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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YBGW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245545**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE - NE II 10/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/17/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

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:

- 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

DEPARTMENT OF HEALTH

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YBGW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245545**

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/13/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)
13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE - NE II 09/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/16/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

> **Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> Substandard Quality of Care 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;

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

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

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was conducted on 8/6/18, through 8/13/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/6/18, through 8/13/18, a recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. An extended survey was conducted on 8/13/18. The survey resulted in an Immediate Jeopardy (IJ) at F757 due to the facility's failure to monitor for and identify adverse side effects for the concurrent use of anticoagulant and antibiotic medication in order to prevent injury or death. The facility administrator, director of nursing (DON), and the assistant director of nursing (ADON) were notified of the IJ on 8/9/18, at 4:25 p.m. which began on 6/18/18, when R2 was prescribed an antibiotic while on Coumadin therapy without increased monitoring implemented. The IJ was removed on 8/10/18, at 11:00 a.m., however, non-compliance remained at a scope and severity level of G. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/04/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Upon receipt of an acceptable ePOC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		9/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician was notified of signs and symptoms of bleeding for 1 of 1 resident (R2) who experienced adverse effects of concurrent anticoagulant and antibiotic use. This failure resulted in actual harm for R2 due to the onset of a gastrointestinal bleed which required hospitalization and blood transfusions. Findings included: R2's quarterly Minimum Data Set (MDS) dated 4/27/18, indicated R2 was cognitively intact and had diagnoses which included urinary tract infection, long term use of anticoagulants (blood thinner), therapeutic drug level monitoring, and atrial fibrillation (an irregular heartbeat that increases the risk of stroke and heart disease). The MDS also indicated R2 required extensive	F 580	Plan: The anti-coagulation policy was updated on 8/09/18 to include increased monitoring while on antibiotics. Physician is to be notified if any readings are out of range. Dr. Ring, Medical Director, present to assist in updating this policy. PT/INRs were checked on current residents receiving anticoagulation therapy on 8/09/18. Any non □ therapeutic levels were reported to Dr. Ring and orders received. Standing orders were changed regarding checking INR every day while on antibiotic and signed by Dr. Ring. All charge nursing staff on the floor 8/09/18 were educated on the updated Anticoagulation Policy and Therapeutic Monitoring of INR Policy. All charge staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 assistance with all activities of daily living except eating and also received anticoagulant medication daily. R2's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 7/11/18, indicated R2 had a longstanding history of urinary tract infections (UTI) with history of increased confusion, hallucinations and delusions associated with UTI. R2's Falls CAA dated 7/11/2018, indicated R2 had a history of atrial fibrillation, use of pacemaker, and hypertension with use of antihypertensive medication that could contribute to orthostatic hypotension and cause falls. The CAA indicated R2's atrial fibrillation was stable, however Coumadin had recently been discontinued due to a gastrointestinal (GI) bleed. R2's care plan dated 7/24/18, indicated R2 had atrial fibrillation and required the use of a pacemaker. Coumadin currently discontinued after last hospital stay related to GI bleed and risk for bleeding with use of Coumadin. The care plan also indicated R2's family would discuss risks/benefits of Coumadin and if it should be restarted, and were aware of current discontinuation of this medication and in agreement at this time Review of R2's medical record from 4/1/18, to 8/13/18, revealed R2 had ongoing issues related to UTI with hallucinations and confusion which required multiple courses of antibiotic therapy. Concurrently, R2's Coumadin regimen required modification and increased monitoring due to fluctuations in INR outside of therapeutic levels.	F 580	were educated on this policy prior to working the floor. All other nursing staff on the floor 8/09/18 were educated on signs and symptoms of non-therapeutic INR including the list below. All nursing staff will be educated prior to working the floor. An emergency meeting was called at 7:30 pm to educate nursing staff on this situation led by Nicole Johnson, DON. Dr. Ring, Medical Director addressed staff at this time. Symptoms of active bleeding were reviewed, employees signed off understanding and took a post test on bleeding as a sign of Coumadin toxicity. " Bleeding from the gums after you brush your teeth " Bleeding between menstrual periods " Diarrhea, vomiting or inability to eat for more than 24 hours " Fever " Severe bleeding, including heavier than normal menstrual bleeding " Red or brown urine " Black or bloody stool " Severe headache or stomach pain " Joint pain, discomfort or swelling, especially after an injury " Vomiting of blood or material that looks like coffee grounds " Coughing up blood " Bruising that develops without an injury you remember " Dizziness or weakness " Vision changes RN involved was educated on importance of assessing residents herself when approached with concerns from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 On 6/13/18, R2 experienced INR results outside of therapeutic range at 1.6 for which medical doctor (MD)-A ordered R2's Coumadin be increased from 2.5 mg to 4 mg 1 tablet daily with recheck in two weeks. R2's Progress note dated 6/18/18, indicated a call 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. R2's Progress Note dated 6/23/18, completed by licensed practical nurse (LPN)-C indicated R2 had two loose stools that were maroon in color. R2's temperature was 97. She denied abdominal pain and stated "Well it is better now that my bowels moved." LPN-C indicated he would monitor for fever, pain and further stools. The note also indicated LPN-C had spoken with R2 at 2:30 p.m. and she had denied abdominal pain. R2 had also stated two days ago she had to strain to have a bowel movement and was wondering if the blood could be from the straining. LPN-C indicated he had offered to have her checked in the ER but R2 had refused. LPN-C left a message for R2's daughter to call the nursing home and while doing so R2's daughter-in-law came to pick her up for an outing. LPN-C informed the daughter-in-law about the stools so family was aware and would watch also. Daughter-in-law aware R2 had declined ER because she declined it again with daughter-in-law present. LPN-C indicated he would continue to monitor when R2 returned and treat as necessary and as R2 and family desired.	F 580	LPN/Charge Nurse. Education provided to her that she needs to notify Physician immediately when there are signs or symptoms of non-therapeutic INR. A mandatory nursing staff in-service was held on August 20th at 1 pm and 2:15pm and scheduled for August 28th at 1 pm and 2:15 pm to follow up on this topic as well as training for LPNS for conducting PT/INR□s. Education including proper ordering of labs, timely drawing of lab orders, acquisition of lab orders and follow ups was provided. Reporting of resident conditions addressed; how they are to be reported immediately to charge nurse on duty and DON. Education provided that Physician needs to be notified immediately when there are signs or symptoms of non-therapeutic INR. Medical Director and Pharmacy present at QAA on 8/22/18 and in agreement with education provided. Fair Meadow nursing staff will institute an IDT meeting on every hospital admission. 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 monitoring completed will be assessed. If there are any problems or areas of concern, Medical Director will be involved in policy and procedure improvement. Our goal is to prevent any unnecessary hospitalizations or medication related adverse events to our residents by providing early detection and preventative measures.	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YBGW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245545**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE - NE II 10/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/17/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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

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:

- 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

DEPARTMENT OF HEALTH

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 R2's clinical record lacked evidence of a registered nurse assessment or physician notification of R2's maroon colored stool. R2's Medication Administration Record (MAR) dated 6/1/18, to 6/30/18, indicated R2 received Coumadin 4 mg on 6/23/18 per order. R2's Progress Notes dated 6/24/18 revealed the following: --10:39 a.m. note completed by LPN-C indicated R2 took scheduled medications without difficulty. R2 reported being tired, denied abdominal pain. The note indicated LPN-C would continue to monitor and obtain a stool sample if able, to check for blood. --1:30 p.m. note completed by assistant director of nursing (ADON) indicated R2 denied abdominal pain as well as tenderness with palpation. Bowel sounds were present in all four quadrants. The noted indicated ADON would continue to monitor and follow up with primary registered nurse (RN) and MD tomorrow unless status changed. --3:03 p.m. note completed by ADON indicated R2 was noted to have increased confusion, fatigue, and hallucinations this afternoon as well as increased clot like appearance and more maroon color to stools this afternoon. The note indicated R2 was also on Bactrim for a UTI and her INR had been affected in the past by her antibiotics. Finger stick INR 8.0 today. The note indicated MD-E ordered R2 be sent to the hospital. Due to R2 not wanting to go to the hospital yesterday, the family was contacted and agreed to have R2 seen at the hospital. A stool sample was obtained this afternoon and sent with the ambulance when they departed the building at	F 580	Audits of lab orders and results will be done monthly by DON or designee. Monitored by DON and QAA. Completed : 9/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 3:25 p.m. R2's Emergency Department (ED) note dated 6/24/18, indicated R2 had been noted to have intermittent blood in her stool over the course of the previous three days. She was on Coumadin chronically due to a history of atrial fibrillation. An INR was checked and found to be significantly elevated at 8 (critical level which could result in a hemorrhage). R2 was mildly tachycardic (heart rate exceeds normal resting rate) and appeared mildly pale. Anoscopy (a scope used to examine the anal canal) revealed black stool with melanotic (having black pigmentation) features. An INR was repeated and was greater than 10. R2's hemoglobin (protein responsible for transporting oxygen in the blood) was 8.9. R2 was given 10 mg of vitamin K (clots blood)intravenously and was admitted to the hospitalist service for further evaluation and treatment. R2's Hospital Progress Note dated 6/26/18, indicated an assessment which included: 1. Acute lower gastrointestinal bleeding. The cause was uncertain. This could have been secondary to diverticulosis, hemorrhoids, angiodysplasia or cancer, most likely because of the supratherapeutic INR. 2. Acute blood loss anemia. R2 dropped her hemoglobin significantly from 8.9 to 7.4. Received two units of packed red blood cells. 3. Supratherapeutic INR on admission. It was above 10 on admission. R2 was given vitamin K 10 mg on admission and 2.5 mg orally on 6/25/18. 4. Atrial fibrillation, rate controlled status post pacemaker placement. 5. Chronic anticoagulation with Coumadin. Hold	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7	F 580		

Coumadin for now.
6. Urinary tract infection. History of UTI. Was on Bactrim, is most likely the cause of her increased INR.

On 8/8/18, at 3:50 p.m. the ADON verified the facility had the capacity to perform point of care testing for INR, however, stated an MD order for the testing was required and she was not sure if INR testing was included in the facility standing orders.

On 8/9/18, at 9:01 a.m. LPN-C indicated side effect monitoring for residents who received anticoagulant therapy included testing for INR and stated the facility had a machine to complete the testing. LPN-C also stated the staff monitored for symptoms such as bloody stools, bloody emesis, or bruising easier. LPN-C indicated the facility had an incident recently related to blood stools when the resident's INR was 8 and the resident had to go into the hospital. LPN-C stated the incident happened on a Saturday and indicated a nursing assistant reported R2 had blood stools and he reported this to the RN. LPN-C stated it wasn't frank blood or coffee ground blood but looked more like something R2 had eaten. LPN-C indicated the stool was a "weird" color and stated the next day the stool color was darker than the day before. LPN-C did not remember if the registered nurse had come down to look at R2 or not. LPN-C stated he could not remember if R2 had a UTI at the time or if she had just been getting over one, however, confirmed R2 became confused with UTI's. LPN-C stated R2 was not confused on 6/23/18, that he recalled.

On 8/9/18, at 9:33 a.m. LPN-B indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8	F 580		

anticoagulation monitoring included checking INR and watching for symptoms such as bleeding or bruises. LPN-B confirmed bloody stools would also be symptom they would monitor. LPN-B stated if any symptoms were noted she would notify the RN if it were the day shift, or would contact the MD if it was the evening shift.

On 8/9/18, at 9:42 a.m. registered nurse (RN)-B confirmed she was R2's primary RN. RN-B stated the physicians managed the residents' Coumadin and stated monthly and as needed (PRN) INR's were completed and adjustments made to Coumadin orders as indicated. RN-B stated she would expect staff to monitor for any signs or symptoms of bleeding such as prolonged bleeding of cuts, bruises, bleeding to gums, rectal bleeding or any change to stool such as stools black, maroon or bright red in color. RN-B stated the NAs were to report any symptoms to the charge nurse and the charge nurse would 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.

R2's medical record was reviewed with RN-B who verified the following:

--6/23/18 progress note indicated R2 had maroon stools
--R2 received 4 mg Coumadin on 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9	F 580		

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 reported to MD-C who covered for MD-A. The ADON verified she had worked on 6/23/18, and confirmed LPN-C had reported R2's maroon colored stool to her and so they went and looked at it and stated the color was "weird." The ADON stated she had LPN-C do a focused assessment of R2 and stated they were in a "monitoring" state at that point. ADON stated family had been at the facility to take R2 out for the day and R2 had been coherent and responsive with no signs of confusion and R2 had been offered the ER which she had refused. ADON confirmed R2 had "left [the facility] in a monitoring state at that time." The ADON verified she had not spoken with the family, however, stated LPN-C had done so. However, the ADON stated she was not sure if LPN-C had explained the risks and benefits of refusing to be evaluated in the ER. The ADON stated "I guess at that point we were trying to determine what the stool was" and passed the information on [to the next shift] and was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10	F 580		

aware if R2 had any further stools after she finished her shift. The ADON verified she had not had R2's dose of Coumadin held, nor had she contacted the physician at that point. In addition, the ADON stated she was not sure she would have done anything differently knowing then what she knew now as R2's stool did not have frank blood and R2 had no other symptoms. The ADON stated she even went an checked the menu to see if they had had beets served during the meal. The ADON verified on 6/24/18, R2 experienced more maroon stools with a "clotting appearance" later in the day and was more lethargic which she attributed the lethargy to R2's outing the previous day. R2 had begun hallucinating which was attributed to a UTI. The ADON stated just prior to shift change, she had an opportunity to talk with the staff which was when they had "put it all together." The ADON stated she contacted R2's family to discuss possible hospitalization and to notify them she would be testing R2's INR. The ADON proceeded to check R2's INR which was 8, so she again contacted the family to see if they would be willing to send R2 to the ER as she was not comfortable with R2's INR result. Once she had obtained the family's approval, she contacted the physician and received orders to transport R2 to the ER. Lastly, the ADON again contacted R2's family to notify them of the plan. The ADON confirmed R2 had been diagnosed with a GI bleed and received two units of blood during a four day hospitalization. The ADON confirmed she could have probably tested R2's INR on 6/23/18, as she was aware of the interactions between Coumadin and antibiotics and stated not to make excuses, but she was not R2's primary RN and probably did not know R2's history as well as RN-B had.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11	F 580		

On 8/9/18, at 12:01 p.m. the director of nursing (DON) confirmed R2's maroon stool was a "red flag" and stated she would have expected ADON to assess the patient herself, checked an INR, hold the Coumadin and contact the physician.

On 8/9/18, at 4:13 p.m. R2's primary physician and facility medical director, MD-A indicated the monitoring for residents who received anticoagulant who were prescribed antibiotics depended on the antibiotic prescribed. MD-D stated usually if it was Cipro, Levaquin or sulfamethoxazole (Bactrim) staff needed to check the INR more often. R2's MD antibiotic order from 6/18/18, was reviewed with MD-A who stated he would have done that differently. MD-A indicated physicians relied on pharmacy to help nursing out. He stated the physician who prescribed the antibiotics should have ordered earlier INR testing, nursing should have asked for earlier INR testing and/or the pharmacist should have also asked for earlier INR testing. MD-A confirmed a maroon colored stool would indicate a cause of concern and should have been a signal to call someone. MD-A indicated he would have expected to be notified when this occurred. MD-A stated they had been working on the facility policy to include INR testing to be initiated per nursing discretions, however, a maroon colored stool, with or without policy changes would have been an indication to notify someone, particularly if the resident was on anticoagulant medication. MD-A was unsure of the facility policy regarding nursing holding the Coumadin medication but indicated they should have contacted the physician prior to giving the medication.

The undated Notification of Physician policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12 directed the primary/on call physician would be notified of any medically unstable condition. The policy directed situations that warranted immediate notification included if the resident's clinical status was unclear or worsening, however, the policy did not address notifications which were not concerning lab or diagnostic test results.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582		8/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 13 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) (CMS 10055) to 3 of 3 residents (R38, R142, R143) upon discontinuation of Medicare Part A benefits, as required Findings include: R38's SNF [skilled nursing facility] Beneficiary Protection Notification Review (CMS-20052), completed by the facility, revealed R38's Medicare Part A services started 6/15/18, and the last covered day of Part A service was 7/23/18.	F 582	Correct Form #CMS-10055 SNFABN was obtained online and business office will use this form along with the Medicare Notice for residents coming off a skilled stay. Effective 8/14/18 the new form was used for any residents coming off Medicare. A CMS Form 10055 was filled out and provided to R38□s family on 8/28/18. Administrator to monitor for compliance. QAA was made aware of deficiencies at meeting on 8/22/18 and will monitor compliance. Completed 8/28/18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 14 The form indicated the "facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted." R38 remained in the facility after 7/23/18. Further record review revealed the facility had provided a NOMNC [Notice of Medicare Non-Coverage] (CMS 10123); however, a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) (CMS 10055) was not provided. R142's CMS-20052, completed by the facility, revealed R142's Medicare Part A services started 6/4/18, and the last covered day of Part A service was 7/2/18. The form indicated the "facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted." R142 discharged from the facility on 7/3/18, with benefit days remaining. Further record review revealed the facility had provided a NOMNC (CMS 10123), however, an SNFABN (CMS 10055) was not provided R143's CMS-20052, completed by the facility, revealed R142's Medicare Part A services started 3/29/18, and the last covered day of Part A service was 7/3/18. The form indicated the "facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted." R143 remained in the facility after 7/3/18. Further record review revealed the facility had provided a NOMNC (CMS 10123), however, an SNFABN (CMS 10055) was not provided On 8/13/18, at 10:19 a.m. the business office manager (BOM) indicated the facility had not been aware of the changes related to beneficiary protection notification and the requirement to provide the SNFABN. The BOM confirmed they	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 15 had not given the notices as required. The undated Demand Bill policy directed when/if resident/resident representative appeal; it was the social worker's responsibility to provide resident/representative with the process of "Appeal Rights" paperwork and contacting information with QIO [quality improvement organization].	F 582		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is	F 604		9/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 16 indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R40) were free from the use of physical restraints. Findings include: The face sheet dated 8/10/18 indicated R40 had diagnoses that included, but were not limited to Parkinson's disease, repeated falls, weakness, hallucinations, and disorientation. R40's quarterly minimum data set (MDS) dated 7/18/18, indicated R40 had severe cognitive impaired, required extensive assistance of two persons for bed mobility and required extensive assistance of one person for transfers and ambulation. The MDS indicated R40 had bowel and bladder incontinence and required extensive assistance for toileting. The MDS also indicated R40 had restraint use daily which included a chair that prevented rising, and a restraint marked as "other" used when R40 was in bed. . Additionally, the MDS indicated R40 had personal alarm's used while in bed and in the wheelchair. Review of the last completed Physical Restraint Elimination Assessment dated 7/18/18, indicated R40 was restrained with an alarmed seat belt in the wheelchair. The specific reason for the restraint use was identified as poor safety judgement and self-transfers with falls. The assessment indicated R40's daughter requested	F 604	8/14/18 Resident□s primary RN and Administrator met with daughter Karen and it was explained that it is her mother□s right to be free from any physical restraint not required to treat her medical symptoms. Also explained to daughter that there is still a risk for potential falls. Daughter agreed to remove the seat belt. On 8/09/18 RN□s met with DON and discussed the appropriate uses of restraints and the need for medical symptoms to warrant the restraint. Two other residents with restraints were reviewed to make sure appropriate symptoms warranted their use. No other changes were made at that time. R 40□s restraint removed on this date 8/20/18. Interventions put in place: Monitoring resident every 15 mins while in room for one week. Monitor every 30 minutes while in room for one week. Monitor every hour while in room for one week. Toileting to be done immediately after meals in an attempt to meet resident needs prior to her attempts to get out of chair independently. Communication board used 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	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 turned them off and would then self transfer 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, agitation, and weakness.	F 604	room. Care plan and care sheet were updated to include use of the communication board. 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. Random weekly audits are performed on rotating shifts to ensure the monitoring sheets are being filled out timely by Primary RN, DON. Audit results to be brought to QAA Committee. QAA was made aware of deficiencies at meeting on 8/22/18 and will monitor compliance. Completed: 9/06/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 604	Continued From page 18 Family member (FM-A) was interviewed on 8/7/18, at 7:30 p.m. during which she stated R40 used the alarmed seat belt so she would not escape her wheelchair. FM-A stated R40 did not like the restraint belt and was embarrassed to have it on. FM-A stated R40 had recently been fitted for a new wheelchair in which R40 was better seated in. FM-A confirmed she would now be open to a restraint reduction. R40 was interviewed on 8/7/18, at 7:35 p.m. and indicated she liked the restraint belt and tried to hide the belt by readjusting her shirt. R40 was observed on 8/8/18, at 7:06 a.m. seated at the dining room table in her wheelchair. R40's alarmed seat belt was still on in the dining room although R40's care plan directed staff to remove the seatbelt while dinning. During an interview on 8/9/18, at 11:30 a.m. register nurse (RN)-A stated she was R40's primary nurse and was responsible for R40's health care. RN-A stated the alarmed seat belt was used for fall prevention and family request. RN-A was not aware family members could not request the use of a restraint device unless a resident had a specific medical symptom to justify the restraint use. RN-A could not identify a specific medical symptom that would warrant the use of a restraint.	F 604		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must	F 676		9/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 19 provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dinning assistance was provided and a communication board was utilized for 1 of 1 resident (R40)	F 676	R 40 is placed on the assisted side of the dining room. Dietary staff have been instructed on 8/28/18 to cut food into bite size pieces prior to serving her tray.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 20 reviewed for activities of daily living. Findings include: R40's face sheet dated 8/10/18 indicated R40 had diagnoses that included, but were not limited to Parkinson's disease, repeated falls, weakness, hallucinations, and disorientation. R40's quarterly minimum data set (MDS) dated 7/18/18, indicated R40 had severe cognitive impaired, required extensive assistance of one to two persons for mobility, and supervision with set up assistance for eating. The MDS indicated R40 had restraint use daily which included a chair that prevented rising. Additionally, the MDS indicated R40 had personal alarm's used while in bed and in the wheelchair. Family member (FM)-A was interviewed on 8/7/18, at 7:30 p.m. during which she stated R40 was recently moved in the dining room to a table where assistance would be provided. FM-A also stated she thought R40 was supposed to be using a communication device developed by the speech language pathologist (SLP) but had not seen the device used. R40's care plan revised on 7/18/18, revealed R40 was at risk for choking related to holding or pocketing food in mouth and cheeks and had unintentionally ate non-edible items like napkins and paper. The care plan indicated R40 required assistance with meals to sit in the upright position, eat slowly, and chew each bit thoroughly. Resident to eat on the assisted side of the dining room for supervision with meals. R40 was observed on 8/8/18, at 7:06 a.m. seated	F 676	Nursing staff are to monitor and cue resident to drink between bites as directed by her care sheet. 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. 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. 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. R 40 and R25 will have increased quality of life by being able to express needs and receive asst when needed. Rn□s and DON will do random walk throughs at meal time and other shifts to assure asst is given when needed and that communication boards are available if needed. Compliance monitored by primary RN, DON, and QAA. Completed: 9/06/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 21	F 676		

at a dining room table. R40 was served the meal which included french toast and bacon. R40 had a difficult time eating because the french toast had not been cut for her and R40 was unable to cut the meal into bite size pieces herself. R40 finished the meal at 8:20 a.m. and at no time were staff observed seated by R40 to assist her with cutting the meal or cueing her to drink between bites of food.

R40 was observed on 8/8/18, from 7:06 a.m. to 3:30 p.m. and 8/9/18, from 8:15-11:00 a.m. and at no time was a communication device implemented to enhance communication.

Nursing assistant (NA)-H was interviewed on 8/9/18, at 9:12 a.m. and stated she was not aware of any communication device or board developed for R40.
-At 9:41 a.m. NA-G stated she was not aware R40 had a communication board however, looked through R40's room and found a communication board in a dresser drawer. Both NA-H and NA-G stated they were not aware of the communication board and had never used it.

Review of the SLP Evaluation and Plan dated 6/5/18, revealed R40 had a decline in communication and was unable to verbally express her wants and needs or to engage in social interaction to provide quality of life. The goal of the SLP for R40 was an increase in quality of life and quality of care by increasing ability to express needs and wants in a timely fashion. The SLP notes indicated on 7/11/18, two manual communication boards using functional personalized vocabulary were developed for R40 and their function was explained to the charge nurse who will use the board during daily cares. A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 22 care plan for using the board had not been found in R40's current care plan. During an interview on 8/9/18, at 11:30 a.m. registered nurse (RN)-A confirmed R40 should have had supervision and set up assitance during the breakfast meal to minimize the risk of choking. RN-A further stated R40 should have been encouraged to use the communication board during activities of daily living to enhance her communication and quality of life.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 1 of 1 resident (R12) who was totally dependent on staff for incontinence cares. Findings include: R12's quarterly Minimum Data Set (MDS) dated 5/23/18 identified R12 with severe cognitive impairment and diagnoses including Alzheimer's disease, and dementia. The MDS indicated R12 required extensive assistance with all activities of daily living and was totally incontinent of bowel and bladder. The Urinary Incontinence Care Area Assessment (CAA) print date 8/8/18, indicated R12 was	F 677	The care sheet contained instructions to toilet every 2-3 hours. Education given to 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 following the care plan given at nursing staff meeting on 8/20 and 8/28/18. Bladder assessment done on R12 on 8/28/18, care sheet and care plan changed to q2h. Charge nurse on each shift is responsible to check the toileting schedules to be sure they have been followed. This was reinforced at the nursing meeting on 8/20 and 8/28/18. Random audits will be done weekly on rotating shifts by RN/DON to assure	8/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 23 incontinent of bladder and required assist of staff to check and change every two hours and as needed. R12's Bladder Assessment Form dated 3/17/18 indicated R12 had functional incontinence, was totally incontinent of bowel and bladder due to physical impairments and cognitive deficits. R12 would be inappropriate for bladder retraining and would be check and change with toileting needs. R12's care plan dated 5/30/18, directed the staff to assist R12 with a check and change of incontinent product schedule of every two hours and as needed. R12 was observed on 8/8/18, during continuous observations from 7:05 a.m. to 10:23 a.m. R12 was not observed to be assisted with incontinence cares during this time. -At 7:05 a.m. R12 was observed seated in a wheelchair (WC) in the dining room. -At 8:24 a.m. licensed practical nurse (LPN)-C wheeled R12 from the dining room to the desk area by the front entrance and positioned her by the wall. -At 8:29 a.m. the therapy aide wheeled R12 to the therapy room. R12 was observed to fold towels and be provided upper and lower range of motion activity. -At 8:51 a.m. the therapy aide wheeled R12 out of the therapy room, returned her to the desk area by the front entrance and positioned her by the wall.	F 677	incontinent cares are done timely. Audit results will be presented to QAA at least quarterly, more often if there are increased issues. QAA was made aware of deficiencies at meeting on 8/22/18 and will monitor compliance. Completed: 8/28/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 24	F 677		

-At 9:01 a.m. the administrator wheeled R12 to the front door and returned her to the desk area by the front entrance and positioned her next to the wall.

-At 9:05 a.m. licensed social worker (LSW)-A wheeled R12 into the activity room. LSW-A turned on the television and sat next to R12.
-At 9:12 a.m. LSW-A left the activity room and R12 continued to be seated in the activity room in her WC.

-At 9:43 a.m. activity aide (AA)-A entered the activity room and informed R12 of Bible study at 10:00 a.m.

-At 10:00 a.m. AA-A offered R12 a glass of water and positioned her at a table with another female resident for Bible study.

-At 10:15 a.m. nursing assistant (NA)-A wheeled R12 from the activity room to her room.

-At 10:21 a.m. NA-A and NA-C assisted R12 to transfer from the wheelchair to the bed via a full body mechanical lift. Once in bed, NA-C changed R12's incontinence brief. R12 was observed to be incontinent of urine and the coccyx and buttock area was red, with no open areas observed.
-At 10:22 a.m., NA-C confirmed R12 was incontinent of urine and her coccyx and buttock area was red. NA-C confirmed she had not provided R12 with incontinence care that morning.
-At 10:23 a.m. NA-B confirmed R2 had last been assisted with incontinence cares at 6:45 a.m. prior to going to the dining room for breakfast at 7:00 a.m. (a total of 3 hours and 30 minutes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 25 earlier). On 8/8/18, at 11:24 a.m. registered nurse (RN)-B confirmed R12 was to be assisted with incontinence cares every two hours as directed by the care plan. On 8/8/18, at 2:00 p.m. the director of nursing (DON) confirmed staff was expected to provide timely repositioning and incontinence cares. A facility policy related to timely provision of incontinence care was requested, however not provided.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning services for 2 of 2 residents (R12, R5) who were identified at risk for pressure ulcers and required staff assistance to reposition.	F 686	Education given to nursing staff on the 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 prevent	8/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 26 Findings include: R12's quarterly Minimum Data Set (MDS) dated 5/23/18, indicated R12 had severe cognitive impairment and diagnoses which included Alzheimer's disease and a coccyx region pressure ulcer. The MDS indicated R12 required extensive assist of two persons for toilet use, bed mobility, transfers and dressing. The MDS also indicated R12 had one unhealed, stage 1 pressure ulcer (intact skin with blanchable redness of a localized area usually over a bony prominence), was at risk for the development of further pressure ulcers, and required a pressure reducing device for bed and chair, a turning and repositioning program, and nutrition/hydration interventions to manage skin problems. R12's Tissue Tolerance dated 3/7/18 indicated R12 was at high risk for pressure ulcer development. R12's Skin Review assessment dated 3/7/18, indicated R12 was at high risk for pressure ulcers, received mechanical soft diet with Boost breeze supplement three times daily, air mattress on bed, repositioning every two hours and check and change every two hours to address incontinence care. R12's care plan provided 8/18/18, indicated R12 was at risk for pressure ulcers related to decreased mobility, need for assistance with bed mobility/offloading and repositioning, bowel incontinence, history of pressure ulcers, history of recent superficial open area on coccyx, and a left above the knee amputation with no prosthesis. The care plan directed the staff to assist with	F 686	pressure ulcers. Bladder assessment done on R12 on 8/28/18, care sheet and care plan changed to q 2h. R 12 will receive toileting and repositioning needs as directed by updated care plan. R12 expired on 9/03/18 with no open areas. A bladder assessment was done on R5 dated 9/07/18. Care plan and care sheet changed to toilet q2h. R5 will receive toileting and repositioning needs as directed by the updated care plan. All residents who require assistance with toileting needs will be reviewed to ensure their care plans accurately reflect their needs. Education provided to all nursing staff by DON regarding the importance of following the care plan given at nursing staff meeting on 8/20 and 8/28/18. Charge nurse on each shift is responsible to check the repositioning schedules to ensure they have been followed. This was reinforced at the nursing meeting on 8/20 and 8/28/18. Shift audits will be completed 3x/wk for the next 90 days by DON or designee to assure incontinent cares are done timely. Compliance monitored by primary RN and 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 the findings. Completed : 9/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27	F 686		

hygiene and general skin care, minimize pressure on bony prominences, reposition with two staff every two hours, and assist with check and change every two hours for incontinence care.

On 8/8/18, during continuous observations from 7:05 a.m. to 10:23 a.m. R12 was not observed to be assisted with repositioning.

-At 7:05 a.m. R12 was observed seated in a wheelchair (WC) in the dining room.

-At 8:24 a.m. licensed practical nurse (LPN)-C wheeled R12 from the dining room to the desk area by the front entrance and positioned her by the wall.

-At 8:29 a.m. the therapy aide wheeled R12 to the therapy room. R12 folded towels and was provided provided upper and lower range of motion activity.

-At 8:51 a.m. the therapy aide wheeled R12 out of the therapy room, returned her to the desk area by the front entrance and positioned her by the wall.

-At 9:01 a.m. the administrator wheeled R12 to the front door and returned her to the desk area by the front entrance and positioned her next to the wall.

-At 9:05 a.m. licensed social worker (LSW)-A wheeled R12 into the activity room. LSW-A turned on the television and sat next to R12. At 9:12 a.m. LSW-A left the activity room and R12 remained seated in the activity room in her WC.

-At 9:43 a.m. activity aide (AA)-A entered the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28	F 686		

activity room and informed R12 of Bible study at 10:00 a.m.

-At 10:00 a.m. AA-A offered R12 a glass of water and positioned her at a table with another female resident for Bible study.

-At 10:15 a.m. nursing assistant (NA)-A wheeled resident from the activity room to her room.

-At 10:21 a.m. NA-A and NA-C assisted R12 to transfer from the wheelchair to the bed via a full body mechanical lift. Once in bed, NA-C changed R12's incontinence brief. R12 was noted to have been incontinent of urine. R12's coccyx and buttock area was red with no open areas observed. At 10:22 a.m., NA-C confirmed R12 was incontinent of urine and her coccyx and buttock area was red. NA-C confirmed she had not provided R12 with incontinence care that morning.

-At 10:23 a.m. NA-B confirmed R2 had last been assisted with incontinence cares at 6:45 a.m. prior to going to the dining room for breakfast at 7:00 a.m. (a total of 3 hours and 30 minutes earlier).

On 8/8/18, at 11:24 a.m. registered nurse (RN)-B confirmed R12 was at risk for pressure ulcers, and was to be assisted with repositioning every two hours as directed by the care plan.

On 8/8/18, at 2:00 p.m. the director of nursing (DON) confirmed the staff was expected to provide timely repositioning every two hours as directed by the care plan.
R5's annual MDS dated 5/2/18, indicated R5 required extensive assistance of two staff for bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29	F 686		

mobility, transfers, dressing, toileting and personal hygiene and was at risk for developing pressure ulcers. The MDS identified R5 had upper and lower extremity impairment on both sides of body.

R5's diagnosis report provided on 8/10/18, included diagnoses of aphasia (disorder that results from damage to portions of the brain that are responsible for language), amyotrophic lateral sclerosis (a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord), and hereditary and idiopathic neuropathy (loss of sensitivity in the hands and feet, and in organs such as the kidneys, heart, and eyes).

R5's skin review assessment dated 5/1/18, indicated R5 was to be repositioned every two hours and had no current skin issues.

R5's care plan provided on 8/10/18, directed the staff to turn and reposition R5 every 1.5 to two hours when in bed. The care plan also indicated R5 had a recent open sore on the coccyx which opened and healed and was most recently open as of 8/2/18.

R5's nursing assistant (NA) care sheet provided on 8/10/18, directed the staff to turn and reposition every 1.5 to two hours when in bed, or as she requested.

On 8/8/18, during continuous observation from 7:16 a.m. until 10:20 a.m. R5 was not provided assistance to turn or reposition.

-At 10:20 a.m. NA-D and NA-E provided incontinence care and turned and repositioned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 30 R5. NA-D & NA-E both confirmed they had not provided care for R5 since the start of their shift at 6 a.m. a total of 4 hours and 20 minutes earlier. On 8/9/18, at 9:19 a.m. NA-E was observed assisting R5 with repositioning. NA-E confirmed R5 had not been repositioned since 6:00 a,m. when she started her shift, a total of 3 hours and 19 minutes earlier. On 8/13/18, at 10:36 a.m. RN-B stated R5 was to be provided assistance with turning and repositioning in order to prevent the development of pressure ulcers every 1.5 to two hours, and per resident request. On 8/13/18, at 1:14 p.m. the DON stated she would expect the residents' to be turned and repositioned according to their care plan. The DON stated three hours in between repositioning was not acceptable care. A facility policy related to timely provision of repositioning was requested, however was not provided.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		9/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 31 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the removal of a knee brace as directed by the care plan for 1 of 1 resident (R19) observed lying in bed with the knee brace on. Findings include: R19's quarterly minimum data set (MDS) dated 5/29/18, indicated R19 was severely cognitively impaired and required extensive assistance from two staff for bed mobility, transfers, dressing, toileting and personal hygiene. R19's admission record provided 8/10/18, indicated diagnoses of osteoarthritis of knee and disorder of bone, unspecified, R19's care plan provided on 8/10/18, indicated R19 had degenerative joint disease of the right knee and directed staff to apply a brace to the right knee when up and to remove when in bed. R19's nursing assistant care sheet provided on 8/10/18, directed staff to apply brace to right knee, over pants and to remove when in bed and when bathing.	F 688	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. Care sheet will be updated to include physician order. Instructions for brace will be updated to include when the brace should be on and off. This will be laminated and placed in resident□s room. Random audits will be completed by DON or designee 3xwk for 1 month/ 2xwk for 2 weeks/ 1xwk for 1 week to ensure that brace is being removed when resident in bed. Compliance monitored by primary RN and 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 32 R19's brace instructions provided by the facility included directions for how to apply and remove the brace. The instructions did not indicate at what times the brace should not be worn. On 8/7/18, at 6:45 p.m. R19 was observed by the nurse's station, seated in wheelchair, with a right knee brace on. The brace was noted to have metal-hinged bars located on each side of the knee. On 8/8/18, at 7:17 a.m. R19 was observed in her room, seated in a wheelchair, with the right knee brace on. -At 12:02 p.m. R19 was observed lying in bed on the right side with the brace on the right knee. R19 stated the brace was uncomfortable to have on when in bed. On 8/09/18, at 2:06 p.m. register nurse (RN)-A stated it was the expectation that the nursing assistants followed R19's care sheets/care plan, which directed the knee brace to be removed when R19 was in bed. On 8/10/18, at 10:17 a.m. NA-B stated R19 should have the knee brace removed when in bed. On 8/10/18, at 10:20 a.m. registered occupational therapist stated R19 should have had the brace removed when she is in bed. On 8/13/18, at 1:13 p.m. the director of nursing (DON) stated she would expect R19's knee brace be removed while in bed, if nothing else, for comfort reasons for resident.	F 688	Completed: 9/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document, review the facility failed to ensure footrests were in place on a wheelchair for 1 of 1 resident (R19) observed to have their foot become lodged underneath their wheelchair during transport. Findings include: R19's quarterly Minimum Data Set (MDS) dated 5/29/18, indicated R19 was severely cognitively impaired, required extensive assistance from two staff for transfers, used a wheelchair and required extensive assistance of one staff for locomotion on/off the unit. R19's Activity of Daily Living/Functional Care Area Assessment (CAA) dated 10/10/17, indicated R19 did, at times, propel self with lots of encouragement. R19's care plan provide on 8/10/18, indicated R19 used a wheelchair for locomotion. R19's nursing assistant care sheet indicated R19 utilized a wheelchair with bilateral leg rests.	F 689	Foot rests were applied to R19's wheelchair on 8/10/18 and are to be used when resident is being pushed to/from locations. Footrests are to remain off when resident is self-propeling with her feet and put on when resident is being pushed for transport. Care sheet updated to instruct on use of footrests. QAA addressed this issue on 8/22/18. Footrest storage bags have been ordered to hang on the back of resident wheelchairs. Those residents that self propel will have footrests off unless being pushed to/from location. Therapy screened all residents for the need for footrests. Care sheets and care plans will be updated based on this information. Those residents who have the need for footrests will have a bag for the footrests on the back of their chair to ensure they are always available when needed. DON provided education to nursing staff at staff meeting on 8/20 and 8/28/18 regarding safe wheelchair transport and	9/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 34 During observations on 8/7/18, at 6:45 p.m. until 7:32 p.m.; 8/8/18, at 7:17 a.m. until 7:24 a.m. and again from 9:27 a.m. to 9:35 a.m. and 9:47 a.m. until 11:57 a.m.; and on 8/9/18, at 9:36 a.m. until 9:53 a.m., R19 was observed in the wheelchair without footrests in place on the wheelchair. R19's Nurse progress note (PN) dated 8/7/18, indicated a staff member was pushing R19's wheelchair, stopped at the dining room for a rest break for resident's legs. Once in the activity room R19 yelled, "I'm mad" at writer, then proceeded to lift feet and tuck them under wheelchair while still in motion. R19 hollered at the writer stating, "Look what you have done!" Staff explained the risks of planting feet while still in locomotion and made sure resident was not injured. On 8/8/18, at 11:57 a.m. nursing assistant (NA)-E was observed pushing R19 in the wheelchair when R19 yelled out when her left foot became entangled under the wheelchair. NA-E stated to R19, "You need to keep your feet up" and continued to push the wheelchair towards R19's room. At 12:02 p.m. R19 stated it hurt when her foot became entangled under the wheelchair. On 8/9/18, at 2:06 p.m. registered nurse (RN)-A stated the foot pedals should have been placed on R19's wheelchair when going long distance, and verified she was aware of instances where R19's foot had been caught underneath the wheelchair when being pushed by staff without the leg rests in place. On 8/13/18, at 1:13 p.m. the director of nursing (DON) stated she would expect the footrests to be used with any resident who was being pushed	F 689	the need for foot rests. Random audits will be completed by DON or designee 3xwk for 1 month/ 2xwk for 2 weeks/ 1xwk for 1 week to assure staff is using footrests at appropriate times to ensure safety of the resident and that feet will not be lodged underneath the wheelchair during transport. Compliance monitored by primary RN and 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. Completed: 9/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35 in a wheelchair.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		9/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 36 This 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 at risk for developing pressure ulcers. The MDS identified R5 had upper and lower extremity impairment on both sides of the body. R5's diagnosis report provided on 8/10/18, included diagnoses of aphasia (disorder that results from damage to portions of the brain that are responsible for language), amyotrophic lateral sclerosis (ALS) (a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord), and hereditary and idiopathic neuropathy (loss of sensitivity in the hands and feet, and in organs such as the kidneys, heart, and eyes). R5's Urinary Care Area Assessment (CAA) dated 5/14/18, indicated R5 was frequently incontinent of bladder, had difficulty using commode related to ALS, mostly used bedpan or staff checking and changing of incontinent brief every 2-3 hours and as needed (PRN). R5 had stress/urge functional urinary incontinence related to neuromuscular disease. R5's care plan provided on 8/10/18, directed staff	F 690	A bladder assessment was done on R5 dated 9/07/18. Care plan and care sheet changed to toilet q2h. R5 will receive toileting needs as directed by the updated care plan. All residents who require assistance with toileting needs will be reviewed to ensure their care plans accurately reflect their needs. Education provided to all nursing staff by DON regarding the importance of following the care plan provided at nursing staff meetings on 8/20 and 8/28/18. Charge nurse on each shift is responsible to check the that toileting schedules have been followed. This was reinforced at the nursing meetings on 8/20 and 8/27/18. Policy relating to toileting was reviewed and updated to ensure timely cares to residents who are continent and incontinent. Shift audits are being completed 3x/wk for the 90 days by DON or designee to assure timely toileting on all shifts. 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. Compliance monitored by primary RN and DON. Completed: 9/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 37	F 690		

to provide extensive assistance of two persons to check and change, use commode, or bedpan every 2-3 hours and prn.

R5's nursing assistant care sheet provided on 8/10/18, directed staff to check and change, use commode or bedpan every 2-3 hours and prn.

On 8/8/18, during continuous observation from 7:16 a.m. until 10:20 a.m. R5 was not provided care for urinary incontinence. At 10:20 a.m. nursing assistant (NA)-D and NA-E were observed to provide R5 incontinence care due R5 having been incontinent of urine. NA-D & NA-E both confirmed they had not provided care for R5 since the start of their shift at 6 a.m. for a total of 4 hours and 20 minutes without incontinence care assistance.

On 8/9/18, at 9:19 a.m. NA-E was observed assisting R5 with repositioning. NA-E confirmed incontinence care/toileting assistance had not been provided to R5 since the start of her shift at 6:00 a.m. for a total of 3 hours and 19 minutes earlier.

On 8/13/18, at 10:36 a.m. registered nurse (RN)-B stated the staff were expected to provide incontinence care or toileting every 2-3 hours and prn.

On 8/13/18, at 1:14 p.m. the director of nursing stated she would expect that residents would be checked and changed/toileted according to the care plan and over three hours without assistance, was not acceptable.

A facility policy related to timely provision of incontinence care was requested, however was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 38 not provided.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess pain, and identify non-pharmacological interventions for 1 of 1 resident (R38) who voiced complaints of pain. The findings include: R38's face sheet dated 8/10/18, indicated R38 had diagnoses including atrial fibrillation, anemia, and muscle weakness. Review of the 30-day prospective payment system (PPS) Minimum Data Set (MDS) dated 7/13/18, indicated R38 had moderately impaired cognitive impairment, and had occasional pain rated at a 6 on a scale of 1-10 with one being the lowest amount of pain and 10 being the most amount of pain. The MDS indicated pain had not made sleep difficult at night and had not limited R38's day-to-day activities. Review of R38's physician order's dated 8/6/18, indicated R38 had been prescribed Tylenol 325 mg one tab every night at bedtime on 8/6/18, and prior to 8/6/18, R38 had an order for Tylenol 325	F 697	A Comprehensive Assessment was done on R38 on 9/04/18 to include the location of the pain, a description of the pain, aggravating factors, alleviating factors, and both pharmacological and non-pharmacological interventions that alleviated the pain. Pain assessments were done on R38 on 9/03 and 9/04 by primary RN. Tylenol was increased to 325 mg 3x/day on 9/04/18. Xanax was ordered on 9/04/18 related to anxiety associated with pain. PT evaluation was ordered with PT to follow if indicated. 7 day monitoring sheet was started on 9/06 to monitor R38's pain on every shift. Monitoring includes: non pharmacological interventions, activity levels, pain rating, location of pain, medication given or not, side effects, level of consciousness. Care plan was updated to include pain: aggravating factors, alleviating factors, non -pharm interventions on 8/10/18. Rehab nursing initiated neck range of motion, heat and massage to resident□s neck on 8/10/18 as a	9/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 39 mg one tablet every four hours as needed for pain. R38's Medication Administration Record from 7/1/18-8/10/18, revealed R38 received Tylenol 325 mg one tablet at least once a day with the exception of four days in that time frame. R38 rated the pain between 3 and 7 on a 1-10 scale. R38 was interviewed on 8/8/18, at 8:46 a.m. and stated she frequently had pain in her neck and back area which was more pronounced during the night time hours (after midnight). R38 described the pain as a dull ongoing ache and rated the pain at a 6 on the 1-10 scale. R38 stated aggravating factors of the neck pain included the bed/mattress supplied by the facility which was uncomfortable, cold air/environment, and strenuous activity. R38 stated regular Tylenol use, and a warm neck roll alleviated the neck/back pain. Review of R38's comprehensive pain assessment provided by the facility was section J of the MDS. The assessment indicated R38 had experienced occasional pain in the last five days, the pain had not limited R38's day-to-day activity, and R38 rated the pain at a 6 on a scale of 1-10. The assessment was not comprehensive, as the assessment failed to identify where R38's pain was located, a description of the pain, aggravating factors, alleviating factors, and both pharmacological and non-pharmacological interventions that alleviated the pain had not been assessed. Review of R38's comprehensive care plan revealed no care plan had been developed which addressed R38's pain symptoms.	F 697	non-pharmacological intervention. A new pillow was ordered 8/29/18 to attempt to alleviate resident□s pain at night. Three mattresses have been tried to best fit for comfort. Warm blankets and heat packs continue to be offered to alleviate pain. Pain management policy was updated to list what the pain assessment should include on 8/29/18. Comprehensive pain assessments will be done for all residents on admission and with new or worsening onset of pain. Residents that are on a current pain 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 complaints of pain. Random audits will also be done 3x/wk for 3 weeks, then 1xwk for 3 weeks. 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 based on the findings. Completed: 9/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 40 On 8/10/18, at 11:37 a.m. registered nurse (RN)-A confirmed R38 had not been comprehensively assessed for pain, and a care plan had not been developed to identify pharmacological and non-pharmacological interventions. The facility policy for Pain management/pain prevention (undated) indicated the staff nurse would complete a pain assessment at the time of admission, following a hospitalization, quarterly, and upon determination of pain. The policy had not identified what the assessment should include.	F 697		
F 757 SS=J	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757		9/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 41 stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based observation, interview and document review, the facility failed to implement increased 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 received an antibiotic while on Coumadin therapy. R2 experienced bloody stool without the identification and notification of the physician and was found to have a critically elevated INR (lab test which evaluates the clotting ability of the blood). This failure resulted in an immediate jeopardy situation for R2 and due to the facility's failure to evaluate their monitoring policies and procedures in order 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) who also received Coumadin. The immediate jeopardy began on 6/18/18, when R2 was prescribed Bactrim DS (an antibiotic) for the treatment of a urinary tract infection and did not receive increased monitoring for signs and symptoms of adverse reaction to the combination of antibiotic and anticoagulant use. The immediate jeopardy was identified on 8/9/18, at 4:25 p.m. at which time the administrator, director of nursing (DON) and assistant director of nursing (ADON) were notified. The immediate jeopardy was removed on 8/10/18, at 11:00 a.m. but noncompliance remained at the lower scope and severity level of G - isolated scope and severity level, which indicated actual harm that is not	F 757	Plan: The anti-coagulation policy was updated on 8/09/18 to include increased monitoring while on antibiotics. Physician is to be notified if any readings are out of range. Dr. Ring, Medical Director, present to assist in updating this policy. PT/INRs were checked on current residents receiving anticoagulation therapy on 8/09/18. Any non □ therapeutic levels were reported to Dr. Ring and orders received. Standing orders were changed regarding checking INR every day while on antibiotic and signed by Dr. Ring. All charge nursing staff on the floor 8/09/18 were educated on the updated Anticoagulation Policy and Therapeutic Monitoring of INR Policy. All charge staff were educated on this policy prior to working the floor. All other nursing staff on the floor 8/09/18 were educated on signs and symptoms of non-therapeutic INR including the list below. All nursing staff will be educated prior to working the floor. An emergency meeting was called at 7:30 pm to educate nursing staff on this situation led by Nicole Johnson, DON. Dr. Ring, Medical Director addressed staff at this time. Symptoms of active bleeding were reviewed, employees signed off understanding and took a post test on bleeding as a sign of Coumadin toxicity.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 42 immediate jeopardy. Findings include: R2's annual Minimum Data Set (MDS) dated 7/11/18, indicated R2 was cognitively intact and had diagnoses which included urinary tract infection, and atrial fibrillation (an irregular heartbeat that increases the risk of stroke and heart disease). The MDS also indicated R2 required extensive assistance with all activities of daily living except eating and also received anticoagulant medication daily. R2's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 7/11/18, indicated R2 had a longstanding history of urinary tract infections (UTI) with history of increased confusion, hallucinations and delusions associated with a UTI. R2's Falls CAA dated 7/11/18, indicated R2 had a history of atrial fibrillation, a pacemaker, and hypertension with use of antihypertensive medication that could contribute to orthostatic hypotension and cause falls. The CAA indicated R2's atrial fibrillation was stable, however, Coumadin (anticoagulant) had recently been discontinued due to a gastrointestinal bleed (GI). R2's care plan dated 7/24/18, indicated R2 had atrial fibrillation and required the use of a pacemaker. Coumadin currently discontinued after last hospital stay related to GI bleed and risk for bleeding. Review of R2's clinical record revealed on 4/10/18, medical doctor (MD)-A started R2 on a course of antibiotics (Bactrim DS) due to urinary	F 757	" Bleeding from the gums after you brush your teeth " Bleeding between menstrual periods " Diarrhea, vomiting or inability to eat for more than 24 hours " Fever " Severe bleeding, including heavier than normal menstrual bleeding " Red or brown urine " Black or bloody stool " Severe headache or stomach pain " Joint pain, discomfort or swelling, especially after an injury " Vomiting of blood or material that looks like coffee grounds " Coughing up blood " Bruising that develops without an injury you remember " Dizziness or weakness " Vision changes RN involved was educated on importance of assessing residents herself when approached with concerns from LPN/Charge Nurse. Education provided to her that she needs to notify Physician immediately when there are signs or symptoms of non-therapeutic INR. A mandatory nursing staff in-service was held on August 20th at 1 pm and 2:15pm and scheduled for August 28th at 1 pm and 2:15 pm to follow up on this topic as well as training for LPNS for conducting PT/INR□s. Education including proper ordering of labs, timely drawing of lab orders, acquisition of lab orders and follow ups was provided. Reporting of resident conditions addressed; how they are to be reported immediately to charge nurse on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 43 tract infection (UTI) with adjustments made of her Coumadin orders (increased risk of bleeding when an antibiotic and Coumadin are used concurrently) which directed the staff to hold the Coumadin for two days and then give scheduled doses every other day for four days then to resume the regular dose of Coumadin 2.5 mg daily and check INR (laboratory test that monitors the effects of anticoagulant treatment) Monday, 4/16/18. The INR results dated 4/16/18, were elevated at 3.8 (Fair Meadow Lab Flow Sheet indicated normal INR range to be between 2.0 - 3.0). R2 was seen by physician assistant (PA)-A for UTI due to a persistent and worsening confusional state and R2 was subsequently admitted to the hospital. R2's Nursing Home Progress Note (NHPN) by MD-A dated 6/1/18, indicated R2 had had several hospitalizations for UTIs. After hospitalization, R2 had been sent home on chronic urinary tract suppression with cephalexin (an antibiotic) 250 mg daily. However, in the past week R2 had a recurrence of UTI symptoms despite the cephalexin use. Therefore, the cephalexin was discontinued and Cipro (an antibiotic) was started with modifications for her INR. The assessment section of the note indicated R2 was doing well on the Cipro and the plan was to complete the course of the Cipro. On 6/2/18, R2's INR result was 3.4 therefore MD-A ordered R2's Coumadin to be held on 6/2/18, then resume every other day. MD-A ordered a recheck of R2's INR on 6/6/18. R2's INR dated 6/6/18, was 2.1, for which MD-A 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	F 757	duty and DON. Education provided that Physician needs to be notified immediately when there are signs or symptoms of non-therapeutic INR. Medical Director and Pharmacy present at QAA on 8/22/18 and in agreement with education provided. Audits of lab orders and results will be done periodically by DON per Consultant Pharmacist recommendations. Fair Meadow nursing staff will institute an IDT meeting on every hospital admission. 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 monitoring completed will be assessed. If there are any problems or areas of concern, Medical Director will be involved in policy and procedure improvement. Our goal is to prevent any unnecessary hospitalizations or medication related adverse events to our residents by providing early detection and preventative measures. Audits of lab orders and results will be done monthly by DON or designee. Monitored by DON and QAA. Completed: 9/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 44	F 757		

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.

R2's nursing PN dated 6/18/18, indicated MD-B had called the facility and prescribed Bactrim DS 1 tab orally, twice a day for seven days and to recheck the INR on 6/25/18, and send to MD-C. However, neither the note nor telephone order identified any modification to R2's Coumadin dose or the need for increased INR monitoring following the initiation of the antibiotic and R2's history of abnormal INR results while receiving an antibiotic.

R2's PN dated 6/23/18, written by licensed practical nurse (LPN)-C, indicated R2 had two loose stools that were "maroon in color." R2's temperature was 97. She denied abdominal pain and , "Well it is better now that my bowels moved." LPN-C indicated he would monitor for fever, pain and further stools. The note also indicated LPN-C had spoken with R2 at 2:30 p.m. and she had denied abdominal pain. R2 had also stated two days ago she had to strain to have a bowel movement and was wondering if the blood could be from the straining. LPN-C indicated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 45	F 757		

had offered to have her checked in the emergency room (ER) but R2 refused. LPN-C left a message for R2's daughter to call the nursing home and while doing so, R2's daughter-in-law came to pick her up for an outing. LPN-C informed the daughter-in-law about the stools so family was aware and would watch also. Daughter-in-law aware R2 had declined ER because she declined it again with daughter-in-law present. LPN-C indicated he would continue to monitor when R2 returned and treat as necessary and as R2 and family desired. R2's clinical record lacked evidence of a registered nurse assessment or physician notification of the maroon stool. R2's Medication Administration Record (MAR) for June 2018, revealed on 6/23/18, R2 had received Coumadin 4 mg as ordered.

R2's PN dated 6/24/18, indicated R2 had increased confusion, fatigue and hallucinations as well as increased clot like appearance and more maroon color to her stools. R2 continues to received Bactrim for a UTI and her INR had been affected in the past by antibiotic use. INR checked today and was found to be 8.0 (at significant risk for major hemorrhage). A stool sample was obtained this afternoon and sent with the ambulance when they departed at 3:25 p.m. A follow up NP noted indicated R2 had been admitted to the hospital.

R2's Emergency Department (ED) note dated 6/24/18, indicated R2 had been noted to have intermittent blood in her stool over the course of the previous 3 days. She was on Coumadin chronically due to a history of atrial fibrillation. An INR was checked and found to be significantly elevated at 8. R2 had not appeared acutely ill

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 46	F 757		

upon arrival to ED and had not offered any acute complaints. R2 was mildly tachycardic (heart rate exceeds normal resting rate) and appeared mildly pale. Anoscopy (a scope used to examine the anal canal) revealed black stool with melanotic (having black pigmentation) features. An INR was repeated and was greater than 10. R2's hemoglobin (protein responsible for transporting oxygen in the blood) was 8.9.. R2 was given 10 mg of vitamin K (helps the blood clot) intravenously and was admitted to the hospitalist service for further evaluation and treatment.

R2's Hospital Consultation Note dated 6/25/18, indicated R2 was evaluated for hematochezia (blood in the stool). R2 reported she had passed some bright red blood per rectum on one occasion on Saturday. Found to have INR >10. R2's son reported her INR had become elevated previously after she had been treated for UTIs. Assessment: diagnosis supratherapeutic (levels greater than would be used in actual treatment of a medical condition) INR, rectal bleeding and acute kidney injury. Hematochezia with elevated INR.

R2's Hospital Progress Note dated 6/26/18, indicated an assessment which included:

1. Acute lower gastrointestinal bleeding. The cause was uncertain. This could have been secondary to diverticulosis (pockets in the digestive tract), hemorrhoids, angiodysplasia (vascular malformation of the gut) or cancer, most likely because of the supratherapeutic INR.
2. Acute blood loss anemia. R2 dropped her hemoglobin significantly from 8.9 to 7.4. Received 2 units of packed red blood cells.
3. Supratherapeutic INR on admission. It was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 47	F 757		

above 10 on admission. R2 was given vitamin K 10 mg on admission and 2.5 mg orally on 6/25/18.
4. Atrial fibrillation, rate controlled, status post pacemaker placement.
5. Chronic anticoagulation with Coumadin. Hold Coumadin for now.
6. Urinary tract infection. History of UTI. Was on Bactrim, is most likely the cause of her increased INR.

On 8/6/18, at approximately 3:15 p.m. R2 was observed seated in a recliner, in her room. R2 was alert, well groomed and oriented to person and place.

On 8/8/18, at 3:50 p.m. the assistant director of nursing (ADON) verified the facility had the capacity to perform point of care/finger stick testing for INR, however, an MD order for the testing was required and she was not sure if INR testing was included in the facility standing orders.

On 8/9/18, at 9:01 a.m. LPN-C stated side effect monitoring for residents who received anticoagulant therapy included testing for INR and the facility also had a machine in house to perform the testing. LPN-C stated the staff monitored for symptoms such as bloody stools, bloody emesis, or bruising. LPN-C confirmed R2 had experienced an elevated INR of 8 which required hospitalization. LPN-C stated the incident happened on a Saturday and verified a nursing assistant (NA) had reported that R2 had bloody stools and he had reported this to the registered nurse (RN). LPN-C stated it was not frank or coffee ground blood and was a "weird" color. LPN-C stated the next day, R2's stool color

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 48	F 757		

was darker than the day before. LPN-C could not remember if the RN had evaluated R2 or not on 6/23/18, when the maroon colored stool was reported. LPN-C also could not remember if R2 had a UTI at the time or if she had just been getting over one. R2's Progress Note dated 6/23/18 was reviewed with LPN-C who confirmed R2 was offered the ER and refused.

On 8/9/18, at 9:33 a.m. LPN-B stated anticoagulation monitoring included checking a resident's INR and watching for symptoms such as bleeding or bruises. LPN-B confirmed bloody stools would be a symptom for which they would monitor. LPN-B stated if any symptoms were noted she would notify the RN if it were the day shift, or would contact the MD if it was the evening shift.

On 8/9/18, at 9:42 a.m. RN-B confirmed she was R2's primary RN. RN-B stated she did not have a specific identified therapeutic goal range for R2's INR, however, indicated 2.0-3.0 was the reference range identified on the laboratory sheets. RN-B verified the physicians managed the residents' Coumadin doses and monthly and as needed (PRN) INRs were completed with adjustments made to the Coumadin orders according to the INR results. RN-B stated she would expect staff to monitor for any signs or symptoms of bleeding such as prolonged bleeding of cuts, bruises, bleeding to gums, rectal bleeding or any change to stool such as stools that were black, maroon or bright red in color. RN-B stated the NAs were to report any symptoms of bleeding to the charge nurse and any observed symptoms would be documented in a progress note. RN-B also stated she would expect the LPNs to monitor for symptoms of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 49	F 757		

bleeding and notify the RN and/or the doctor. RN-B stated she had not been working on 6/23/18, or 6/24/18, so she was not sure if R2's maroon stool had been reported to the RN or if the RN had assessed R2 once reported to her.

R2's medical record was reviewed with RN-B who verified the following:

--6/23/18, progress note indicated R2 had maroon stools.
--R2 received 4 mg Coumadin on 6/23/18.
--Bactrim DS 800-160 mg had been prescribed on 6/18/18, and R2 continued to receive the antibiotic through the morning of 6/24/18.
--R2's clinical record contained no documentation to indicate R2 had been assessed by an RN on 6/23/18.
--Progress note dated 6/24/18, at 1:30 p.m. indicated the ADON would 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 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 DS on 6/18/18. The ADON indicated R2's primary MD (MD-A) had been out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 50	F 757		

so it was another provider, MD-B, who prescribed the antibiotic and the INR results were to have been reported to MD-C, who covered for MD-A.

The ADON verified she had worked on 6/23/18, and confirmed LPN-C had reported R2's maroon colored stool to her and they had looked at it. The ADON stated the stool was a weird color. The ADON stated she had LPN-C do a focused assessment of R2 and that they [staff] were in a monitoring state at that point. The ADON stated family had been at the facility to take R2 out for the day and R2 had been coherent and responsive with no signs of confusion. The ADON confirmed R2 had been offered to be evaluated at the ER for which she had refused therefore, when R2 had left the facility with family, she had "left in a monitoring state at that time." The ADON stated she had not spoken with the family, however, LPN-C had done so and was not sure if LPN-C had explained the risks and benefits of R2 refusing to be evaluated in the ER. The ADON stated, "I guess at that point we were trying to determine what the stool was and passed the information on [to the next shift]." The ADON stated she was not aware if R2 had any further stools after she had left the facility. In addition, the ADON confirmed that following the observation of the maroon colored stool, she had not had R2's dose of Coumadin held, nor had she contacted the physician. The ADON stated she was not sure if she would have done anything differently knowing then what she knew now. The ADON stated the stool did not have frank blood and R2 had no other symptoms. ADON stated she even went and checked the menu to see if the residents had been served beets.

The ADON stated on 6/24/18, R2 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 51	F 757		

experienced more maroon stools with a "clotting appearance" and more lethargy, however, the staff had attributed the lethargy to R2's outing the previous day. R2 then began hallucinating which they attributed to a UTI. The ADON stated just before shift change she had the opportunity to discuss R2 with staff and was able to "put it all together" so the first thing she did was contact R2's family to discuss possible hospitalization and to notify them she would be testing R2's INR. The ADON performed the INR test which revealed the INR level was 8. The ADON contacted the family again to inform them she was not comfortable with R2's INR results and ask if they would be willing to send R2 to the ER for an evaluation. Once the family had approved, the ADON contacted the physician and received orders to transport R2 to the ER. The ADON verified at the ER, R2 was diagnosed with a GI bleed and subsequently had received two units of blood during a four day hospitalization. The ADON stated she could have probably tested R2's INR on 6/23/18, as she was aware of the adverse interactions between Coumadin and antibiotics, however, not to make excuses, but she was not R2's primary RN and probably did not know her history as well as RN-B. The ADON stated following R2's adverse medication event, a formal discussion with the interdisciplinary team regarding R2's hospitalization was not conducted, however, she had talked with RN-B and LPN-C about the incident. The ADON stated the facility had not made any changes to the anticoagulant monitoring system because they felt they had done what they should have done and R2 had since had her order of Coumadin discontinued.

On 8/9/18, at 11:58 a.m. the unit clerk (UC) verified there were three residents in house who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 52	F 757		

currently received Coumadin, R13, R19, and R29.

On 8/9/18, at 12:01 p.m. the director of nursing (DON) confirmed R2's maroon stool was a red 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 and facility medical director, MD-A indicated the monitoring for residents who received anticoagulant medication who were also prescribed antibiotics depended on the antibiotic prescribed. MD-A stated usually if the antibiotic was Cipro, Levaquin or sulfamethoxazole (Bactrim), staff needed to check the INR more often. R2's antibiotic order from 6/18/18, was reviewed with MD-A who stated he would have done that differently. MD-A stated the physicians relied on the pharmacy to help nursing out. He stated the physician who prescribed the antibiotics should have ordered earlier INR testing, nursing should have asked for earlier INR testing and/or the pharmacist should have also asked for earlier INR testing. MA-D confirmed a maroon colored stool was a cause for concern and should have been a signal to call someone. MD-A stated he would have expected to be notified when R2 had the first maroon colored stool. MD-A indicated the staff had been working on the facility policy to include INR testing to be initiated per nursing discretion, however, stated a maroon stool, with or without policy changes would have been an indication to notify someone,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 53	F 757		

particularly if the resident was on anticoagulant medication. MD-A was unsure of the facility policy regarding nursing staff holding the Coumadin medication without an order but indicated they should have contacted the physician prior to giving the medication.

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.

The immediate jeopardy that began on 6/18/18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 54	F 757		

was removed on 8/10/18, at 11:00 a.m. when the facility implemented the following actions:

-checked the current INR levels of residents who currently received Coumadin
-updated the facility standing orders regarding INR testing
-updated their anticoagulation policy to include increased monitoring while on antibiotics
-educated all nursing staff regarding the updated policies including the signs and symptoms of a non-therapeutic INR
-developed a plan to educate staff not working to ensure education was received prior to the start of their next shift.
-updated their procedures to include interdisciplinary team review of each resident hospital admission for measures to prevent unnecessary hospitalizations or medication related adverse events.

R19's Diagnosis Report dated 8/10/18, indicated R19's diagnoses included dementia with behavioral disturbances, chronic embolism and thrombosis (blood clot), edema, and long term anticoagulant use.

R19's 14 day MDS dated 6/5/18, indicated R19 had moderately impaired cognition, did not ambulate, and required extensive assistance of one to two staff for ADLs. The MDS also indicated R18 received anticoagulant medication daily during the MDS reference period.

R19's Order Summary Report dated 8/10/18, revealed an order for Aspirin 81 mg daily, and Coumadin 5 mg daily for chronic embolism and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 55	F 757		

thrombosis. The physican also ordered monthly INR checks. The report did not identify the use of antibiotic medication.

R19's FMNH fax report sheet dated 8/9/18, indicated R19's most recent INR was 2.0. The physician response was to continue the same dose of coumadin and recheck the INR in two weeks then monthly.

R13's quarterly MDS dated 8/1/18, indicated R13's diagnoses included diabetes, and a history of a UTI. The MDS also indicated R13 had moderately impaired cognition, required extensive assist of one to two staff for activities of daily living (ADL) except for eating, and received anticoagulant medication daily during the MDS reference period.

R13's FMNH fax report dated 8/9/18, indicated R13's INR was 1.5 and the physician responded with an order to increase the Coumadin to 2 mg daily and to recheck the INR in two weeks.

R29's quarterly MDS dated 6/27/8, indicated R29's diagnoses included anemia, heart failure, diabetes, Parkinson's, a seizure disorder and dementia. The MDS also indicated R29 had intact cognition, required extensive staff assistance for all ADLs except for eating in which R29 was independent, required supervision for transfers, and received anticoagulant medicaiton daily during the MDS reference period.

R29's FMNH fax report dated 8/9/18, indicated R29's INR was 1.5 which revealed a significant drop since the 8/1/18, INR of 3.7. The physician responded with an order to increase the Coumadin to 3 mg daily and to recheck the INR in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 56 two weeks and 4 weeks.	F 757		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		9/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 57 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included policies and procedures for the care and treatment of residents with infections. In addition, the facility failed to develop and maintain an infection surveillance program, which was completed timely in order to identify any trends and/or potential infectious	F 880	Infection control deficiency discussed at QAA 8/22/18. This topic is QAA□s top priority. Infection and prevention program will include a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all staff and residents. The QAA Committee has assigned a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 58 outbreaks. Lastly, the facility failed to store respiratory equipment in a manner to prevent contamination for 1 of 1 resident (R19) observed to have oxygen and nebulizer treatment equipment stored in the bathroom, uncovered. Findings include: On 8/13/18, at 11:35 a.m. the infection control program was reviewed with the director of nurses (DON) and the administrator. The administrator stated the current DON had started at the facility less than one week prior to the survey. The former DON had left the facility in May 2018. When the infection control information was reviewed by the facility, they had identified that the facility lacked policies, procedures and monitoring information for the infection control program. The administrator stated the facility policies had been missing since May 2018. The DON stated the facility had started collecting infection control policies as they were located throughout the facility including the DON's office and had placed them into a three ring binder. Review of the infection control binder, included policies and procedures for the identification and follow up of infections, hand washing, surveillance reporting, contact precautions and a grid related to which type of personal protective equipment was required for an identified organism. At 11:45 a.m. the DON confirmed the policies and procedures were not comprehensive and did not give clear facility guidance for the care of infections. At 11:46 p.m., the administrator stated the facility had a comprehensive infection control program, however, it had last been seen in May 2018.	F 880	Performance Improvement Project for UTI□s that has been in place since 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/infections occur. All new infections and antibiotics to 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 antibiotic stewardship RN. DON will assess infection patterns among residents and employees. Isolation precautions will be discontinued per policy depending on infectious organism/agent. New policies written for Use and Storage 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 of Critical Devices, Cleaning of CPAP/Bi-Level Equipment, Cleaning of Nebulizer Equipment, Cleaning of Oxygen Equipment, Linen Handling, Multi-drug Resistant Organisms, Guidelines for MRSA, Guidelines for VRE, C-Diff,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 59 -At 11:50 a.m. the facility infection surveillance was reviewed with the DON and the administrator. The administrator stated the facility had been unable to locate any type of infection surveillance prior to May 2018. The administrator stated the interim DON had completed surveillance from 5/9/18, until the current DON started on 8/1/18. The administrator stated the DON's were responsible for reviewing the records and placing any identified concern such as signs and symptoms of illness or antibiotic use on the infection control log. -At 11:55 a.m. the DON confirmed she reviewed all progress notes entered into the computer records on a daily basis and documented any type of signs and symptoms of illness on an infection control log. The DON confirmed she was the only staff member reviewing the records for symptoms of infection as the staff nurses were not responsible for documenting information onto the infection control logs. The DON confirmed the infections/signs or symptoms of illness were not recorded in real time. The DON indicated if a resident developed an illness, which would require isolation techniques, the facility did not have approved policies or procedures in which to guide the staff. -At 1:15 p.m. the administrator stated to her knowledge, the facility had not experienced any type of infectious outbreak in the past 12 months. The Facility Assessment dated 11/1/17, indicated the facility would have an infection control program in which the facility would be able to care for resident with or residents who had developed infections or a combination of conditions that	F 880	Influenza Vaccine for Residents, Prevention of Catheter-Associated UTI□s and Cleaning, Disinfection and Sterilization. Employee illnesses are to be recorded by DON to ensure resident safety and to prevent the spread of illness. Associate illness policy states work restrictions and their duration depending on infection type. Staff symptoms will be logged to see if any patterns exist. The sick slips employees fill out on return from an illness include the symptoms of illness. The relevance of this was reiterated to staff at the nursing staff meetings on 8/20 and 8/28/18. Other department heads given direction on 8/31/18 to remind their departmental employees to include the nature of their illness on the sick slip upon return to work. A facility map will be used monthly to show locations of infections/ illnesses to show 'at a glance' any patterns. Antibiotic Stewardship RN/DON to monitor log daily to look for patterns. Command hooks were hung on resident walls 8/10/18 for O2 tubing to be hung on. Oxygen concentrators and tubing will not be stored in resident bathrooms. Oxygen tubing safety policy updated to include safe storage including tubing. Care sheets updated regarding tubing placement and using command hooks. Closed three bin storage system initiated for all residents with nebulizers for safe storage outside of resident bathroom (policy updated). Hand & Respiratory Hygiene Station with CDC cover your cough signage ordered for Visitors/Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 60 required complex care and care management. Infections such as skin, respiratory, urinary infection, influenza and other common infectious disease could be treated in the facility. The facility assessment indicated the facility infection control program included monitoring and management of the identified diagnoses. Lastly, the facility assessment indicated surveillance and monitoring of the infections was to be completed in a timely manner. On 8/7/18, at 7:32 a.m. R19's nebulizer equipment (mask, tubing, medication canister) was observed on a paper towel placed on the shelf located to the right of the bathroom sink, uncovered. R19's oxygen tubing and nasal cannula were coiled together and hanging by Velcro on R19's concentrator, uncovered in the bathroom. -At 7:46 p.m. R19 was observed receiving a nebulizer treatment via a facial mask. On 8/8/18, at 9:05 a.m. R19's nebulizer equipment (mask, tubing, medication canister) were observed on a paper towel placed on the shelf located to the right of the bathroom sink, uncovered. R19's oxygen tubing and nasal cannula were observed coiled together and hanging by Velcro on R19's concentrator, uncovered in the bathroom. On 8/9/18, at 8:33 a.m. R19's oxygen concentrator was observed in bathroom with an uncovered nasal cannula draped over the towel bar located to the right of the sink. R19's physician orders provided on 8/10/18, included orders to monitor number of hours of oxygen use, uses more at bedtime and night,	F 880	for main entry area. Gloves are to be moved out of resident bathrooms and placed upon entrance into resident room along with hand sanitizer in each resident room by 9/30/18. Infection control education provided at all staff meeting on 8/20/18 and 8/28/18. Skills fair upon employee hire and annually to cover infection control, handwashing, standard precautions, and isolation. Safe transport of linen is addressed on hire and annually at our skills fair. O2 training for nursing employees on hire and annually to include safe storage r/t infection control. DON is scheduled to visit neighboring Nursing Home on 8/23/18 to gain knowledge on their infection control program and their antibiotic stewardship program. Oxygen, neb treatment, and crash cart education by Northwest Respiratory scheduled for Sept. 2018. Random audits will be done on all shifts to check for appropriate infection control practices by RNs and DON. Audits will be given to QAA, which was made aware of deficiencies at meeting on 8/22/18 and will monitor progression and compliance. Completed: 9/30/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61 monitor oxygen saturations to keep >90% every 8 hours as needed (PRN) for complaints of shortness of breath, /DuoNeb solution 0.5-2.5 milligrams (mg)/3 milliliters (ml) administer one vial via nebulizer two times daily and every 6 hours prn for complaints of shortness of breath. On 8/9/18, at 2:06 p.m. registered nurse (RN)-A stated the nasal cannula and nebulizer equipment should not be stored, uncovered, in a resident's bathroom. RN-A confirmed R19 required oxygen during the night hours. On 8/13/18, at 1:13 p.m. the DON stated she would not expect to find oxygen & nebulizer equipment stored in a resident's bathroom. The Oxygen Tubing Safety policy dated 4/6/18 indicated that oxygen tubing was to be stored in a clean bag when not in use. This policy did not address nebulizer equipment.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included the development of	F 881	Antibiotic Stewardship discussed at QAA 8/22/18. This topic is one of QAA□s top priorities.	9/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	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 identified. -At 11:40 a.m. the administrator stated the former DON had left the facility in May 2018 and any infection control practices, which had been in place prior to May 2018, were unable to be located. To the administrator's knowledge, the facility did not have any antibiotic stewardship 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 confirmed the facility had not established an antibiotic stewardship program and they did not have any type of polices or procedures regarding antibiotic stewardship.	F 881	New policy written for Antibiotic Stewardship to include protocols and systems to monitor antibiotic use to improve the safety and quality of resident care. DON is scheduled to visit neighboring Nursing Home on 8/23/18 to gain knowledge on their infection control program and their antibiotic stewardship program. Infection control log will include symptom monitoring during antibiotic use and after. Staff symptoms will be logged to see if any patterns exist. A facility map will be used monthly to show locations of infections/ illnesses to show 'at a glance' any patterns. Charge nurses working the floor will fill out infection control log as illnesses/ symptoms occur. Primary RN's/DON to monitor log daily to look for patterns. New surveillance reporting policy discusses who should receive resulting information after surveillance has been completed. Employee illnesses are to be recorded by charge nurse upon call-in and given to DON to ensure resident safety and to prevent the spread of illness. New policies written for Associate Illness, Shingles, Antibiotic Stewardship, Surveillance, Infection Identification, Multi-drug Resistant Organisms, Guidelines for MRSA, Guidelines for VRE, C-Diff, Prevention of Catheter-Associated UTI□s and Cleaning. Policies state guidelines on when residents should be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 63	F 881	tested for infections agents/organisms. Infection control log initiated on each resident wing to be tracked by charge nurses as illnesses/symptoms/infections occur. All new infections and antibiotics to be logged with symptoms and isolation to be initiated by primary charge nurse. Symptoms to be tracked until resolved per policy. Compliance will be monitored by Antibiotic Stewardship RN. DON will assess infection patterns among residents and employees. Antibiotic Usage Report log includes resident, antibiotic, dose, length of treatment, date of culture, organism sensitivity to antibiotic, clinical signs of infection, physician involved, and when the infection was resolved. Criteria for initiating antibiotics for an indication of urinary tract infection education from the State Operations Manual provided to RN Unit Coordinators and added to infection control log. Primary RN's/DON to monitor log daily to look for patterns. Education provided to CNA□s/Nursing staff at all staff meeting held on 8/20/18 and 8/28/18. Staff members were educated on the importance of prevention and early detection and reporting of symptoms of infection. QAA was made aware of deficiencies at meeting on 8/22/18 and will monitor compliance. Completed: 9/15/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Fair Meadow Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us and Angela.kappenman@ state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Fair Meadow Nursing Home is a 1-story building, without a basement, and constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1972 the south wing was added to the original building and was determined to be of Type II (111) construction. The south wing is separated with at least a 2 hour fire barrier from an apartment building. The facility is divided into 4 separate smoke zones by 30 minute fire barriers. The facility has a fire alarm system with smoke detection throughout the corridor system and in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition with automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The building is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems with quick response heads. Hazardous areas have automatic fire detection that is on the fire alarm system. The facility also has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 42 beds and had a census of 40 at the time of the survey.	K 000		
K 353 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		8/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 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. Findings include: On the facility tour between 9:00 am to 12:30 pm on 08/08/2018 observations revealed a sprinkler head in resident room 14 full of paint. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 353	Sprinkler head was replaced on 08-23-18 by Simplex Grinnell. Monitoring to be done by Maintenance Supervisor upon completion of any painting or renovation.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient	K 920		8/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 4 care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the use of extension cords and multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2..4.2.1 . This deficient practice could affect and an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 9:00 am to 12:30 pm on 08/08/2018 observations revealed an extension cord, serving a light, plugged into a multi plug adapter across from the main nurses station. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 920	Multiple plug in adapter and extension cords were removed. Down's Electric relocated an additional outlet in this area by nurses station on 08/16/2018. Facility wide inspection done by Maintenance Supervisor on 8/16/18 to make sure compliance is being followed. Random monthly audits done by Maintenance Staff added to maintenance checklist.	

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/6/18 through 8/13/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		9/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician was notified of signs and symptoms of bleeding for 1 of 1 resident (R2) who experienced adverse effects of concurrent anticoagulant and antibiotic use. This failure resulted in actual harm for R2 due to the onset of a gastrointestinal bleed which required hospitalization and blood transfusions. Findings included: R2's quarterly Minimum Data Set (MDS) dated 4/27/18, indicated R2 was cognitively intact and had diagnoses which included urinary tract infection, long term use of anticoagulants (blood thinner), therapeutic drug level monitoring, and atrial fibrillation (an irregular heartbeat that increases the risk of stroke and heart disease). The MDS also indicated R2 required extensive assistance with all activities of daily living except eating and also received anticoagulant medication daily. R2's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 7/11/18, indicated R2 had a longstanding history of urinary tract infections (UTI) with history of increased confusion, hallucinations and delusions associated with UTI. R2's Falls CAA dated 7/11/2018, indicated R2 had a history of atrial fibrillation, use of pacemaker, and hypertension with use of antihypertensive medication that could contribute to orthostatic hypotension and cause falls. The	2 265	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 4 CAA indicated R2's atrial fibrillation was stable, however Coumadin had recently been discontinued due to a gastrointestinal (GI) bleed. R2's care plan dated 7/24/18, indicated R2 had atrial fibrillation and required the use of a pacemaker. Coumadin currently discontinued after last hospital stay related to GI bleed and risk for bleeding with use of Coumadin. The care plan also indicated R2's family would discuss risks/benefits of Coumadin and if it should be restarted, and were aware of current discontinuation of this medication and in agreement at this time Review of R2's medical record from 4/1/18, to 8/13/18, revealed R2 had ongoing issues related to UTI with hallucinations and confusion which required multiple courses of antibiotic therapy. Concurrently, R2's Coumadin regimen required modification and increased monitoring due to fluctuations in INR outside of therapeutic levels. On 6/13/18, R2 experienced INR results outside of therapeutic range at 1.6 for which medical doctor (MD)-A ordered R2's Coumadin be increased from 2.5 mg to 4 mg 1 tablet daily with recheck in two weeks. R2's Progress note dated 6/18/18, indicated a call 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. R2's Progress Note dated 6/23/18, completed by licensed practical nurse (LPN)-C indicated R2 had two loose stools that were maroon in color.	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 5 R2's temperature was 97. She denied abdominal pain and stated "Well it is better now that my bowels moved." LPN-C indicated he would monitor for fever, pain and further stools. The note also indicated LPN-C had spoken with R2 at 2:30 p.m. and she had denied abdominal pain. R2 had also stated two days ago she had to strain to have a bowel movement and was wondering if the blood could be from the straining. LPN-C indicated he had offered to have her checked in the ER but R2 had refused. LPN-C left a message for R2's daughter to call the nursing home and while doing so R2's daughter-in-law came to pick her up for an outing. LPN-C informed the daughter-in-law about the stools so family was aware and would watch also. Daughter-in-law aware R2 had declined ER because she declined it again with daughter-in-law present. LPN-C indicated he would continue to monitor when R2 returned and treat as necessary and as R2 and family desired. R2's clinical record lacked evidence of a registered nurse assessment or physician notification of R2's maroon colored stool. R2's Medication Administration Record (MAR) dated 6/1/18, to 6/30/18, indicated R2 received Coumadin 4 mg on 6/23/18 per order. R2's Progress Notes dated 6/24/18 revealed the following: --10:39 a.m. note completed by LPN-C indicated R2 took scheduled medications without difficulty. R2 reported being tired, denied abdominal pain. The note indicated LPN-C would continue to monitor and obtain a stool sample if able, to check for blood. --1:30 p.m. note completed by assistant director	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6	2 265		

of nursing (ADON) indicated R2 denied abdominal pain as well as tenderness with palpation. Bowel sounds were present in all four quadrants. The noted indicated ADON would continue to monitor and follow up with primary registered nurse (RN) and MD tomorrow unless status changed.
--3:03 p.m. note completed by ADON indicated R2 was noted to have increased confusion, fatigue, and hallucinations this afternoon as well as increased clot like appearance and more maroon color to stools this afternoon. The note indicated R2 was also on Bactrim for a UTI and her INR had been affected in the past by her antibiotics. Finger stick INR 8.0 today. The note indicated MD-E ordered R2 be sent to the hospital. Due to R2 not wanting to go to the hospital yesterday, the family was contacted and agreed to have R2 seen at the hospital. A stool sample was obtained this afternoon and sent with the ambulance when they departed the building at 3:25 p.m.

R2's Emergency Department (ED) note dated 6/24/18, indicated R2 had been noted to have intermittent blood in her stool over the course of the previous three days. She was on Coumadin chronically due to a history of atrial fibrillation. An INR was checked and found to be significantly elevated at 8 (critical level which could result in a hemorrhage). R2 was mildly tachycardic (heart rate exceeds normal resting rate) and appeared mildly pale. Anoscopy (a scope used to examine the anal canal) revealed black stool with melanotic (having black pigmentation) features. An INR was repeated and was greater than 10. R2's hemoglobin (protein responsible for transporting oxygen in the blood) was 8.9. R2 was given 10 mg of vitamin K (clots blood)intravenously and was admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 7 hospitalist service for further evaluation and treatment. R2's Hospital Progress Note dated 6/26/18, indicated an assessment which included: 1. Acute lower gastrointestinal bleeding. The cause was uncertain. This could have been secondary to diverticulosis, hemorrhoids, angiodysplasia or cancer, most likely because of the supratherapeutic INR. 2. Acute blood loss anemia. R2 dropped her hemoglobin significantly from 8.9 to 7.4. Received two units of packed red blood cells. 3. Supratherapeutic INR on admission. It was above 10 on admission. R2 was given vitamin K 10 mg on admission and 2.5 mg orally on 6/25/18. 4. Atrial fibrillation, rate controlled status post pacemaker placement. 5. Chronic anticoagulation with Coumadin. Hold Coumadin for now. 6. Urinary tract infection. History of UTI. Was on Bactrim, is most likely the cause of her increased INR. On 8/8/18, at 3:50 p.m. the ADON verified the facility had the capacity to perform point of care testing for INR, however, stated an MD order for the testing was required and she was not sure if INR testing was included in the facility standing orders. On 8/9/18, at 9:01 a.m. LPN-C indicated side effect monitoring for residents who received anticoagulant therapy included testing for INR and stated the facility had a machine to complete the testing. LPN-C also stated the staff monitored for symptoms such as bloody stools, bloody emesis, or bruising easier. LPN-C indicated the facility had an incident recently	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 8	2 265		

related to blood stools when the resident's INR was 8 and the resident had to go into the hospital. LPN-C stated the incident happened on a Saturday and indicated a nursing assistant reported R2 had blood stools and he reported this to the RN. LPN-C stated it wasn't frank blood or coffee ground blood but looked more like something R2 had eaten. LPN-C indicated the stool was a "weird" color and stated the next day the stool color was darker than the day before. LPN-C did not remember if the registered nurse had come down to look at R2 or not. LPN-C stated he could not remember if R2 had a UTI at the time or if she had just been getting over one, however, confirmed R2 became confused with UTI's. LPN-C stated R2 was not confused on 6/23/18, that he recalled.

On 8/9/18, at 9:33 a.m. LPN-B indicated anticoagulation monitoring included checking INR and watching for symptoms such as bleeding or bruises. LPN-B confirmed bloody stools would also be symptom they would monitor. LPN-B stated if any symptoms were noted she would notify the RN if it were the day shift, or would contact the MD if it was the evening shift.

On 8/9/18, at 9:42 a.m. registered nurse (RN)-B confirmed she was R2's primary RN. RN-B stated the physicians managed the residents' Coumadin and stated monthly and as needed (PRN) INR's were completed and adjustments made to Coumadin orders as indicated. RN-B stated she would expect staff to monitor for any signs or symptoms of bleeding such as prolonged bleeding of cuts, bruises, bleeding to gums, rectal bleeding or any change to stool such as stools black, maroon or bright red in color. RN-B stated the NAs were to report any symptoms to the charge nurse and the charge nurse would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	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.

R2's medical record was reviewed with RN-B who verified the following:

--6/23/18 progress note indicated R2 had maroon stools
--R2 received 4 mg Coumadin on 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 reported to MD-C who covered for MD-A. The ADON verified she had worked on 6/23/18, and confirmed LPN-C had reported R2's maroon colored stool to her and so they went and looked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 10	2 265		

at it and stated the color was "weird." The ADON stated she had LPN-C do a focused assessment of R2 and stated they were in a "monitoring" state at that point. ADON stated family had been at the facility to take R2 out for the day and R2 had been coherent and responsive with no signs of confusion and R2 had been offered the ER which she had refused. ADON confirmed R2 had "left [the facility] in a monitoring state at that time." The ADON verified she had not spoken with the family, however, stated LPN-C had done so. However, the ADON stated she was not sure if LPN-C had explained the risks and benefits of refusing to be evaluated in the ER. The ADON stated "I guess at that point we were trying to determine what the stool was" and passed the information on [to the next shift] and was not aware if R2 had any further stools after she finished her shift. The ADON verified she had not had R2's dose of Coumadin held, nor had she contacted the physician at that point. In addition, the ADON stated she was not sure she would have done anything differently knowing then what she knew now as R2's stool did not have frank blood and R2 had no other symptoms. The ADON stated she even went an checked the menu to see if they had had beets served during the meal. The ADON verified on 6/24/18, R2 experienced more maroon stools with a "clotting appearance" later in the day and was more lethargic which she attributed the lethargy to R2's outing the previous day. R2 had begun hallucinating which was attributed to a UTI. The ADON stated just prior to shift change, she had an opportunity to talk with the staff which was when they had "put it all together." The ADON stated she contacted R2's family to discuss possible hospitalization and to notify them she would be testing R2's INR. The ADON proceeded to check R2's INR which was 8, so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 11	2 265		

she again contacted the family to see if they would be willing to send R2 to the ER as she was not comfortable with R2's INR result. Once she had obtained the family's approval, she contacted the physician and received orders to transport R2 to the ER. Lastly, the ADON again contacted R2's family to notify them of the plan. The ADON confirmed R2 had been diagnosed with a GI bleed and received two units of blood during a four day hospitalization. The ADON confirmed she could have probably tested R2's INR on 6/23/18, as she was aware of the interactions between Coumadin and antibiotics and stated not to make excuses, but she was not R2's primary RN and probably did not know R2's history as well as RN-B had.

On 8/9/18, at 12:01 p.m. the director of nursing (DON) confirmed R2's maroon stool was a "red flag" and stated she would have expected ADON to assess the patient herself, checked an INR, hold the Coumadin and contact the physician.

On 8/9/18, at 4:13 p.m. R2's primary physician and facility medical director, MD-A indicated the monitoring for residents who received anticoagulant who were prescribed antibiotics depended on the antibiotic prescribed. MD-D stated usually if it was Cipro, Levaquin or sulfamethoxazole (Bactrim) staff needed to check the INR more often. R2's MD antibiotic order from 6/18/18, was reviewed with MD-A who stated he would have done that differently. MD-A indicated physicians relied on pharmacy to help nursing out. He stated the physician who prescribed the antibiotics should have ordered earlier INR testing, nursing should have asked for earlier INR testing and/or the pharmacist should have also asked for earlier INR testing. MD-A confirmed a maroon colored stool would indicate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 12 a cause of concern and should have been a signal to call someone. MD-A indicated he would have expected to be notified when this occurred. MD-A stated they had been working on the facility policy to include INR testing to be initiated per nursing discretions, however, a maroon colored stool, with or without policy changes would have been an indication to notify someone, particularly if the resident was on anticoagulant medication. MD-A was unsure of the facility policy regarding nursing holding the Coumadin medication but indicated they should have contacted the physician prior to giving the medication. The undated Notification of Physician policy directed the primary/on call physician would be notified of any medically unstable condition. The policy directed situations that warranted immediate notification included if the resident's clinical status was unclear or worsening, however, the policy did not address notifications which were not concerning lab or diagnostic test results. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could update policies and procedures and then educate staff on examples on when the physician should be notified. The DON or designee could perform audits of medical records to determine if the physician had been notified appropriately. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 265		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints	2 510		9/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 510	Continued From page 13 Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R40) were free from the use of physical restraints. Findings include: The face sheet dated 8/10/18 indicated R40 had diagnoses that included, but were not limited to Parkinson's disease, repeated falls, weakness, hallucinations, and disorientation. R40's quarterly minimum data set (MDS) dated 7/18/18, indicated R40 had severe cognitive impaired, required extensive assistance of two persons for bed mobility and required extensive assistance of one person for transfers and ambulation. The MDS indicated R40 had bowel and bladder incontinence and required extensive assistance for toileting. The MDS also indicated R40 had restraint use daily which included a chair that prevented rising, and a restraint marked as "other" used when R40 was in bed. . Additionally, the MDS indicated R40 had personal alarm's used while in bed and in the wheelchair. Review of the last completed Physical Restraint Elimination Assessment dated 7/18/18, indicated R40 was restrained with an alarmed seat belt in the wheelchair. The specific reason for the restraint use was identified as poor safety	2 510	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 510	Continued From page 14	2 510		

judgement and self-transfers with falls. The assessment indicated R40's daughter requested 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 turned them off and would then self transfer 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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 510	Continued From page 15 agitation, and weakness. Family member (FM-A) was interviewed on 8/7/18, at 7:30 p.m. during which she stated R40 used the alarmed seat belt so she would not escape her wheelchair. FM-A stated R40 did not like the restraint belt and was embarrassed to have it on. FM-A stated R40 had recently been fitted for a new wheelchair in which R40 was better seated in. FM-A confirmed she would now be open to a restraint reduction. R40 was interviewed on 8/7/18, at 7:35 p.m. and indicated she liked the restraint belt and tried to hide the belt by readjusting her shirt. R40 was observed on 8/8/18, at 7:06 a.m. seated at the dining room table in her wheelchair. R40's alarmed seat belt was still on in the dining room although R40's care plan directed staff to remove the seatbelt while dinning. During an interview on 8/9/18, at 11:30 a.m. register nurse (RN)-A stated she was R40's primary nurse and was responsible for R40's health care. RN-A stated the alarmed seat belt was used for fall prevention and family request. RN-A was not aware family members could not request the use of a restraint device unless a resident had a specific medical symptom to justify the restraint use. RN-A could not identify a specific medical symptom that would warrant the use of a restraint. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop/review and or revise policies and procedures on the appropriate use of physical	2 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 510	Continued From page 16 restraints. All appropriate staff could be educated on the process of appropriate use of physical restraints. The Director of Nursing or her designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 510		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess pain, and identify non-pharmacological interventions for 1 of 1 resident (R38) who voiced complaints of pain. The findings include: R38's face sheet dated 8/10/18, indicated R38 had diagnoses including atrial fibrillation, anemia,	2 830	Corrected.	9/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 and muscle weakness. Review of the 30-day prospective payment system (PPS) Minimum Data Set (MDS) dated 7/13/18, indicated R38 had moderately impaired cognitive impairment, and had occasional pain rated at a 6 on a scale of 1-10 with one being the lowest amount of pain and 10 being the most amount of pain. The MDS indicated pain had not made sleep difficult at night and had not limited R38's day-to-day activities. Review of R38's physician order's dated 8/6/18, indicated R38 had been prescribed Tylenol 325 mg one tab every night at bedtime on 8/6/18, and prior to 8/6/18, R38 had an order for Tylenol 325 mg one tablet every four hours as needed for pain. R38's Medication Administration Record from 7/1/18-8/10/18, revealed R38 received Tylenol 325 mg one tablet at least once a day with the exception of four days in that time frame. R38 rated the pain between 3 and 7 on a 1-10 scale. R38 was interviewed on 8/8/18, at 8:46 a.m. and stated she frequently had pain in her neck and back area which was more pronounced during the night time hours (after midnight). R38 described the pain as a dull ongoing ache and rated the pain at a 6 on the 1-10 scale. R38 stated aggravating factors of the neck pain included the bed/mattress supplied by the facility which was uncomfortable, cold air/environment, and strenuous activity. R38 stated regular Tylenol use, and a warm neck roll alleviated the neck/back pain. Review of R38's comprehensive pain assessment provided by the facility was section J of the MDS.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 18 The assessment indicated R38 had experienced occasional pain in the last five days, the pain had not limited R38's day-to-day activity, and R38 rated the pain at a 6 on a scale of 1-10. The assessment was not comprehensive, as the assessment failed to identify where R38's pain was located, a description of the pain, aggravating factors, alleviating factors, and both pharmacological and non-pharmacological interventions that alleviated the pain had not been assessed. Review of R38's comprehensive care plan revealed no care plan had been developed which addressed R38's pain symptoms. On 8/10/18, at 11:37 a.m. registered nurse (RN)-A confirmed R38 had not been comprehensively assessed for pain, and a care plan had not been developed to identify pharmacological and non-pharmacological interventions. The facility policy for Pain management/pain prevention (undated) indicated the staff nurse would complete a pain assessment at the time of admission, following a hospitalization, quarterly, and upon determination of pain. The policy had not identified what the assessment should include. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop, review and revise as necessary the policies and procedures regarding the comprehensive assessment of and non-pharmacological interventions for pain management. The DON could provide training for all appropriate staff on	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 these policies and procedures. The quality assessment and assurance committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided	2 840		8/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 20 promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. 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 for 1 of 1 resident (R12) who was totally dependent on staff for incontinence cares. Findings include: R12's quarterly Minimum Data Set (MDS) dated 5/23/18 identified R12 with severe cognitive impairment and diagnoses including Alzheimer's disease, and dementia. The MDS indicated R12 required extensive assistance with all activities of daily living and was totally incontinent of bowel and bladder. The Urinary Incontinence Care Area Assessment (CAA) print date 8/8/18, indicated R12 was incontinent of bladder and required assist of staff to check and change every two hours and as needed. R12's Bladder Assessment Form dated 3/17/18 indicated R12 had functional incontinence, was	2 840	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 21 totally incontinent of bowel and bladder due to physical impairments and cognitive deficits. R12 would be inappropriate for bladder retraining and would be check and change with toileting needs. R12's care plan dated 5/30/18, directed the staff to assist R12 with a check and change of incontinent product schedule of every two hours and as needed. R12 was observed on 8/8/18, during continuous observations from 7:05 a.m. to 10:23 a.m. R12 was not observed to be assisted with incontinence cares during this time. -At 7:05 a.m. R12 was observed seated in a wheelchair (WC) in the dining room. -At 8:24 a.m. licensed practical nurse (LPN)-C wheeled R12 from the dining room to the desk area by the front entrance and positioned her by the wall. -At 8:29 a.m. the therapy aide wheeled R12 to the therapy room. R12 was observed to fold towels and be provided upper and lower range of motion activity. -At 8:51 a.m. the therapy aide wheeled R12 out of the therapy room, returned her to the desk area by the front entrance and positioned her by the wall. -At 9:01 a.m. the administrator wheeled R12 to the front door and returned her to the desk area by the front entrance and positioned her next to the wall. -At 9:05 a.m. licensed social worker (LSW)-A wheeled R12 into the activity room. LSW-A turned	2 840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 22	2 840		

on the television and sat next to R12.
-At 9:12 a.m. LSW-A left the activity room and R12 continued to be seated in the activity room in her WC.

-At 9:43 a.m. activity aide (AA)-A entered the activity room and informed R12 of Bible study at 10:00 a.m.

-At 10:00 a.m. AA-A offered R12 a glass of water and positioned her at a table with another female resident for Bible study.

-At 10:15 a.m. nursing assistant (NA)-A wheeled R12 from the activity room to her room.

-At 10:21 a.m. NA-A and NA-C assisted R12 to transfer from the wheelchair to the bed via a full body mechanical lift. Once in bed, NA-C changed R12's incontinence brief. R12 was observed to be incontinent of urine and the coccyx and buttock area was red, with no open areas observed.
-At 10:22 a.m., NA-C confirmed R12 was incontinent of urine and her coccyx and buttock area was red. NA-C confirmed she had not provided R12 with incontinence care that morning.
-At 10:23 a.m. NA-B confirmed R2 had last been assisted with incontinence cares at 6:45 a.m. prior to going to the dining room for breakfast at 7:00 a.m. (a total of 3 hours and 30 minutes earlier).

On 8/8/18, at 11:24 a.m. registered nurse (RN)-B confirmed R12 was to be assisted with incontinence cares every two hours as directed by the care plan.

On 8/8/18, at 2:00 p.m. the director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 23 (DON) confirmed staff was expected to provide timely repositioning and incontinence cares. R5's annual MDS dated 5/2/18, indicated R5 required extensive assistance of two staff for bed mobility, transfers, dressing, toileting and personal hygiene and was at risk for developing pressure ulcers. The MDS identified R5 had upper and lower extremity impairment on both sides of body. R5's diagnosis report provided on 8/10/18, included diagnoses of aphasia (disorder that results from damage to portions of the brain that are responsible for language), amyotrophic lateral sclerosis (a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord), and hereditary and idiopathic neuropathy (loss of sensitivity in the hands and feet, and in organs such as the kidneys, heart, and eyes). R5's skin review assessment dated 5/1/18, indicated R5 was to be repositioned every two hours and had no current skin issues. R5's care plan provided on 8/10/18, directed the staff to turn and reposition R5 every 1.5 to two hours when in bed. The care plan also indicated R5 had a recent open sore on the coccyx which opened and healed and was most recently open as of 8/2/18. R5's nursing assistant (NA) care sheet provided on 8/10/18, directed the staff to turn and reposition every 1.5 to two hours when in bed, or as she requested. On 8/8/18, during continuous observation from	2 840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 24 7:16 a.m. until 10:20 a.m. R5 was not provided assistance to turn or reposition. -At 10:20 a.m. NA-D and NA-E provided incontinence care and turned and repositioned R5. NA-D & NA-E both confirmed they had not provided care for R5 since the start of their shift at 6 a.m. a total of 4 hours and 20 minutes earlier. On 8/9/18, at 9:19 a.m. NA-E was observed assisting R5 with repositioning. NA-E confirmed R5 had not been repositioned since 6:00 a,m. when she started her shift, a total of 3 hours and 19 minutes earlier. On 8/13/18, at 10:36 a.m. RN-B stated R5 was to be provided assistance with turning and repositioning in order to prevent the development of pressure ulcers every 1.5 to two hours, and per resident request. On 8/13/18, at 1:14 p.m. the DON stated she would expect the residents' to be turned and repositioned according to their care plan. The DON stated three hours in between repositioning was not acceptable care. A facility policy related to timely provision of repositioning was requested, however was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring incontinence care is provided for each individual resident . The director of nursing or	2 840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 25 designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning services for 2 of 2 residents (R12, R5) who were identified at risk for pressure ulcers and required staff assistance to reposition. Findings include: R12's quarterly Minimum Data Set (MDS) dated 5/23/18, indicated R12 had severe cognitive impairment and diagnoses which included Alzheimer's disease and a coccyx region pressure ulcer. The MDS indicated R12 required extensive assist of two persons for toilet use, bed mobility, transfers and dressing. The MDS also	2 905	Corrected.	8/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 26 indicated R12 had one unhealed, stage 1 pressure ulcer (intact skin with blanchable redness of a localized area usually over a bony prominence), was at risk for the development of further pressure ulcers, and required a pressure reducing device for bed and chair, a turning and repositioning program, and nutrition/hydration interventions to manage skin problems. R12's Tissue Tolerance dated 3/7/18 indicated R12 was at high risk for pressure ulcer development. R12's Skin Review assessment dated 3/7/18, indicated R12 was at high risk for pressure ulcers, received mechanical soft diet with Boost breeze supplement three times daily, air mattress on bed, repositioning every two hours and check and change every two hours to address incontinence care. R12's care plan provided 8/18/18, indicated R12 was at risk for pressure ulcers related to decreased mobility, need for assistance with bed mobility/offloading and repositioning, bowel incontinence, history of pressure ulcers, history of recent superficial open area on coccyx, and a left above the knee amputation with no prosthesis. The care plan directed the staff to assist with hygiene and general skin care, minimize pressure on bony prominences, reposition with two staff every two hours, and assist with check and change every two hours for incontinence care. On 8/8/18, during continuous observations from 7:05 a.m. to 10:23 a.m. R12 was not observed to be assisted with repositioning. -At 7:05 a.m. R12 was observed seated in a wheelchair (WC) in the dining room.	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 27 -At 8:24 a.m. licensed practical nurse (LPN)-C wheeled R12 from the dining room to the desk area by the front entrance and positioned her by the wall. -At 8:29 a.m. the therapy aide wheeled R12 to the therapy room. R12 folded towels and was provided provided upper and lower range of motion activity. -At 8:51 a.m. the therapy aide wheeled R12 out of the therapy room, returned her to the desk area by the front entrance and positioned her by the wall. -At 9:01 a.m. the administrator wheeled R12 to the front door and returned her to the desk area by the front entrance and positioned her next to the wall. -At 9:05 a.m. licensed social worker (LSW)-A wheeled R12 into the activity room. LSW-A turned on the television and sat next to R12. At 9:12 a.m. LSW-A left the activity room and R12 remained seated in the activity room in her WC. -At 9:43 a.m. activity aide (AA)-A entered the activity room and informed R12 of Bible study at 10:00 a.m. -At 10:00 a.m. AA-A offered R12 a glass of water and positioned her at a table with another female resident for Bible study. -At 10:15 a.m. nursing assistant (NA)-A wheeled resident from the activity room to her room. -At 10:21 a.m. NA-A and NA-C assisted R12 to transfer from the wheelchair to the bed via a full	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 28 body mechanical lift. Once in bed, NA-C changed R12's incontinence brief. R12 was noted to have been incontinent of urine. R12's coccyx and buttock area was red with no open areas observed. At 10:22 a.m., NA-C confirmed R12 was incontinent of urine and her coccyx and buttock area was red. NA-C confirmed she had not provided R12 with incontinence care that morning. -At 10:23 a.m. NA-B confirmed R2 had last been assisted with incontinence cares at 6:45 a.m. prior to going to the dining room for breakfast at 7:00 a.m. (a total of 3 hours and 30 minutes earlier). On 8/8/18, at 11:24 a.m. registered nurse (RN)-B confirmed R12 was at risk for pressure ulcers, and was to be assisted with repositioning every two hours as directed by the care plan. On 8/8/18, at 2:00 p.m. the director of nursing (DON) confirmed the staff was expected to provide timely repositioning every two hours as directed by the care plan SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents receive the repositioning assistance according the assessed need. The DON or designee could develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as 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 at risk for developing pressure ulcers. The MDS identified R5 had upper and lower extremity impairment on both sides of the body. R5's diagnosis report provided on 8/10/18,	2 910	Corrected.	9/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 30 included diagnoses of aphasia (disorder that results from damage to portions of the brain that are responsible for language), amyotrophic lateral sclerosis (ALS) (a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord), and hereditary and idiopathic neuropathy (loss of sensitivity in the hands and feet, and in organs such as the kidneys, heart, and eyes). R5's Urinary Care Area Assessment (CAA) dated 5/14/18, indicated R5 was frequently incontinent of bladder, had difficulty using commode related to ALS, mostly used bedpan or staff checking and changing of incontinent brief every 2-3 hours and as needed (PRN). R5 had stress/urge functional urinary incontinence related to neuromuscular disease. R5's care plan provided on 8/10/18, directed staff to provide extensive assistance of two persons to check and change, use commode, or bedpan every 2-3 hours and prn. R5's nursing assistant care sheet provided on 8/10/18, directed staff to check and change, use commode or bedpan every 2-3 hours and prn. On 8/8/18, during continuous observation from 7:16 a.m. until 10:20 a.m. R5 was not provided care for urinary incontinence. At 10:20 a.m. nursing assistant (NA)-D and NA-E were observed to provide R5 incontinence care due R5 having been incontinent of urine. NA-D & NA-E both confirmed they had not provided care for R5 since the start of their shift at 6 a.m. for a total of 4 hours and 20 minutes without incontinence care assistance. On 8/9/18, at 9:19 a.m. NA-E was observed	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 31 assisting R5 with repositioning. NA-E confirmed incontinence care/toileting assistance had not been provided to R5 since the start of her shift at 6:00 a.m. for a total of 3 hours and 19 minutes earlier. On 8/13/18, at 10:36 a.m. registered nurse (RN)-B stated the staff were expected to provide incontinence care or toileting every 2-3 hours and prn. On 8/13/18, at 1:14 p.m. the director of nursing stated she would expect that residents would be checked and changed/toileted according to the care plan and over three hours without assistance, was not acceptable. A facility policy related to timely provision of incontinence care was requested, however was not provided. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure resident received appropriate assisted toileting care and services. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate	2 915		9/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 32 treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dinning assistance was provided and a communication board was utilized for 1 of 1 resident (R40) reviewed for activities of daily living. Findings include: R40's face sheet dated 8/10/18 indicated R40 had diagnoses that included, but were not limited to Parkinson's disease, repeated falls, weakness, hallucinations, and disorientation. R40's quarterly minimum data set (MDS) dated 7/18/18, indicated R40 had severe cognitive impaired, required extensive assistance of one to two persons for mobility, and supervision with set up assistance for eating. The MDS indicated R40 had restraint use daily which included a chair that prevented rising. Additionally, the MDS indicated R40 had personal alarm's used while in bed and	2 915	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 33 in the wheelchair. Family member (FM)-A was interviewed on 8/7/18, at 7:30 p.m. during which she stated R40 was recently moved in the dining room to a table where assistance would be provided. FM-A also stated she thought R40 was supposed to be using a communication device developed by the speech language pathologist (SLP) but had not seen the device used. R40's care plan revised on 7/18/18, revealed R40 was at risk for choking related to holding or pocketing food in mouth and cheeks and had unintentionally ate non-edible items like napkins and paper. The care plan indicated R40 required assistance with meals to sit in the upright position, eat slowly, and chew each bit thoroughly. Resident to eat on the assisted side of the dining room for supervision with meals. R40 was observed on 8/8/18, at 7:06 a.m. seated at a dining room table. R40 was served the meal which included french toast and bacon. R40 had a difficult time eating because the french toast had not been cut for her and R40 was unable to cut the meal into bite size pieces herself. R40 finished the meal at 8:20 a.m. and at no time were staff observed seated by R40 to assist her with cutting the meal or cueing her to drink between bites of food. R40 was observed on 8/8/18, from 7:06 a.m. to 3:30 p.m. and 8/9/18, from 8:15-11:00 a.m. and at no time was a communication device implemented to enhance communication. Nursing assistant (NA)-H was interviewed on 8/9/18, at 9:12 a.m. and stated she was not aware of any communication device or board	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 34 developed for R40. -At 9:41 a.m. NA-G stated she was not aware R40 had a communication board however, looked through R40's room and found a communication board in a dresser drawer. Both NA-H and NA-G stated they were not aware of the communication board and had never used it. Review of the SLP Evaluation and Plan dated 6/5/18, revealed R40 had a decline in communication and was unable to verbally express her wants and needs or to engage in social interaction to provide quality of life. The goal of the SLP for R40 was an increase in quality of life and quality of care by increasing ability to express needs and wants in a timely fashion. The SLP notes indicated on 7/11/18, two manual communication boards using functional personalized vocabulary were developed for R40 and their function was explained to the charge nurse who will use the board during daily cares. A care plan for using the board had not been found in R40's current care plan. During an interview on 8/9/18, at 11:30 a.m. registered nurse (RN)-A confirmed R40 should have had supervision and set up assitance during the breakfast meal to minimize the risk of choking. RN-A further stated R40 should have been encouraged to use the communication board during activities of daily living to enhance her communication and quality of life. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents that need assistance with eating to assure they are receiving the necessary services. The director of nursing or designee, could conduct random audits of the delivery of care to	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 35 ensure appropriate care and services are implemented. TIME PERIOD OF CORRECTION: Twenty-one (21) days	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included policies and procedures for the care and treatment of residents with infections. In addition, the facility failed to develop and maintain an infection surveillance program, which was completed timely in order to identify any trends and/or potential infectious outbreaks. Lastly, the facility failed to store respiratory equipment in a manner to prevent contamination for 1 of 1 resident (R19) observed to have oxygen and nebulizer treatment equipment stored in the bathroom, uncovered. Findings include: On 8/13/18, at 11:35 a.m. the infection control program was reviewed with the director of nurses (DON) and the administrator. The administrator stated the current DON had started at the facility less than one week prior to the survey. The former DON had left the facility in May 2018.	21375	Corrected.	9/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 36 When the infection control information was reviewed by the facility, they had identified that the facility lacked policies, procedures and monitoring information for the infection control program. The administrator stated the facility policies had been missing since May 2018. The DON stated the facility had started collecting infection control policies as they were located throughout the facility including the DON's office and had placed them into a three ring binder. Review of the infection control binder, included policies and procedures for the identification and follow up of infections, hand washing, surveillance reporting, contact precautions and a grid related to which type of personal protective equipment was required for an identified organism. At 11:45 a.m. the DON confirmed the policies and procedures were not comprehensive and did not give clear facility guidance for the care of infections. At 11:46 p.m., the administrator stated the facility had a comprehensive infection control program, however, it had last been seen in May 2018. -At 11:50 a.m. the facility infection surveillance was reviewed with the DON and the administrator. The administrator stated the facility had been unable to locate any type of infection surveillance prior to May 2018. The administrator stated the interim DON had completed surveillance from 5/9/18, until the current DON started on 8/1/18. The administrator stated the DON's were responsible for reviewing the records and placing any identified concern such as signs and symptoms of illness or antibiotic use on the infection control log. -At 11:55 a.m. the DON confirmed she reviewed	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 37	21375		

all progress notes entered into the computer records on a daily basis and documented any type of signs and symptoms of illness on an infection control log. The DON confirmed she was the only staff member reviewing the records for symptoms of infection as the staff nurses were not responsible for documenting information onto the infection control logs. The DON confirmed the infections/signs or symptoms of illness were not recorded in real time. The DON indicated if a resident developed an illness, which would require isolation techniques, the facility did not have approved policies or procedures in which to guide the staff.

-At 1:15 p.m. the administrator stated to her knowledge, the facility had not experienced any type of infectious outbreak in the past 12 months.

The Facility Assessment dated 11/1/17, indicated the facility would have an infection control program in which the facility would be able to care for resident with or residents who had developed infections or a combination of conditions that required complex care and care management. Infections such as skin, respiratory, urinary infection, influenza and other common infectious disease could be treated in the facility. The facility assessment indicated the facility infection control program included monitoring and management of the identified diagnoses. Lastly, the facility assessment indicated surveillance and monitoring of the infections was to be completed in a timely manner.

On 8/7/18, at 7:32 a.m. R19's nebulizer equipment (mask, tubing, medication canister) was observed on a paper towel placed on the shelf located to the right of the bathroom sink, uncovered. R19's oxygen tubing and nasal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 38	21375		

cannula were coiled together and hanging by Velcro on R19's concentrator, uncovered in the bathroom.

-At 7:46 p.m. R19 was observed receiving a nebulizer treatment via a facial mask.

On 8/8/18, at 9:05 a.m. R19's nebulizer equipment (mask, tubing, medication canister) were observed on a paper towel placed on the shelf located to the right of the bathroom sink, uncovered. R19's oxygen tubing and nasal cannula were observed coiled together and hanging by Velcro on R19's concentrator, uncovered in the bathroom.

On 8/9/18, at 8:33 a.m. R19's oxygen concentrator was observed in bathroom with an uncovered nasal cannula draped over the towel bar located to the right of the sink.

R19's physician orders provided on 8/10/18, included orders to monitor number of hours of oxygen use, uses more at bedtime and night, monitor oxygen saturations to keep >90% every 8 hours as needed (PRN) for complaints of shortness of breath, /DuoNeb solution 0.5-2.5 milligrams (mg)/3 milliliters (ml) administer one vial via nebulizer two times daily and every 6 hours prn for complaints of shortness of breath.

On 8/9/18, at 2:06 p.m. registered nurse (RN)-A stated the nasal cannula and nebulizer equipment should not be stored, uncovered, in a resident's bathroom. RN-A confirmed R19 required oxygen during the night hours.

On 8/13/18, at 1:13 p.m. the DON stated she would not expect to find oxygen & nebulizer equipment stored in a resident's bathroom.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 39 The Oxygen Tubing Safety policy dated 4/6/18 indicated that oxygen tubing was to be stored in a clean bag when not in use. This policy did not address nebulizer equipment. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or revise policies and procedures for infection control monitoring and antibiotic stewardship. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21375		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the	21535		9/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 40 Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based observation, interview and document review, the facility failed to implement increased 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 received an antibiotic while on Coumadin therapy. R2 experienced bloody stool without the identification and notification of the physician and was found to have a critically elevated INR (lab test which evaluates the clotting ability of the blood). This failure resulted in an immediate jeopardy situation for R2 and due to the facility's failure to evaluate their monitoring policies and procedures in order 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) who also received Coumadin. The immediate jeopardy began on 6/18/18, when R2 was prescribed Bactrim DS (an antibiotic) for the treatment of a urinary tract infection and did not receive increased monitoring for signs and symptoms of adverse reaction to the combination of antibiotic and anticoagulant use. The immediate jeopardy was identified on 8/9/18, at 4:25 p.m. at which time the administrator, director of nursing (DON) and assistant director of nursing	21535	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 41	21535		

(ADON) were notified. The immediate jeopardy was removed on 8/10/18, at 11:00 a.m. but noncompliance remained at the lower scope and severity level of G - isolated scope and severity level, which indicated actual harm that is not immediate jeopardy.

Findings include:

R2's annual Minimum Data Set (MDS) dated 7/11/18, indicated R2 was cognitively intact and had diagnoses which included urinary tract infection, and atrial fibrillation (an irregular heartbeat that increases the risk of stroke and heart disease). The MDS also indicated R2 required extensive assistance with all activities of daily living except eating and also received anticoagulant medication daily.

R2's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 7/11/18, indicated R2 had a longstanding history of urinary tract infections (UTI) with history of increased confusion, hallucinations and delusions associated with a UTI.

R2's Falls CAA dated 7/11/18, indicated R2 had a history of atrial fibrillation, a pacemaker, and hypertension with use of antihypertensive medication that could contribute to orthostatic hypotension and cause falls. The CAA indicated R2's atrial fibrillation was stable, however, Coumadin (anticoagulant) had recently been discontinued due to a gastrointestinal bleed (GI).

R2's care plan dated 7/24/18, indicated R2 had atrial fibrillation and required the use of a pacemaker. Coumadin currently discontinued after last hospital stay related to GI bleed and risk for bleeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 42	21535		

Review of R2's clinical record revealed on 4/10/18, medical doctor (MD)-A started R2 on a course of antibiotics (Bactrim DS) due to urinary tract infection (UTI) with adjustments made of her Coumadin orders (increased risk of bleeding when an antibiotic and Coumadin are used concurrently) which directed the staff to hold the Coumadin for two days and then give scheduled doses every other day for four days then to resume the regular dose of Coumadin 2.5 mg daily and check INR (laboratory test that monitors the effects of anticoagulant treatment) Monday, 4/16/18. The INR results dated 4/16/18, were elevated at 3.8 (Fair Meadow Lab Flow Sheet indicated normal INR range to be between 2.0 - 3.0). R2 was seen by physician assistant (PA)-A for UTI due to a persistent and worsening confusional state and R2 was subsequently admitted to the hospital.

R2's Nursing Home Progress Note (NHPN) by MD-A dated 6/1/18, indicated R2 had had several hospitalizations for UTIs. After hospitalization, R2 had been sent home on chronic urinary tract suppression with cephalexin (an antibiotic) 250 mg daily. However, in the past week R2 had a recurrence of UTI symptoms despite the cephalexin use. Therefore, the cephalexin was discontinued and Cipro (an antibiotic) was started with modifications for her INR. The assessment section of the note indicated R2 was doing well on the Cipro and the plan was to complete the course of the Cipro.

On 6/2/18, R2's INR result was 3.4 therefore MD-A ordered R2's Coumadin to be held on 6/2/18, then resume every other day. MD-A ordered a recheck of R2's INR on 6/6/18. R2's INR dated 6/6/18, was 2.1, for which MD-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 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.

R2's nursing PN dated 6/18/18, indicated MD-B had called the facility and prescribed Bactrim DS 1 tab orally, twice a day for seven days and to recheck the INR on 6/25/18, and send to MD-C. However, neither the note nor telephone order identified any modification to R2's Coumadin dose or the need for increased INR monitoring following the initiation of the antibiotic and R2's history of abnormal INR results while receiving an antibiotic.

R2's PN dated 6/23/18, written by licensed practical nurse (LPN)-C, indicated R2 had two loose stools that were "maroon in color." R2's temperature was 97. She denied abdominal pain and , "Well it is better now that my bowels moved." LPN-C indicated he would monitor for fever, pain and further stools. The note also indicated LPN-C had spoken with R2 at 2:30 p.m. and she had denied abdominal pain. R2 had also stated two days ago she had to strain to have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 44	21535		

bowel movement and was wondering if the blood could be from the straining. LPN-C indicated he had offered to have her checked in the emergency room (ER) but R2 refused. LPN-C left a message for R2's daughter to call the nursing home and while doing so, R2's daughter-in-law came to pick her up for an outing. LPN-C informed the daughter-in-law about the stools so family was aware and would watch also. Daughter-in-law aware R2 had declined ER because she declined it again with daughter-in-law present. LPN-C indicated he would continue to monitor when R2 returned and treat as necessary and as R2 and family desired. R2's clinical record lacked evidence of a registered nurse assessment or physician notification of the maroon stool. R2's Medication Administration Record (MAR) for June 2018, revealed on 6/23/18, R2 had received Coumadin 4 mg as ordered.

R2's PN dated 6/24/18, indicated R2 had increased confusion, fatigue and hallucinations as well as increased clot like appearance and more maroon color to her stools. R2 continues to received Bactrim for a UTI and her INR had been affected in the past by antibiotic use. INR checked today and was found to be 8.0 (at significant risk for major hemorrhage). A stool sample was obtained this afternoon and sent with the ambulance when they departed at 3:25 p.m. A follow up NP noted indicated R2 had been admitted to the hospital.

R2's Emergency Department (ED) note dated 6/24/18, indicated R2 had been noted to have intermittent blood in her stool over the course of the previous 3 days. She was on Coumadin chronically due to a history of atrial fibrillation. An INR was checked and found to be significantly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 45	21535		

elevated at 8. R2 had not appeared acutely ill upon arrival to ED and had not offered any acute complaints. R2 was mildly tachycardic (heart rate exceeds normal resting rate) and appeared mildly pale. Anoscopy (a scope used to examine the anal canal) revealed black stool with melanotic (having black pigmentation) features. An INR was repeated and was greater than 10. R2's hemoglobin (protein responsible for transporting oxygen in the blood) was 8.9.. R2 was given 10 mg of vitamin K (helps the blood clot) intravenously and was admitted to the hospitalist service for further evaluation and treatment.

R2's Hospital Consultation Note dated 6/25/18, indicated R2 was evaluated for hematochezia (blood in the stool). R2 reported she had passed some bright red blood per rectum on one occasion on Saturday. Found to have INR >10. R2's son reported her INR had become elevated previously after she had been treated for UTIs. Assessment: diagnosis supratherapeutic (levels greater than would be used in actual treatment of a medical condition) INR, rectal bleeding and acute kidney injury. Hematochezia with elevated INR.

R2's Hospital Progress Note dated 6/26/18, indicated an assessment which included:

1. Acute lower gastrointestinal bleeding. The cause was uncertain. This could have been secondary to diverticulosis (pockets in the digestive tract), hemorrhoids, angiodysplasia (vascular malformation of the gut) or cancer, most likely because of the supratherapeutic INR.
2. Acute blood loss anemia. R2 dropped her hemoglobin significantly from 8.9 to 7.4. Received 2 units of packed red blood cells.
3. Supratherapeutic INR on admission. It was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 46	21535		

above 10 on admission. R2 was given vitamin K 10 mg on admission and 2.5 mg orally on 6/25/18.
4. Atrial fibrillation, rate controlled, status post pacemaker placement.
5. Chronic anticoagulation with Coumadin. Hold Coumadin for now.
6. Urinary tract infection. History of UTI. Was on Bactrim, is most likely the cause of her increased INR.

On 8/6/18, at approximately 3:15 p.m. R2 was observed seated in a recliner, in her room. R2 was alert, well groomed and oriented to person and place.

On 8/8/18, at 3:50 p.m. the assistant director of nursing (ADON) verified the facility had the capacity to perform point of care/finger stick testing for INR, however, an MD order for the testing was required and she was not sure if INR testing was included in the facility standing orders.

On 8/9/18, at 9:01 a.m. LPN-C stated side effect monitoring for residents who received anticoagulant therapy included testing for INR and the facility also had a machine in house to perform the testing. LPN-C stated the staff monitored for symptoms such as bloody stools, bloody emesis, or bruising. LPN-C confirmed R2 had experienced an elevated INR of 8 which required hospitalization. LPN-C stated the incident happened on a Saturday and verified a nursing assistant (NA) had reported that R2 had bloody stools and he had reported this to the registered nurse (RN). LPN-C stated it was not frank or coffee ground blood and was a "weird" color. LPN-C stated the next day, R2's stool color was darker than the day before. LPN-C could not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 47	21535		

remember if the RN had evaluated R2 or not on 6/23/18, when the maroon colored stool was reported. LPN-C also could not remember if R2 had a UTI at the time or if she had just been getting over one. R2's Progress Note dated 6/23/18 was reviewed with LPN-C who confirmed R2 was offered the ER and refused.

On 8/9/18, at 9:33 a.m. LPN-B stated anticoagulation monitoring included checking a resident's INR and watching for symptoms such as bleeding or bruises. LPN-B confirmed bloody stools would be a symptom for which they would monitor. LPN-B stated if any symptoms were noted she would notify the RN if it were the day shift, or would contact the MD if it was the evening shift.

On 8/9/18, at 9:42 a.m. RN-B confirmed she was R2's primary RN. RN-B stated she did not have a specific identified therapeutic goal range for R2's INR, however, indicated 2.0-3.0 was the reference range identified on the laboratory sheets. RN-B verified the physicians managed the residents' Coumadin doses and monthly and as needed (PRN) INRs were completed with adjustments made to the Coumadin orders according to the INR results. RN-B stated she would expect staff to monitor for any signs or symptoms of bleeding such as prolonged bleeding of cuts, bruises, bleeding to gums, rectal bleeding or any change to stool such as stools that were black, maroon or bright red in color. RN-B stated the NAs were to report any symptoms of bleeding to the charge nurse and any observed symptoms would be documented in a progress note. RN-B also stated she would expect the LPNs to monitor for symptoms of bleeding and notify the RN and/or the doctor. RN-B stated she had not been working on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 48 6/23/18, or 6/24/18, so she was not sure if R2's maroon stool had been reported to the RN or if the RN had assessed R2 once reported to her. R2's medical record was reviewed with RN-B who verified the following: --6/23/18, progress note indicated R2 had maroon stools. --R2 received 4 mg Coumadin on 6/23/18. --Bactrim DS 800-160 mg had been prescribed on 6/18/18, and R2 continued to receive the antibiotic through the morning of 6/24/18. --R2's clinical record contained no documentation to indicate R2 had been assessed by an RN on 6/23/18. --Progress note dated 6/24/18, at 1:30 p.m. indicated the ADON would 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 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 DS on 6/18/18. The ADON indicated 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 reported to MD-C, who covered for MD-A.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 49 The ADON verified she had worked on 6/23/18, and confirmed LPN-C had reported R2's maroon colored stool to her and they had looked at it. The ADON stated the stool was a weird color. The ADON stated she had LPN-C do a focused assessment of R2 and that they [staff] were in a monitoring state at that point. The ADON stated family had been at the facility to take R2 out for the day and R2 had been coherent and responsive with no signs of confusion. The ADON confirmed R2 had been offered to be evaluated at the ER for which she had refused therefore, when R2 had left the facility with family, she had "left in a monitoring state at that time." The ADON stated she had not spoken with the family, however, LPN-C had done so and was not sure if LPN-C had explained the risks and benefits of R2 refusing to be evaluated in the ER. The ADON stated, "I guess at that point we were trying to determine what the stool was and passed the information on [to the next shift]." The ADON stated she was not aware if R2 had any further stools after she had left the facility. In addition, the ADON confirmed that following the observation of the maroon colored stool, she had not had R2's dose of Coumadin held, nor had she contacted the physician. The ADON stated she was not sure if she would have done anything differently knowing then what she knew now. The ADON stated the stool did not have frank blood and R2 had no other symptoms. ADON stated she even went and checked the menu to see if the residents had been served beets. The ADON stated on 6/24/18, R2 had experienced more maroon stools with a "clotting appearance" and more lethargy, however, the staff had attributed the lethargy to R2's outing the previous day. R2 then began hallucinating which	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 50	21535		

they attributed to a UTI. The ADON stated just before shift change she had the opportunity to discuss R2 with staff and was able to "put it all together" so the first thing she did was contact R2's family to discuss possible hospitalization and to notify them she would be testing R2's INR. The ADON performed the INR test which revealed the INR level was 8. The ADON contacted the family again to inform them she was not comfortable with R2's INR results and ask if they would be willing to send R2 to the ER for an evaluation. Once the family had approved, the ADON contacted the physician and received orders to transport R2 to the ER. The ADON verified at the ER, R2 was diagnosed with a GI bleed and subsequently had received two units of blood during a four day hospitalization. The ADON stated she could have probably tested R2's INR on 6/23/18, as she was aware of the adverse interactions between Coumadin and antibiotics, however, not to make excuses, but she was not R2's primary RN and probably did not know her history as well as RN-B. The ADON stated following R2's adverse medication event, a formal discussion with the interdisciplinary team regarding R2's hospitalization was not conducted, however, she had talked with RN-B and LPN-C about the incident. The ADON stated the facility had not made any changes to the anticoagulant monitoring system because they felt they had done what they should have done and R2 had since had her order of Coumadin discontinued.

On 8/9/18, at 11:58 a.m. the unit clerk (UC) verified there were three residents in house who currently received Coumadin, R13, R19, and R29.

On 8/9/18, at 12:01 p.m. the director of nursing (DON) confirmed R2's maroon stool was a red

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 and facility medical director, MD-A indicated the monitoring for residents who received anticoagulant medication who were also prescribed antibiotics depended on the antibiotic prescribed. MD-A stated usually if the antibiotic was Cipro, Levaquin or sulfamethoxazole (Bactrim), staff needed to check the INR more often. R2's antibiotic order from 6/18/18, was reviewed with MD-A who stated he would have done that differently. MD-A stated the physicians relied on the pharmacy to help nursing out. He stated the physician who prescribed the antibiotics should have ordered earlier INR testing, nursing should have asked for earlier INR testing and/or the pharmacist should have also asked for earlier INR testing. MA-D confirmed a maroon colored stool was a cause for concern and should have been a signal to call someone. MD-A stated he would have expected to be notified when R2 had the first maroon colored stool. MD-A indicated the staff had been working on the facility policy to include INR testing to be initiated per nursing discretion, however, stated a maroon stool, with or without policy changes would have been an indication to notify someone, particularly if the resident was on anticoagulant medication. MD-A was unsure of the facility policy regarding nursing staff holding the Coumadin medication without an order but indicated they should have contacted the physician prior to giving the medication.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 52 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. The immediate jeopardy that began on 6/18/18, was removed on 8/10/18, at 11:00 a.m. when the facility implemented the following actions: -checked the current INR levels of residents who currently received Coumadin -updated the facility standing orders regarding INR testing	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 53	21535		

-updated their anticoagulation policy to include increased monitoring while on antibiotics
-educated all nursing staff regarding the updated policies including the signs and symptoms of a non-therapeutic INR
-developed a plan to educate staff not working to ensure education was received prior to the start of their next shift.
-updated their procedures to include interdisciplinary team review of each resident hospital admission for measures to prevent unnecessary hospitalizations or medication related adverse events.

R19's Diagnosis Report dated 8/10/18, indicated R19's diagnoses included dementia with behavioral disturbances, chronic embolism and thrombosis (blood clot), edema, and long term anticoagulant use.

R19's 14 day MDS dated 6/5/18, indicated R19 had moderately impaired cognition, did not ambulate, and required extensive assistance of one to two staff for ADLs. The MDS also indicated R18 received anticoagulant medication daily during the MDS reference period.

R19's Order Summary Report dated 8/10/18, revealed an order for Aspirin 81 mg daily, and Coumadin 5 mg daily for chronic embolism and thrombosis. The physican also ordered monthly INR checks. The report did not identify the use of antibiotic medication.

R19's FMNH fax report sheet dated 8/9/18, indicated R19's most recent INR was 2.0. The physician response was to continue the same dose of coumadin and recheck the INR in two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 54 weeks then monthly. R13's quarterly MDS dated 8/1/18, indicated R13's diagnoses included diabetes, and a history of a UTI. The MDS also indicated R13 had moderately impaired cognition, required extensive assist of one to two staff for activities of daily living (ADL) except for eating, and received anticoagulant medication daily during the MDS reference period. R13's FMNH fax report dated 8/9/18, indicated R13's INR was 1.5 and the physician responded with an order to increase the Coumadin to 2 mg daily and to recheck the INR in two weeks. R29's quarterly MDS dated 6/27/8, indicated R29's diagnoses included anemia, heart failure, diabetes, Parkinson's, a seizure disorder and dementia. The MDS also indicated R29 had intact cognition, required extensive staff assistance for all ADLs except for eating in which R29 was independent, required supervision for transfers, and received anticoagulant medicaiton daily during the MDS reference period. R29's FMNH fax report dated 8/9/18, indicated R29's INR was 1.5 which revealed a significant drop since the 8/1/18, INR of 3.7. The physician responded with an order to increase the Coumadin to 3 mg daily and to recheck the INR in two weeks and 4 weeks. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the system in place, with applicable policies and procedures, to ensure potential side effects of anticoagulant medications are monitored, reviewed, and reported. The DON or	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/13/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 55 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		