18, during c	ces, reposition with two staff and assist with check and nours for incontinence care. continuous observations from a.m. R12 was not observed to positioning.				
		was observed seated in a				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING		08/	13/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AIR ME	ADOW NURSING HO	MF	00 GARFIELD / E, MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	age 27	2 905			
	wheeled R12 from	sed practical nurse (LPN)-C the dining room to the desk ntrance and positioned her by				
	therapy room. R12	nerapy aide wheeled R12 to the folded towels and was upper and lower range of	9			
	the therapy room, r	nerapy aide wheeled R12 out o returned her to the desk area ce and positioned her by the	f			
	the front door and	dministrator wheeled R12 to returned her to the desk area ce and positioned her next to				
	wheeled R12 into t on the television ar a.m. LSW-A left the	sed social worker (LSW)-A he activity room. LSW-A turned nd sat next to R12. At 9:12 e activity room and R12 n the activity room in her WC.	d			
		ty aide (AA)-A entered the nformed R12 of Bible study at				
		A offered R12 a glass of water at a table with another female tudy.				
		sing assistant (NA)-A wheeled activity room to her room.				
		A and NA-C assisted R12 to /heelchair to the bed via a full				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING	B. WING		13/2018
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		10/2010
	ADOW NURSING HO	MF	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 905	Continued From pa	-	2 905			
	changed R12's inco noted to have been coccyx and buttock areas observed. A R12 was incontinen buttock area was re	ft. Once in bed, NA-C ontinence brief. R12 was in incontinent of urine. R12's carea was red with no open it 10:22 a.m., NA-C confirmed nt of urine and her coccyx and ed. NA-C confirmed she had with incontinence care that				
	assisted with incon prior to going to the	B confirmed R2 had last been tinence cares at 6:45 a.m. e dining room for breakfast at f 3 hours and 30 minutes				
	confirmed R12 was and was to be assi	a.m. registered nurse (RN)-B s at risk for pressure ulcers, sted with repositioning every ted by the care plan.				
	(DON) confirmed th	p.m. the director of nursing he staff was expected to sitioning every two hours as e plan				
	director of nursing develop, review, an procedures to ensu- repositioning assist need. The DON or	THOD OF CORRECTION: The (DON) or designee could nd/or revise policies and ure residents receive the tance according the assessed designee could develop an ensure ongoing compliance.				
	TIME PERIOD FO (21) days. epartment of Health	R CORRECTION: Twenty-one				

OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE	
	00460	B. WING		08/13/2018	
ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
DOW NURSING HO	MF		OAVENUE SOUTHEAST		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLET DATE
Incontinence Subp. 5. Incontinent have a continuous management to reconnecessary use of comprehensive rest home must ensure A. a resident without an indwelling unless the resident that catheterization B. a resident with receives appropriate prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: tho enters a nursing home ng catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder the treatment and services to ct infections and to restore as	2 910		Ę	9/1/18
by: Based on observati review, the facility f assistance with incoresidents (R5) who for incontinent care Findings include: R5's annual Minimu 5/2/18, indicated R assistance of two s dressing, toileting a	ion, interview and document ailed to provide timely ontinence cares of 1 of 3 required extensive assistance s. um Data Set (MDS) dated 5 required extensive taff for bed mobility, transfers, and personal hygiene and was		Corrected.		
	DOW NURSING HO SUMMARY STA (EACH DEFICIENC' REGULATORY OR L MN Rule 4658.052 Incontinence Subp. 5. Incontine have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac much normal bladc This MN Requirem by: Based on observat review, the facility f assistance with inc residents (R5) who for incontinent care Findings include: R5's annual Minimu 5/2/18, indicated R assistance of two s dressing, toileting a	ROVIDER OR SUPPLIER       STREET AL         DOW NURSING HOME       BOX 8 30 FERTILE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence         Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:         A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.         This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares of 1 of 3 residents (R5) who required extensive assistance for incontinent cares.	ADVIDER OR SUPPLIER       STREET ADDRESS, CITY, BOX 8 300 GARFIELD         DOW NURSING HOME       BOX 8 300 GARFIELD         SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence       2 910         Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:       2 910         A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.         This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares of 1 of 3 residents (R5) who required extensive assistance for incontinent cares.         Findings include:         R5's annual Minimum Data Set (MDS) dated 5/2/18, indicated R5 required extensive assistance of two staff for bed mobility, transfers, dressing, toileting and personal hygiene and was	Location         STREET ADDRESS, CITY, STATE, ZIP CODE           DOW NURSING HOME         BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         D PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY)           MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence         2 910         CROSS-REFERENCE TO THE APPRC DEFICIENCY)           MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence         2 910         EFICIENCY)           MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence         2 910         EFICIENCY)           MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence         2 910         EFICIENCY)           MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence         2 910         EFICIENCY)           MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence         2 910         EFICIENCY)           MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence         2 910         Corrected.           MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence         Corrected.         EFICIENCY)           MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinent to reduce innontinent dataget readget and the construction as possible.         Corrected.         Corrected.           This MN Requirement is not met as evidenced by: Based on observation, interview and document re	Overloter or supplier     Detect       DOW NURSING HOME     STREET ADDRESS, CITY, STATE, ZIP CODE       BOW NURSING HOME     BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540       SUMMARY STATEMENT OF DEFICIENCES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG       MIN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence     2 910       SUBp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the comprehensive resident assessment, a nursing home must ensure that:     2 910       A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.     Corrected.       This MN Requirement is not met as evidenced by: Based on observation, interview and document treview, the facility failed to provide timely assistance with incontinence cares of 1 of 3 residents (R5) who required extensive assistance for incontinent cares.     Corrected.       Findings include:     R5's annual Minimum Data Set (MDS) dated 5/2/18, indicated R5 required extensive assistance of two staff for bed mobility, transfers, dressing, toleting and personal hygiene and was

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If continuation sheet 30 of 56

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING		08/13/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		BOX 8 3	00 GARFIELD	AVENUE SOUTHEAST		
	ADOW NURSING HO	FERTILE	, MN 56540			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 30	2 910			
	results from damage are responsible for sclerosis (ALS) (a disease that affects the spinal cord), ar neuropathy (loss of	s of aphasia (disorder that ge to portions of the brain that language), amyotrophic latera progressive neurodegenerative s nerve cells in the brain and hd hereditary and idiopathic f sensitivity in the hands and such as the kidneys, heart,				
	5/14/18, indicated I of bladder, had diff to ALS, mostly use changing of inconti as needed (PRN).	Area Assessment (CAA) dated R5 was frequently incontinent iculty using commode related d bedpan or staff checking and nent brief every 2-3 hours and R5 had stress/urge functional re related to neuromuscular	I			
	to provide extensiv	<i>v</i> ided on 8/10/18, directed staff e assistance of two persons to , use commode, or bedpan d prn.				
	8/10/18, directed st	ant care sheet provided on taff to check and change, use an every 2-3 hours and prn.				
	7:16 a.m. until 10:2 care for urinary inc nursing assistant (I observed to provid having been incont	continuous observation from 20 a.m. R5 was not provided ontinence. At 10:20 a.m. NA)-D and NA-E were e R5 incontinence care due R5 inent of urine. NA-D & NA-E whad not provided care for P5				
	since the start of th	y had not provided care for R5 heir shift at 6 a.m. for a total of hutes without incontinence care				
	On 8/0/18 at 0.10	a.m. NA-E was observed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00460	B. WING		08/	13/2018
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AIR ME	ADOW NURSING HO	MF	00 GARFIELD / E, MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	nge 31	2 910			
	incontinence care/t been provided to R	epositioning. NA-E confirmed oileting assistance had not 5 since the start of her shift at I of 3 hours and 19 minutes				
	(RN)-B stated the s	6 a.m. registered nurse staff were expected to provide or toileting every 2-3 hours and	1			
	stated she would exchecked and changed	p.m. the director of nursing xpect that residents would be ged/toileted according to the three hours without t acceptable.				
		ted to timely provision of vas requested, however was				
	The director of nurs develop, review, an procedures to ensu appropriate assiste The DON or design	THODS OF CORRECTION: sing (DON) or designee could ad /or revise policies and ure resident received d toileting care and services. nee could develop monitoring ongoing compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			9/1/18
	comprehensive res home must ensure	of daily living. Based on the ident assessment, a nursing that: given the appropriate				

If continuation sheet 32 of 56

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00460	B. WING		08/13/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
AIR ME	ADOW NURSING HO	MF	300 GARFIELD AVENUE SOUTHEAST .E, MN 56540				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE		
2 915	Continued From pa	age 32	2 915				
	deterioration is a net the resident's cond part, activities of da resident's ability to: (1) bathe, dres (2) transfer ar (3) use the toi (4) eat; and (5) use speec	ss, and groom; nd ambulate;					
	by: Based on observat review, the facility f assistance was pro board was utilized	ent is not met as evidenced ion, interview and document failed to ensure dinning ovided and a communication for 1 of 1 resident (R40) ies of daily living.		Corrected.			
	Findings include:						
	had diagnoses that	ated 8/10/18 indicated R40 t included, but were not limited ase, repeated falls, weakness disorientation.					
	7/18/18, indicated I impaired, required two persons for mo up assistance for e had restraint use d	nimum data set (MDS) dated R40 had severe cognitive extensive assistance of one to obility, and supervision with set eating. The MDS indicated R40 aily which included a chair that dditionally, the MDS indicated					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING		08/13/201	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 915	Continued From pa	age 33	2 915			
	in the wheelchair.					
	8/7/18, at 7:30 p.m was recently move where assistance v stated she thought using a communica	M)-A was interviewed on . during which she stated R40 d in the dining room to a table would be provided. FM-A also R40 was supposed to be ation device developed by the pathologist (SLP) but had not ed.				
	was at risk for chole pocketing food in n unintentionally ate and paper. The car assistance with me position, eat slowly thoroughly. Reside	vised on 7/18/18, revealed R40 king related to holding or nouth and cheeks and had non-edible items like napkins re plan indicated R40 required eals to sit in the upright and chew each bit nt to eat on the assisted side for supervision with meals.				
	at a dining room ta which included frem a difficult time eating had not been cut for cut the meal into bing finished the meal a were staff observed	on 8/8/18, at 7:06 a.m. seated ble. R40 was served the meal ach toast and bacon. R40 had bg because the french toast or her and R40 was unable to ite size pieces herself. R40 t 8:20 a.m. and at no time d seated by R40 to assist her al or cueing her to drink od.				
	3:30 p.m. and 8/9/1 no time was a com	on 8/8/18, from 7:06 a.m. to l8, from 8:15-11:00 a.m. and a munication device hance communication.	t			
	8/9/18, at 9:12 a.m	NA)-H was interviewed on . and stated she was not nunication device or board				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00460	B. WING		08/	8/13/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
AIR ME	ADOW NURSING HO	MF	0 GARFIELD , MN 56540	AVENUE SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 915	developed for R40. -At 9:41 a.m. NA-G R40 had a communithrough R40's room board in a dresser stated they were not board and had nev Review of the SLP 6/5/18, revealed R4 communication and express her wants social interaction to goal of the SLP for of life and quality of express needs and SLP notes indicate communication boa personalized vocat and their function vinurse who will use care plan for using in R40's current ca During an interview registered nurse (F have had supervisi the breakfast meal choking. RN-A furth been encouraged t	A stated she was not aware nication board however, looked n and found a communication drawer. Both NA-H and NA-G ot aware of the communication er used it. Evaluation and Plan dated 40 had a decline in d was unable to verbally and needs or to engage in o provide quality of life. The R40 was an increase in quality f care by increasing ability to I wants in a timely fashion. The d on 7/11/18, two manual ards using functional bulary were developed for R40 vas explained to the charge the board during daily cares. A the board had not been found re plan. A on 8/9/18, at 11:30 a.m. RN)-A confirmed R40 should on and set up assitance during to minimize the risk of her stated R40 should have o use the communication ties of daily living to enhance					
	The director of nurs all residents that ne assure they are rec The director of nurs	THOD OF CORRECTION: sing or designee, could review eed assistance with eating to ceiving the necessary services. sing or designee, could udits of the delivery of care to					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 08/13/2018	
		00460	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	0 GARFIELE MN 56540	OAVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLET DATE
2 915	Continued From pa	ge 35	2 915			
	ensure appropriate implemented.	care and services are				
	TIME PERIOD OF (21) days	CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			9/1/18
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.					
	by: Based on interview facility failed to esta program which inclu for the care and tre- infections. In additi develop and mainta program, which was identify any trends a outbreaks. Lastly, the respiratory equipment contamination for 1 to have oxygen and	ent is not met as evidenced and document review, the ablish an infection control uded policies and procedures atment of residents with on, the facility failed to ain an infection surveillance s completed timely in order to and/or potential infectious he facility failed to store ent in a manner to prevent of 1 resident (R19) observed a nebulizer treatment n the bathroom, uncovered.		Corrected.		
	Findings include:					
	program was review (DON) and the adm stated the current D less than one week	5 a.m. the infection control wed with the director of nurses ninistrator. The administrator OON had started at the facility prior to the survey. The ft the facility in May 2018.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00460	B. WING	c		08/13/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
FAIR ME	ADOW NURSING HO	MF	00 GARFIELD / 5, MN 56540	AVENUE SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21375	When the infection reviewed by the fac	age 36 control information was cility, they had identified that policies, procedures and	21375				
	monitoring informa program. The adm policies had been r DON stated the fac infection control po throughout the faci	tion for the infection control inistrator stated the facility missing since May 2018. The cility had started collecting licies as they were located lity including the DON's office em into a three ring binder.					
	policies and proceed follow up of infection surveillance reporting grid related to whice equipment was reco- organism. At 11:45 policies and proceed and did not give cle- care of infections. administrator state comprehensive infe	ing, contact precautions and a th type of personal protective juired for an identified a.m. the DON confirmed the dures were not comprehensive ear facility guidance for the At 11:46 p.m., the					
	was reviewed with administrator. The facility had been ur infection surveilland administrator state completed surveilla current DON starte administrator state for reviewing the re	administrator stated the nable to locate any type of ce prior to May 2018. The d the interim DON had ance from 5/9/18, until the					
	of illness or antibio log.	tic use on the infection control					

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED			
		00460	B. WING		08/13/2018				
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE					
FAIR MEADOW NURSING HOME       BOX 8 300 GARFIELD AVENUE SOUTHEAST         FERTILE, MN 56540									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE			
21375	Continued From pa	age 37	21375						
	records on a daily k type of signs and s infection control log the only staff memb symptoms of infect not responsible for the infection contro infections/signs or recorded in real tim resident developed require isolation tec have approved poli guide the staff.	entered into the computer basis and documented any ymptoms of illness on an g. The DON confirmed she was ber reviewing the records for ion as the staff nurses were documenting information onto I logs. The DON confirmed the symptoms of illness were not the. The DON indicated if a an illness, which would chniques, the facility did not cies or procedures in which to dministrator stated to her							
	type of infectious of The Facility Assess the facility would ha program in which th for resident with or infections or a com required complex of Infections such as infection, influenza disease could be tr facility assessment control program incom management of the the facility assessment	ility had not experienced any utbreak in the past 12 months. ment dated 11/1/17, indicated ave an infection control ne facility would be able to care residents who had developed bination of conditions that care and care management. skin, respiratory, urinary and other common infectious eated in the facility. The indicated the facility infection cluded monitoring and e identified diagnoses. Lastly, nent indicated surveillance and fections was to be completed							
	equipment (mask, t was observed on a shelf located to the	a.m. R19's nebulizer tubing, medication canister) paper towel placed on the right of the bathroom sink, oxygen tubing and nasal							

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/13/2018	
		00460	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME	00 GARFIELD / ., MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	ige 38	21375			
		d together and hanging by ncentrator, uncovered in the				
	-At 7:46 p.m. R19 v nebulizer treatment	vas observed receiving a t via a facial mask.				
	equipment (mask, f were observed on a shelf located to the uncovered. R19's cannula were obse	a.m. R19's nebulizer tubing, medication canister) a paper towel placed on the right of the bathroom sink, oxygen tubing and nasal rved coiled together and on R19's concentrator, athroom.				
		bserved in bathroom with an annula draped over the towel				
	included orders to r oxygen use, uses n monitor oxygen sat hours as needed (F shortness of breath milligrams (mg)/3 n vial via nebulizer tw	ders provided on 8/10/18, monitor number of hours of nore at bedtime and night, urations to keep >90% every 8 PRN) for complaints of n, /DuoNeb solution 0.5-2.5 nilliliters (mI) administer one vo times daily and every 6 laints of shortness of breath.	8			
	stated the nasal ca should not be store	o.m. registered nurse (RN)-A nnula and nebulizer equipmen d, uncovered, in a resident's onfirmed R19 required oxygen urs.				
	would not expect to	p.m. the DON stated she find oxygen & nebulizer n a resident's bathroom.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING		08/13/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	DATE
21375	Continued From pa	ge 39	21375			
	indicated that oxyge	Safety policy dated 4/6/18 en tubing was to be stored in a in use. This policy did not equipment.				
	director of nursing of and/or revise policie control monitoring a Education could be quality assurance c	HOD OF CORRECTION: The or designee could review es and procedures for infection and antibiotic stewardship. provided to the staff. The ommittee could develop a he effectiveness of the plan.				
	TIME PERIOD OF (21) Days.	CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary al	21535			9/1/18
	must be free from u unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the preset which indicate the o discontinued. In addition to the di part 4658.1310, the	al. A resident's drug regimen innecessary drugs. An is any drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences lose should be reduced or rug regimen review required in e nursing home must comply e Interpretive Guidelines for				
	Code of Federal Re 483.25 (1) found in Operations Manual	e Interpretive Guidelines for gulations, title 42, section Appendix P of the State Guidance to Surveyors for icilities, published by the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00460	B. WING		08/	08/13/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
FAIR ME	ADOW NURSING HO	MF	00 GARFIELI , MN 56540	O AVENUE SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 40	21535				
	Health Care Finand This standard is ind available through the system and the Sta	Ith and Human Services, cing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan ate Law Library. It is not change.					
	subject to frequent change. This MN Requirement is not met as evidence by: Based observation, interview and document review, the facility failed to implement increas monitoring and identify symptoms of bleeding which resulted in a gastrointestinal bleed and required hospitalization and subsequent blood transfusions for 1 of 1 resident (R2) who rece an antibiotic while on Coumadin therapy. R2 experienced bloody stool without the identifica and notification of the physician and was four have a critically elevated INR (lab test which evaluates the clotting ability of the blood). Thi failure resulted in an immediate jeopardy situat for R2 and due to the facility's failure to evalua- their monitoring policies and procedures in or to identify areas for improvement and/or opportunities for staff education to prevent or minimize future occurrences resulted in the potential for harm that was not immediate jeopardy for 3 of 3 residents (R19, R13, R29) also received Coumadin.	, interview and document ailed to implement increased ntify symptoms of bleeding gastrointestinal bleed and ation and subsequent blood of 1 resident (R2) who received on Coumadin therapy. R2 y stool without the identification he physician and was found to vated INR (lab test which ng ability of the blood). This in immediate jeopardy situation he facility's failure to evaluate licies and procedures in order improvement and/or aff education to prevent or currences resulted in the hat was not immediate residents (R19, R13, R29) who nadin.	n D	Corrected.			
	R2 was prescribed the treatment of a unot receive increas symptoms of adver of antibiotic and an immediate jeopard	pardy began on 6/18/18, when Bactrim DS (an antibiotic) for urinary tract infection and did ed monitoring for signs and se reaction to the combination ticoagulant use. The y was identified on 8/9/18, at time the administrator, director					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00460	B. WING		08/	13/2018	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
FAIR ME	ADOW NURSING HO	MF	00 GARFIELD / E, MN 56540	AVENUE SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)		
21535	was removed on 8/ noncompliance rem severity level of G - level, which indicate immediate jeopardy Findings include: R2's annual Minimu 7/11/18, indicated F had diagnoses which infection, and atrial heartbeat that incre- heart disease). Th required extensive daily living except ea anticoagulant medi R2's Urinary Incont Catheter Care Area 7/11/18, indicated F of urinary tract infe- increased confusio associated with a L	ed. The immediate jeopardy '10/18, at 11:00 a.m. but hained at the lower scope and - isolated scope and severity ed actual harm that is not y. um Data Set (MDS) dated R2 was cognitively intact and ch included urinary tract fibrillation (an irregular eases the risk of stroke and e MDS also indicated R2 assistance with all activities of eating and also received cation daily. inence and Indwelling a Assessment (CAA) dated R2 had a longstanding history ctions (UTI) with history of n, hallucinations and delusions JTI.	3				
	history of atrial fibri hypertension with u medication that cou hypotension and ca R2's atrial fibrillatio Coumadin (anticoa	ed 7/11/18, indicated R2 had a llation, a pacemaker, and use of antihypertensive uld contribute to orthostatic ause falls. The CAA indicated n was stable, however, gulant) had recently been o a gastrointestinal bleed (GI).					
	atrial fibrillation and pacemaker. Coum	ed 7/24/18, indicated R2 had I required the use of a adin currently discontinued tay related to GI bleed and risk	x l				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 08/13/2018	
		00460	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
AIR ME	ADOW NURSING HO	ME	0 GARFIELD	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ige 42	21535		,	
	4/10/18, medical do course of antibiotica tract infection (UTI) Coumadin orders (i when an antibiotica concurrently) which Coumadin for two of doses every other of resume the regular daily and check INF the effects of antico 4/16/18. The INR r elevated at 3.8 (Fai indicated normal IN 3.0). R2 was seen for UTI due to a per	ical record revealed on botor (MD)-A started R2 on a s (Bactrim DS) due to urinary with adjustments made of her increased risk of bleeding and Coumadin are used differentiation of the staff to hold the days and then give scheduled day for four days then to dose of Coumadin 2.5 mg R (laboratory test that monitors bagulant treatment) Monday, results dated 4/16/18, were in Meadow Lab Flow Sheet IR range to be between 2.0 - by physician assistant (PA)-A rsistent and worsening and R2 was subsequently pital.				
	MD-A dated 6/1/18, hospitalizations for had been sent hom suppression with ce mg daily. However recurrence of UTI s cephalexin use. Th discontinued and C with modifications f section of the note	e Progress Note (NHPN) by , indicated R2 had had several UTIs. After hospitalization, R2 ie on chronic urinary tract ephalexin (an antibiotic) 250 r, in the past week R2 had a symptoms despite the herefore, the cephalexin was sipro (an antibiotic) was started for her INR. The assessment indicated R2 was doing well e plan was to complete the				
	MD-A ordered R2's 6/2/18, then resume ordered a recheck	R result was 3.4 therefore Coumadin to be held on e every other day. MD-A of R2's INR on 6/6/18. R2's vas 2.1, for which MD-A				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From pa	age 43	21535			
	ordered R2's Coumadin held for two days and then resumed at 2.5 mg daily with a recheck of the INR on 6/13/18, due to R2 just finishing the course of Cipro. R2's Fair Meadow Nursing Home (FMNH) fax communication dated 6/13/18, indicated R2's INR was 1.6. MD-A responded with an order to increase R2's Coumadin to 4 mg, 1 tablet daily and to recheck in two weeks. Concurrently, R2's nursing Progress Notes (PN) dated 6/13/18, indicated R2 experienced hallucinations and lethargy/sleepiness. The note further indicated an order had been received from MD-A to culture R2's urine and if R2 experienced increased weakness or uncontrolled hallucinations she may be sent to the emergency room.					
	had called the facili 1 tab orally, twice a recheck the INR or However, neither th identified any modified dose or the need for following the initiation	ated 6/18/18, indicated MD-B ity and prescribed Bactrim DS a day for seven days and to a 6/25/18, and send to MD-C. he note nor telephone order fication to R2's Coumadin or increased INR monitoring on of the antibiotic and R2's I INR results while receiving an				
	practical nurse (LP loose stools that we temperature was 9 and, "Well it is bett moved." LPN-C ind fever, pain and furt indicated LPN-C ha	8/18, written by licensed N)-C, indicated R2 had two ere "maroon in color." R2's 7. She denied abdominal pain ter now that my bowels licated he would monitor for her stools. The note also ad spoken with R2 at 2:30 p.m. d abdominal pain. R2 had also				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED				
		00460	B. WING		08/	13/2018				
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE						
FAIR MEADOW NURSING HOME       BOX 8 300 GARFIELD AVENUE SOUTHEAST         FERTILE, MN 56540										
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE				
21535	Continued From pa	age 44	21535							
	had offered to have emergency room (E left a message for I nursing home and y daughter-in-law car LPN-C informed the stools so family wa Daughter-in-law aw because she declin daughter-in-law pre would continue to n treat as necessary R2's clinical record registered nurse as notification of the m Administration Rec	straining. LPN-C indicated he e her checked in the ER) but R2 refused. LPN-C R2's daughter to call the while doing so, R2's me to pick her up for an outing e daughter-in-law about the s aware and would watch also vare R2 had declined ER ned it again with esent. LPN-C indicated he nonitor when R2 returned and and as R2 and family desired. lacked evidence of a esessment or physician naroon stool. R2's Medication ord (MAR) for June 2018, 8, R2 had received Coumadin								
	increased confusio well as increased c maroon color to he received Bactrim for affected in the past checked today and significant risk for n sample was obtained the ambulance whe	4/18, indicated R2 had n, fatigue and hallucinations as lot like appearance and more r stools. R2 continues to or a UTI and her INR had been by antibiotic use. INR was found to be 8.0 (at najor hemorrhage). A stool ed this afternoon and sent with en they departed at 3:25 p.m. A indicated R2 had been spital.								
	6/24/18, indicated F intermittent blood in the previous 3 days chronically due to a	epartment (ED) note dated R2 had been noted to have h her stool over the course of S. She was on Coumadin history of atrial fibrillation. An and found to be significantly								

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00460	B. WING		08/	08/13/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
FAIR ME	ADOW NURSING HO	MF	)0 GARFIELD / , MN 56540	AVENUE SOUTHEAST			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETE DATE	
21535	Continued From pa	ge 45	21535				
	upon arrival to ED a complaints. R2 was exceeds normal res pale. Anoscopy (a anal canal) revealed (having black pigme was repeated and w hemoglobin (protein oxygen in the blood mg of vitamin K (he intravenously and w service for further e R2's Hospital Cons indicated R2 was e (blood in the stool). some bright red blo occasion on Saturd R2's son reported h previously after she Assessment: diagr greater than would a medical condition	ad not appeared acutely ill and had not offered any acute s mildly tachycardic (heart rate sting rate) and appeared mildly scope used to examine the d black stool with melanotic entation) features. An INR vas greater than 10. R2's n responsible for transporting was 8.9 R2 was given 10 leps the blood clot) vas admitted to the hospitalist evaluation and treatment. ultation Note dated 6/25/18, valuated for hematochezia R2 reported she had passed od per rectum on one ay. Found to have INR >10. her INR had become elevated a had been treated for UTIs. hosis supratherapeutic (levels be used in actual treatment of ) INR, rectal bleeding and Hematochezia with elevated					
		ess Note dated 6/26/18, sment which included:					
	cause was uncertai secondary to diverti digestive tract), her (vascular malforma most likely because 2. Acute blood loss hemoglobin signific Received 2 units of	trointestinal bleeding. The n. This could have been iculosis (pockets in the norrhoids, angiodysplasia tion of the gut) or cancer, of the supratherapeutic INR. anemia. R2 dropped her antly from 8.9 to 7.4. packed red blood cells. c INR on admission. It was					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00460	B. WING	VING		08/13/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
AIR ME	ADOW NURSING HO	MF	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 46	21535				
	<ol> <li>mg on admission</li> <li>6/25/18.</li> <li>Atrial fibrillation,</li> <li>pacemaker placem</li> <li>Chronic anticoa</li> <li>Coumadin for now.</li> <li>Urinary tract infer</li> </ol>	gulation with Coumadin. Hold					
	observed seated in	oximately 3:15 p.m. R2 was a recliner, in her room. R2 omed and oriented to person					
	nursing (ADON) ve capacity to perform testing for INR, how testing was require	p.m. the assistant director of erified the facility had the n point of care/finger stick wever, an MD order for the ed and she was not sure if INR ed in the facility standing					
	monitoring for resid anticoagulant thera and the facility also perform the testing monitored for symp bloody emesis, or b had experienced a required hospitaliza incident happened nursing assistant (I bloody stools and b registered nurse (F frank or coffee grou	a.m. LPN-C stated side effect dents who received apy included testing for INR o had a machine in house to . LPN-C stated the staff otoms such as bloody stools, oruising. LPN-C confirmed R2 n elevated INR of 8 which ation. LPN-C stated the on a Saturday and verified a NA) had reported that R2 had ne had reported this to the RN). LPN-C stated it was not und blood and was a "weird" ed the next day, R2's stool color					

STATEME	D <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
	00460		B. WING		08/	08/13/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
FAIR ME	ADOW NURSING HO	MF	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 47	21535				
	6/23/18, when the r reported. LPN-C a had a UTI at the tin getting over one. F 6/23/18 was review R2 was offered the On 8/9/18, at 9:33 a anticoagulation mo resident's INR and as bleeding or bruis stools would be a s monitor. LPN-B sta noted she would no						
	R2's primary RN. F specific identified th INR, however, indic reference range ide sheets. RN-B verif the residents' Coun as needed (PRN) II adjustments made according to the IN would expect staff symptoms of bleed bleeding of cuts, br bleeding of cuts, br bleeding of cuts, br bleeding or any cha that were black, ma RN-B stated the NA symptoms of bleed any observed symp a progress note. RI expect the LPNs to	a.m. RN-B confirmed she was RN-B stated she did not have a herapeutic goal range for R2's cated 2.0-3.0 was the entified on the laboratory ied the physicians managed nadin doses and monthly and NRs were completed with to the Coumadin orders R results. RN-B stated she to monitor for any signs or ing such as prolonged uises, bleeding to gums, recta ange to stool such as stools aroon or bright red in color. As were to report any ing to the charge nurse and otoms would be documented in N-B also stated she would monitor for symptoms of the RN and/or the doctor.					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING		08/13/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	0 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 48	21535			
	maroon stool had b	, so she was not sure if R2's been reported to the RN or if sed R2 once reported to her.				
	R2's medical record was reviewed with RN-B who verified the following:					
	maroon stools. R2 received 4 mg Bactrim DS 800-1 on 6/18/18, and R2 antibiotic through th R2's clinical recor to indicate R2 had 6/23/18. Progress note dat indicated the ADON	a note indicated R2 had Coumadin on 6/23/18. 160 mg had been prescribed continued to receive the me morning of 6/24/18. rd contained no documentation been assessed by an RN on ted 6/24/18, at 1:30 p.m. N would contact RN-B and 6/25/18, unless R2's status				
	On 8/9/18, at 11:29 a.m. the ADON confirmed the residents on Coumadin were monitored for symptoms such as bruising, blood in urine, color of skin, lethargy, and blood in the stool and would expect any symptoms to be reported to the charge nurse so the RN could assess and monitor to "see where the situation was headed." The ADON stated the MDs did not generally give them individual INR therapeutic ranges rather, stated she would refer to the lab report results for INR parameters. In addition, the ADON stated all INR results were reviewed by the physician. The ADON verified on 6/23/18, R2's Coumadin order was for 4 mg daily and R2 had also been					
	prescribed Bactrim indicated R2's prim so it was another p the antibiotic and th	DS on 6/18/18. The ADON ary MD (MD-A) had been out rovider, MD-B, who prescribed he INR results were to have D-C, who covered for MD-A.				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00460	B. WING		08/13/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	0 GARFIELD , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 49	21535			
nnesota D	and confirmed LPN colored stool to her The ADON stated to The ADON stated to The ADON stated s assessment of R2 a monitoring state at family had been at the day and R2 had responsive with no ADON confirmed R evaluated at the EF therefore, when R2 she had "left in a m The ADON stated s family, however, LF sure if LPN-C had a benefits of R2 refus The ADON stated, trying to determine passed the informa ADON stated she w further stools after addition, the ADON observation of the r not had R2's dose contacted the phys was not sure if she differently knowing ADON stated the s and R2 had no other she even went and the residents had b The ADON stated of experienced more r appearance" and r					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00460	B. WING		08/13/2018	
NAME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	•	
AIR ME	ADOW NURSING HO	MF	00 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	before shift change discuss R2 with sta together" so the firs R2's family to discu- to notify them she The ADON perform revealed the INR le- contacted the famil was not comfortabl ask if they would be for an evaluation. Of the ADON contacted orders to transport verified at the ER, bleed and subseque blood during a four ADON stated she of R2's INR on 6/23/1 adverse interaction antibiotics, howeves she was not R2's p not know her histor stated following R2 formal discussion of regarding R2's hos however, she had to about the incident. had not made any monitoring system done what they sho since had her orde On 8/9/18, at 11:58 verified there were currently received of R29. On 8/9/18, at 12:01	UTI. The ADON stated just e she had the opportunity to aff and was able to "put it all st thing she did was contact uss possible hospitalization and would be testing R2's INR. ned the INR test which evel was 8. The ADON ly again to inform them she le with R2's INR results and e willing to send R2 to the ER Once the family had approved, ed the physician and received R2 to the ER. The ADON R2 was diagnosed with a GI iently had received two units of day hospitalization. The could have probably tested 8, as she was aware of the as between Coumadin and er, not to make excuses, but orimary RN and probably did ry as well as RN-B. The ADON I's adverse medication event, a with the interdisciplinary team pitalization was not conducted talked with RN-B and LPN-C The ADON stated the facility changes to the anticoagulant because they felt they had ould have done and R2 had r of Coumadin discontinued. B a.m. the unit clerk (UC) three residents in house who Coumadin, R13, R19, and				
		R2's maroon stool was a red				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED
		00460	B. WING	B. WING		13/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME	0 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>1</sup>	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	21535 Continued From page 51 flag and stated she would have expected the ADON to have assessed the patient herself, checked an INR, held the Coumadin, and contacted the physician. The DON also stated she felt the situation should have been reviewed in order to identify areas for facility process improvement. On 8/9/18, at 4:13 p.m. R2's primary physician		21535			
	and facility medical monitoring for resid anticoagulant medi prescribed antibioti prescribed. MD-A was Cipro, Levaqui (Bactrim), staff nee often. R2's antibiot reviewed with MD-A done that differently relied on the pharm	director, MD-A indicated the				
	antibiotics should h testing, nursing sho testing and/or the p asked for earlier IN maroon colored sto	ave ordered earlier INR buld have asked for earlier INR pharmacist should have also R testing. MA-D confirmed a bol was a cause for concern een a signal to call someone.				
	MD-A stated he wo notified when R2 ha stool. MD-A indicat on the facility policy initiated per nursing	uld have expected to be ad the first maroon colored ted the staff had been working / to include INR testing to be g discretion, however, stated a				
	would have been a particularly if the re medication. MD-A policy regarding nu	or without policy changes n indication to notify someone, sident was on anticoagulant was unsure of the facility rsing staff holding the ion without an order but				
innesota D		Id have contacted the iving the medication.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			- 08/13/2018	
		00460	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AIR ME	ADOW NURSING HO	MF		AVENUE SOUTHEAST		
(X4) ID	SUMMARY STA		MN 56540	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLET DATE
21535	Continued From pa	ge 52	21535			
	The undated Therapeutic Monitoring of INR policy directed staff to ensure a physician order was obtained per standing orders or physician order. The policy also directed if a resident was on warfarin (Coumadin) therapy and had signs of bleeding (i.e. bruising, bleeding gums, rectal bleeding, signs of blood in stool, blood in urine, etc.) nursing discretion could be used to complete a finger stick INR in house.					
	The undated Anticoagulation Management policy indicated the physician would identify potentially serious medication interactions with warfarin for example: concurrent use with digoxin, Dilantin, amiodarone and many antibiotics. The policy also indicated the physician would stop, taper, or change medications that interacted with warfarin, or monitor PT/INR very closely while the individual received warfarin to ensure the PT/INR stabilized. The policy also indicated the staff and physician would monitor for possible complications in individuals who were being anticoagulated and would manage related problems. If an individual on anticoagulation therapy showed signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other evidence of bleeding, the nurse would discuss the situation with the physician before giving the next scheduled dose of anticoagulant.					
	was removed on 8/ facility implemented	bardy that began on 6/18/18, 10/18, at 11:00 a.m. when the d the following actions: ht INR levels of residents who				
	currently received (					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AIR ME	ADOW NURSING HO	ME	0 GARFIELD / , MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	-updated their antici increased monitorin -educated all nursin policies including th non-therapeutic INI -developed a plan t ensure education w of their next shift. -updated their proc interdisciplinary tea hospital admission	coagulation policy to include ng while on antibiotics ng staff regarding the updated ne signs and symptoms of a R to educate staff not working to was received prior to the start edures to include am review of each resident for measures to prevent talizations or medication	21535			
	R19's diagnoses in behavioral disturba	eport dated 8/10/18, indicated cluded dementia with nces, chronic embolism and clot), edema, and long term				
	had moderately imp ambulate, and requ one to two staff for	dated 6/5/18, indicated R19 paired cognition, did not uired extensive assistance of ADLs. The MDS also indicated pagulant medication daily erence period.				
	revealed an order f Coumadin 5 mg da thrombosis. The ph	hary Report dated 8/10/18, or Aspirin 81 mg daily, and hily for chronic embolism and hysican also ordered monthly eport did not identify the use of n.				
	indicated R19's mo physician response	port sheet dated 8/9/18, st recent INR was 2.0. The was to continue the same and recheck the INR in two				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00460	B. WING	B. WING		13/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME	00 GARFIELD / E, MN 56540	AVENUE SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 54	21535			
	weeks then monthl	ly.				
	R13's diagnoses in of a UTI. The MDS moderately impaire assist of one to two living (ADL) except	DS dated 8/1/18, indicated included diabetes, and a history is also indicated R13 had ed cognition, required extensive to staff for activities of daily t for eating, and received ication daily during the MDS				
	R13's INR was 1.5 with an order to inc	eport dated 8/9/18, indicated and the physician responded crease the Coumadin to 2 mg ck the INR in two weeks.				
	R29's diagnoses in diabetes, Parkinso dementia. The MD cognition, required all ADLs except for independent, requi	DS dated 6/27/8, indicated included anemia, heart failure, n's, a seizure disorder and S also indicated R29 had intac extensive staff assistance for eating in which R29 was red supervision for transfers, bagulant medicaiton daily ference period.	t			
	R29's INR was 1.5 drop since the 8/1/ responded with an	eport dated 8/9/18, indicated which revealed a significant 18, INR of 3.7. The physician order to increase the daily and to recheck the INR in reeks.	ז			
	The director of nurse review the system policies and proceed effects of anticoage	THOD OF CORRECTION: sing (DON) or designee could in place, with applicable dures, to ensure potential side ulant medications are ed, and reported. The DON or				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIENCLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         AND PLAN OF CORRECTION       00460       B. WING       08/13/2018         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       08/13/2018         FAIR MEADOW NURSING HOME       BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540       PROVIDER'S PLAN OF CORRECTION ECONSECTION       (x9)         (Y4) ID       SUMMARY STATEMENT OF DEFICIENCIES TAG       ID       PROVIDER'S PLAN OF CORRECTION ECONSECTION ECONSECTION ECONSECTION SEGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTION SEGULATORY OR LSC IDENTIFYING INFORMATION)       CACH CORRECTION ECONSECTION ECONSECTION SEGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTION SEGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTION SEGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTION SEGULATORY OR LSC IDENTIFYING INFORMATION)       ID       CACH CORRECTION SEGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVIDER'S PLAN OF CORRECTION SEGULATORY OR LSC IDENTIFY ING INFORMATION)       ID       CACH CORRECTION SEGULATORY OR LSC IDENTIFY ING INFORMATION)       ID       CACH CORRECTION SEGULATORY OR LSC IDENTIFY ING INFORMATION)       ID       ID       COMPLETE       COMPLETE         21535       Continued From page 55       ID       ID       ID       ID       ID <th>AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         MARE OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BOX 8 300 GARFIELD AVENUE SOU         FAIR MEADOW NURSING HOME         MAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BOX 8 300 GARFIELD AVENUE SOU         FERTILE, MN 56540         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVI (EACH CROSS-RE         21535       Continued From page 55       21535       21535         designee could educate all appropriate staff. The DON or designee could audit to ensure ongoing compliance and report those results to the quality assurance group.       ID       ID         TIME PERIOD FOR CORRECTION: Twenty-one       ID       ID       ID</th> <th></th> <th>I ORANIZA I ROVED</th>	AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         MARE OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BOX 8 300 GARFIELD AVENUE SOU         FAIR MEADOW NURSING HOME         MAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BOX 8 300 GARFIELD AVENUE SOU         FERTILE, MN 56540         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID       PROVI (EACH CROSS-RE         21535       Continued From page 55       21535       21535         designee could educate all appropriate staff. The DON or designee could audit to ensure ongoing compliance and report those results to the quality assurance group.       ID       ID         TIME PERIOD FOR CORRECTION: Twenty-one       ID       ID       ID		I ORANIZA I ROVED		
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	Minnesota Department of Health				