

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 16, 2021

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

RE: CCN: 245545 Cycle Start Date: March 2, 2021

Dear Administrator:

On March 2, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

Fair Meadow Nursing Home March 16, 2021 Page 2

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor Bemidji District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, MN 56601-2933 Email: Jennifer.bahr@state.mn.us Office: (218) 308-2104 Mobile: (218) 368-3683

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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

Fair Meadow Nursing Home March 16, 2021 Page 3

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 June 2, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by September 2, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

Fair Meadow Nursing Home March 16, 2021 Page 4 Feel free to contact me if you have questions.

Sincerely,

5 6

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

cc: Licensing and Certification File

		AND HUMAN SERVICES			FO	RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245545	B. WING			C 03/02/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
FAIR ME	ADOW NURSING HO	ME			0 GARFIELD AVENUE SOUTHEAST ERTILE, MN 56540	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ſS	F 0	000		
	abbreviated survey to conduct a compl was found to be NC Part 483, Requirem Facilities.	3/3/21, a standard was completed at your facility aint investigation. Your facility DT in compliance with 42 CFR tents for Long Term Care				
	SUBSTANTIATED:	250) with deficiency cited at 991, MN56001) 578) 737) 907)				
F 689 SS=D	signature is not req page of the CMS-2 correction is require acknowledge receip Free of Accident Ha	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents. azards/Supervision/Devices 1)(2)	F 6	689		3/30/21
	supervision and as accidents.	resident receives adequate sistance devices to prevent NT is not met as evidenced				
	-	tion, interview and document			DON and nursing team reviewed polic	es
	DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(X6) DATE 03/17/2021

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

PRINTED: 03/24/2021

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES	1		OMB NO.	0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	Сом	E SURVEY PLETED	
		245545	B. WING			C 02/2021	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
FAIR ME	ADOW NURSING HC	DME		300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540			
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F 689	review the facility frinterventions used of 6 (R7) residents Findings include: R7's quarterly Mini 11/11/20, identified impairment and re- transfers, toileting, on/off the unit. R7 falls, dementia, and weakness, syncop symptoms of dizzir R7 had two or mor assessment period one fall with injury. medications for an R7's Fall Risk Asse identified R7 had a the past three mor balance problems and had jerking more when making turns R7's care plan, rev	ailed to implement assessed to reduce the risk for falls for 1 reviewed for falls. mum Data Set (MDS) dated R1 had severe cognitive quired assistance with bed mobility and locomotion 's diagnoses included repeated xiety disorder, generalized e and collapse (diagnosis with ness and collapsing). Further, re falls since the last d dated 8/26/20, which included Further, R7 was receiving xiety and depression. essment dated 2/10/21, a history of three or more falls in oths, was chair bound, had while standing and walking, ovements or was unstable	F 689	 and procedures related to falls resident supervision to assure assessment and interventions implemented. DON and nursi reviewed R7's care plan and f interventions. The tab alarm v removed from the recliner at t desk. Staff were instructed th should not be placed in the re evenings when staff are not p new, wider, low bed was put in to encourage her to sleep in h Essential oils will be used at b promote relaxation and sleep. updated. All nursing staff will be re-edu policy, interventions, and the i of following the care plan. Sta is scheduled for March 30. Random shift audits for monit consistent intervention implem be completed by DON or desi for 1 month, then 2x/wk for 2 then 1x/wk for 1 week. QAA wavare of the deficiency. The will be brought to QAA for input 	e proper s are being ing team all was he front at R7 cliner in the resent. A n R7's room ier bed. bedtime to Care plan cated on fall mportance aff meeting oring nentation will gnee 3x/wk weeks, and was made audit results		
	to and since admit, had an unsteady gait, attempted to self-transfer, did not remember to use the call light for assistance and received high risk medications. Interventions included: ensure R7 was wearing non-skid socks and shoes when walking or mobilizing in wheelchair; sensor pad alarm on bed, on recliner in room and on wheelchair; and tab alarm in recliner chair at the front nurse's station.			increase, decrease or discont based on findings. RN's performed fall assessme those at risk for falls and the I primary RN's and IDT reviewe for those residents. A "Fall log addressing time of fall, locatio interventions in place, and roo analysis was started and revie	ents on DON, ed care plans g" n of fall, ot cause		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00460

If continuation sheet Page 2 of 5

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				E SURVEY PLETED
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		245545	B. WING				02/2021
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F 689		-	F 68	89			
	from 9/9/20, through 2/20/21. The facility identified two falls where R7's care plan was not being followed to reduce the risk of falls. On 11/1/20, R7 was found on the floor next to her bed and the sensor pad was found unplugged. On 2/20/21, R7 was found on the floor in her room next to her recliner and after investigation the facility determined that R7's chair sensor pad was not placed under resident.				recorded and evaluated for any pat for effectiveness of interventions in Individualized care plans updated t reflect any changes.	place.	
					In addition, for future monitoring, pa ARD, IDT will meet and review card and interventions quarterly.	nd review care plans rterly.	
	was seated in the r station, in a recline was attached to up	o on 3/3/21, at 11:15 a.m. R7 recliner near the front nurses d position. The chair tab alarm oper left corner of the recliner angling down towards floor and 7.			The random audits mentioned abor completed on all residents at risk for not just R7. Compliance monitored by DON and primary RN.	or falls,	
	next to the recliner chair pad sensor w Activity aide (AA)-A and proceeded to p The tab alarm was	as seated in her wheelchair near the nurses station. R7's vas on the seat of the recliner. A assisted R7 into the recliner place R7 in a reclined position. dangling from the left side of as not attached to resident.					
	near the nurse's st hanging from the le	ontinued to sit in same recliner ation with the tab alarm still eft side of the chair and still not ff were not near the nurse's vas seated.					
	assistant (TMA)-A pad when seated in when she was in h a tab alarm clipped recliner near the nu uncertain why or w	5 a.m. trained medication stated R7 used a chair alarm n the recliner in her room and er wheelchair. R7 usually had t to her while seated in the urses station, and was ho placed R7 on the chair n't clip the tab alarm to her.					

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 3 of 5

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/24/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED C
		245545	B. WING				02/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			00 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540		
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F 689	Further, R7 was ob seated in the recline the alarms were us was moving and no a.m. staff were not station where R7 w attempted to self tra During interview on stated when R7 wa or while seated in th station R7 would at forward and attemp increased activity w aware of how frequ transfer. Further, st to R7 when she wa nurses station to ale When interviewed of director of nursing (to the facility for free falls since admission past to not follow th not know why the si plan. She had tried importance of follow worked for a while a into their old ways. responsible to ensu following the care p was responsible to care plan. The facilities Facilit Risk Assessment p 1/16/20, indicated li responsible for iden	served by staff when she was er at the nurses station and ed to alert staff that a resident t to prevent falls. At 11:15 present near the nurses as seated, to intervene if R7	F	589			

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES				FORM	03/24/2021 APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY
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		245545	B. WING				C 02/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	ME			300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540		
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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00460

PRINTED: 03/24/2021



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 16, 2021

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

Re: State Nursing Home Licensing Orders Event ID: TXFW11

Dear Administrator:

The above facility was surveyed on March 2, 2021 through March 2, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Fair Meadow Nursing Home March 16, 2021 Page 2

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

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

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

Jen Bahr, RN, Unit Supervisor Bemidji District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street NW, Suite A Bemidji, MN 56601-2933 Email: Jennifer.bahr@state.mn.us Office: (218) 308-2104 Mobile: (218) 368-3683

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

Minneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
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		00460	B. WING		C 03/0	, 2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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		FERTILE,	MN 56540			
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2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is siency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires requirements of the number and MN Re When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result fror orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnesota D	survey was conduct with State Licensur NOT in compliance Please indicate in y correction that you and identify the dat	TS: h 3/3/21, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. your electronic plan of have reviewed these orders, e when they will be completed.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for N Homes. The assigned tag number appears in the far left column entitl	ftware. to Nursing	
	epartment of Health Y DIRECTOR'S OR PROVII	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed

STATEMEN	ota Department of H	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G:	COMPI	LETED
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		00460	D. WING		03/0	2/2021
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	SUBSTANTIATED H5545008C (MN7	0250) with state licensing order 4658.0520 Subp. 1 0830 3160) 5991, MN56001) 2578) 36737) 57907)		Prefix Tag." The state statute/rul compliance is listed in the "Sumr Statement of Deficiencies" colum replaces the "To Comply" portion correction order. This column als includes the findings which are ir of the state statute after the state "This Rule is not met as evidence Following the surveyors findings Suggested Method of Correction period for Correction.	mary nn and of the or violation ement, e by." are the	
	the State Licensin federal software. T assigned to Minne Nursing Homes. T appears in the far Tag." The state st listed in the "Sum column and replac the correction orde the findings which statute after the st as evidence by." F	ment of Health is documenting g Correction Orders using Tag numbers have been esota state statutes/rules for The assigned tag number left column entitled "ID Prefix tatute/rule out of compliance is mary Statement of Deficiencies' ces the "To Comply" portion of er. This column also includes are in violation of the state tatement, "This Rule is not met Following the surveyors findings d Method of Correction and prrection.		You have agreed to participate in electronic receipt of State licensu consistent with the Minnesota De of Health Informational Bulletin 1 available at http://www.health.state.mn.us/div info/infobul.htm. The State licens orders are delineated on the atta Minnesota Department of Health being submitted to you electronic Although no plan of correction is necessary for State Statutes/Rul enter the word "CORRECTED" in available for text. You must then in the electronic State licensure p	ure orders epartment 4-01, /s/fpc/prof sing ched orders cally. es, please n the box indicate process,	
	receipt of State lic the Minnesota Dep Informational Bulle http://www.health. obul.htm. The Sta delineated on the Department of He you electronically. is necessary for S enter the word "CO	to participate in the electronic ensure orders consistent with partment of Health etin 14-01, available at state.mn.us/divs/fpc/profinfo/inf te licensing orders are attached Minnesota alth orders being submitted to Although no plan of correction tate Statutes/Rules, please ORRECTED" in the box You must then indicate in the		under the heading completion date date your orders will be corrected electronically submitting to the M Department of Health. The facilit enrolled in ePOC and therefore a signature is not required at the be the first page of state form. PLEASE DISREGARD THE HEA THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN C CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE	d prior to linnesota y is a ottom of ADING OF H DF S TO Y. THIS	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00460	B. WING			02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	IELD AVEN MN 56540	UE SOUTHEAST		
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2 000	-	age 2 ensure process, under the	2 000			
	heading completion be corrected prior of the Minnesota Dep is enrolled in ePOC not required at the state form. PLEASE DISREGA FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			3/30/21
	receive nursing can custodial care, and individual needs ar the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from	e general. A resident must re and treatment, personal and l supervision based on ad preferences as identified in e resident assessment and scribed in parts 4658.0400 and sing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				
	by: Based on observat review the facility fa	ent is not met as evidenced ion, interview and document ailed to implement assessed to reduce the risk for falls for 1 reviewed for falls.		Corrected.		
	Findings include:					

STATE FORM

TXFW11

If continuation sheet 3 of 7

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00460	B. WING			02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	FIELD AVENU , MN 56540	E SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 3	2 830			
	11/11/20, identified impairment and rea transfers, toileting, on/off the unit. R7's falls, dementia, anx weakness, syncope symptoms of dizzin R7 had two or more assessment period one fall with injury. medications for anx R7's Fall Risk Asse identified R7 had a the past three mont balance problems v and had jerking mo when making turns R7's care plan, revi was at risk for falls to and since admit, attempted to self-tra use the call light for risk medications. In R7 was wearing no walking or mobilizin alarm on bed, on re wheelchair; and tab front nurse's station R7's facility Fall Re from 9/9/20, throug identified two falls v being followed to re 11/1/20, R7 was for bed and the sensor	ewed on 2/18/21, identified R7 related to repeated falls prior had an unsteady gait, ansfer, did not remember to assistance and received high nterventions included: ensure n-skid socks and shoes when ing in wheelchair; sensor pad ecliner in room and on alarm in recliner chair at the				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COMPLETED	
		00460	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	RFIELD AVENU E, MN 56540	E SOUTHEAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ge 4	2 830			
	room next to her re	 cliner and after investigation led that R7's chair sensor pad 				
 was seated in the station, in a reclowas attached to with the clip end not connected to and proceeded of the recliner and proceeded of the tab alarm with the recliner and -At 1:46 p.m. R7 near the nurse's hanging from the clipped to R7. Seataion where R On 3/3/21, at 11 assistant (TMA) pad when seate when she was in a tab alarm clipper celiner near the uncertain why or the context of the tab alarm clipper to the tab alarm clipper tab alarm	was seated in the restation, in a reclined was attached to up	on 3/3/21, at 11:15 a.m. R7 ecliner near the front nurses d position. The chair tab alarn per left corner of the recliner ngling down towards floor and 7.				
	next to the recliner chair pad sensor w Activity aide (AA)-A and proceeded to p The tab alarm was	as seated in her wheelchair near the nurses station. R7's as on the seat of the recliner. assisted R7 into the recliner place R7 in a reclined position. dangling from the left side of s not attached to resident.				
	near the nurse's sta hanging from the le	ontinued to sit in same recliner ation with the tab alarm still oft side of the chair and still not f were not near the nurse's as seated.				
	assistant (TMA)-As pad when seated in when she was in he a tab alarm clipped recliner near the nu uncertain why or wh alarm pad and didm	a.m. trained medication stated R7 used a chair alarm in the recliner in her room and er wheelchair. R7 usually had to her while seated in the urses station, and was no placed R7 on the chair 't clip the tab alarm to her.				
	seated in the reclin the alarms were us was moving and no a.m. staff were not	served by staff when she was er at the nurses station and ed to alert staff that a resident to prevent falls. At 11:15 present near the nurses as seated, to intervene if R7				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	COM	E SURVEY PLETED
		00460	B. WING		C 03/02/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIR ME	ADOW NURSING HO	MF	FIELD AVENU , MN 56540	E SOUTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 5	2 830			
	stated when R7 wa or while seated in t station R7 would at forward and attemp increased activity w aware of how freque transfer. Further, st to R7 when she wa nurses station to al When interviewed of director of nursing to the facility for fre falls since admission past to not follow the not know why the se plan. She had tried importance of follow worked for a while into their old ways. responsible to ensu following the care p was responsible to care plan.	a 3/3/21, at 1:52 p.m. AA-A is left unattended in their room the recliner near the nurses it times become antsy, scoot of to transfer themselves. R7's vas random and AA-A not it to transfer themselves. R7's of 3/3/21, at 2:43 p.m. the (DON) stated R7 was admitted quent falls and had multiple on. Staff were identified in the ne care plans and the DON did taff were not following the care to re-educate staff on the wing the care plans. This and then staff would fall back The charge nurses were use the staff on their shift were olan, and ultimately, the DON ensure staff were following the	f			
	Risk Assessment p 1/16/20, indicated I responsible for ider	y Accident Prevention - Fall oolicy and procedure, reviewed icensed nursing staff were ntifying each at risk resident fo Ils and implementation of event accidents.				
	The DON or design policies and proceed and resident super assessment and in	THOD OF CORRECTION: hee, could review/revise dures related to falls, accidents vision to assure proper terventions are being v could re-educate staff on the				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IED
		00460	B. WING		C 03/02/	2021
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	·	
	ADOW NURSING HO			E SOUTHEAST		
		FERTILE	E, MN 56540			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one					
	(21) days.	R CORRECTION: Twenty-one				