



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 23, 2026

Administrator
FAIR MEADOW NURSING HOME
300 GARFIELD AVENUE SOUTHEAST
FERTILE, MN 56540

RE: CCN:245545
Cycle Start Date: July 15, 2026

Dear Administrator:

On July 15, 2026, a survey was completed at your facility by the Minnesota Department of Health 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.

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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 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 October 15, 2026 (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 January 15, 2027 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 23, 2026

Administrator
FAIR MEADOW NURSING HOME
300 GARFIELD AVENUE SOUTHEAST
FERTILE, MN 56540

Re: State Nursing Home Licensing Orders
Event ID: 25D975-H1

Dear Administrator:

The above facility survey was completed on July 15, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Nikki Harvey, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon St.
Marshall, MN 56258
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0000	INITIAL COMMENTS On 7/13/26, through 7/15/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H55453156C (3068352) with no deficiencies. Deficient practice was identified related to incidental finding at F609, 610, 656. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			07/27/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the			F0609	F609 Deficiency: The facility failed to report an allegation of an injury of unknown origin to the State Agency within the required reporting timeframe for one resident reviewed for injury of unknown origin. The Director of Nursing and Social Services Designee reviewed the incident documentation and confirmed that the allegation of injury of unknown origin was not reported according to required procedures. The Director of Nursing or designee reviewed current incident reports, progress notes, risk management documentation, and hospital transfer documentation for the previous 30 days to identify any injuries of unknown origin or allegations requiring reporting. Any identified concern was reviewed to confirm that timely reporting and investigation requirements were met.		09/23/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0609 SS = D	Continued from page 1 administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to report an allegation of an injury of unknown origin to the State Agency (SA) within two hours for 1 of 1 resident (R1) investigated for injury of unknown origin. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/16/26, identified moderately impaired cognition without behaviors. R1 had impairment of lower bilateral extremities and used a manual wheelchair for mobility. R1 required partial/moderate assistance with toileting hygiene, personal hygiene, sitting on side of bed to lying flat on bed, substantial/maximal assistance to transfer from chair/bed to chair transfer, and walked 15 feet once standing in a corridor or similar space. R1's diagnoses included anemia (low red blood count), congestive heart failure (CHF), and anxiety. R1's care plan dated 7/10/26, identified R1 was a vulnerable adult (VA) due to placement, diagnoses, and dependence. Staff were instructed to follow care plans to ensure safety. Per facility abuse policy guidelines, report episodes of abuse to charge nurse, director of nursing (DON), social services designee (SSD), and administrator. Report to common entry report per policy if intervention or a VA report is needed. R1's progress notes dated 7/2/26, through 7/4/26, identified: 7/2/26 at 10:00 a.m., R1 had been having difficulty with transfers and became fearful. Attempted to stand with moderate assist of two staff and became			F0609	Continued from page 1 The facility's abuse prevention and reporting policy was reviewed with nursing leadership, social services, therapy leadership, and administrative staff. Education was provided to licensed nurses, rehab coordinator, social services, and department managers regarding immediate notification expectations and required reporting timelines. Education included recognition of injuries of unknown origin, allegations of abuse or neglect, serious bodily injury, reporting to the Social Services Designee (SSD) and/or the Director of Nursing (DON), if report deemed necessary. The SSD will initiate the Vulnerable Adult report and complete the investigation findings within required timeframes. Additionally, at the skills fair on August 17th and 18th, the SSD will educate all staff on reporting requirements and safe patient handling. Furthermore, a reporting guideline was implemented for all incidents involving allegations of abuse, neglect, exploitation, mistreatment, injuries of unknown origin, and misappropriation of resident property. The guideline outlines what is reportable and nonreportable per CMS guidelines. The Director of Nursing or designee will audit incident reports, progress notes, hospital transfers, and risk management documentation two times per week for four weeks, then weekly for four weeks, to ensure allegations and injuries of unknown origin are identified, reported, investigated, and documented within required timeframes. Audit findings will be reviewed by the Administrator and reported to the Quality Assurance and Performance Improvement Committee for review, trend analysis, and further corrective action as needed.		09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0609 SS = D	Continued from page 2 resistant. Due to inconsistency, will be Hoyer (full body mechanical lift) for transfers to/from bed and recliner and assist of two to use grab bar and commode for toileting. 7/2/26 at 11:15 a.m., R1 had bruise to left outer calf and swollen ankle, tender to touch. Staff reported last evening and this morning she had been difficult to transfer. Bruise to calf may have been caused by bed frame during a transfer. Provider gave orders to transfer to local emergency department (ED) for x-ray of left knee and ankle. 7/2/26 at 4:53 p.m., Received update from ED physician, R1 was admitted to hospital with diagnoses of acute renal injury and left ankle fracture non-displaced (bone cracked but remained properly aligned). 7/4/26 at 1:49 p.m., R1 returned to facility at 11:20 a.m., R1 had a CAM boot (walking boot) to left ankle/foot and transferred via Hoyer lift. Facility internal incident report dated 7/2/26 at 11:15 a.m., R1 was noted to have a bruise on her left outer calf, swollen ankle and tender to touch. Trained medication assistant (TMA) reported this morning, last evening and this morning R1 had been difficult to transfer. Bruise to outer calf may have been caused by bed frame during a transfer. Intervention: screen was placed for R1's increased difficulty with transfers. R1 was presently doing a restorative nursing program working on transfers and ambulation. R1 was unable to give description. Immediate action taken orders given by provider for transfer to ED for evaluation and x-ray of left knee and ankle. R1 rated her ankle pain at 10 out of 10. Tylenol 650 milligrams (mg) was given by mouth. No injuries observed post incident. Mental status: oriented to person confused, weakness, and impaired memory. Predisposing situation factors: during transfer. Statements: no statements found. Emergency Department (ED) provider notes dated 7/2/26 at 2:08 p.m., identified R1 was sent from care facility with signs of trauma. The history is not exactly clear and did not match the physical examination. According to the facility nurse and therapist, R1 sustained bruises on her left breast with the use of the sit to stand device at the facility. R1 walked with the parallel bars by their report this morning and noticed swelling of the ankle later, no history of significant injury, noted R1 possibly bumped her leg on the bed or something during a transfer, but no fall was reported. R1's movement became increasingly difficult, and a Hoyer lift was			F0609			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0609 SS = D	Continued from page 3 used instead. ED provider spoke with podiatry MD, x-rays were reviewed and confirmed a fracture of the left ankle, agreed the boot for now and planned a follow-up in one week. Upon physical exam R1 had edema, erythema (redness caused by increased blood flow), some ecchymosis (bruising caused by blood leaking from broken blood vessels into the subcutaneous tissue beneath the skin) on the left and right lower extremities. Radiology Results Report dated 7/2/26 at 3:13 p.m., identified indication: trauma. Findings/Impression: Bones – decreased osseous mineralization (a reduction in the mineral content of bones, primarily calcium and phosphorus, which can lead to weakened bone structure and increased fracture risk). R1’s discharge summary dated 7/4/26, identified she was admitted to hospital with a presumed fall. R1’s cognition was impairment and unfortunately made it difficult to remember how and when she fell. This was an unwitnessed fall that resulted in a closed fracture of the left medial malleolus (inner side of the ankle), non-displaced with extensive bruising on the left side of her body congruent with the fall. Physical therapy recommended Hoyer lift. R1’s primary provider medical doctor (MD) visit dated 7/7/26, identified R1 was seen for follow-up from her recent hospitalization for a malleolar fracture of unknown origin. R1 was a poor historian with dementia, and an accurate depiction of events leading up to the fracture could not be obtained. Staff noted bruising and swelling and sent R1 to ED for evaluation. R1 returned to facility with a CAM boot and hospital staff had used a Hoyer lift, avoiding weight bearing activities. Plan: continue CAM boot, use lift with cares, and follow up with podiatry. Interview on 7/15/26 at 4:27 p.m., DON stated R1 had moderate forgetfulness, impaired cognition and at risk for falls. R1 was unable to process to turn her feet when she stood up, unable to turn around, scared of the stand lift and anything that moved her around. Before R1 fractured her ankle she was assist of two, FWW, and commode. R1 was unable to respond to commands, staff were expected have two physical assistance when R1 transferred and to lay R1 in bed. R1 likely hit or bumped ankle/foot on bed frame, resulted in a bruise on the calf of left leg, and most likely occurred on 7/1/26, when her legs hung over the bed. COTA saw R1’s back of the leg rested on the bed frame. R1 was on anticoagulants (blood			F0609			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0609 SS = D	Continued from page 4 thinner). R1 was able move forward but unable to turn. DON was unsure if it affected her ankle but could have caused R1 to have a fractured ankle. "We did not have a clue she had a fracture until an x-ray was done. We were unable to identify how it happened." DON stated she was made aware of R1's fractured left ankle on 7/2/26, in the afternoon. The DON did not suspect abuse or neglect but thought it was possibly from a transfer. There were no falls or her ankle hitting anything during a transfer that we were aware of. DON stated this would have been an injury of unknown origin, should have been reported to the State Agency (SA) within two hours. DON stated this incident was not reported because it was discussed at length as a team and the hospital filed a report with Minnesota Adult Abuse Reporting Center (MARCC). "I did not think we had to report it since they already filed one." Facility policy Vulnerable Adult (VA) Abuse Prohibition Plan, Freedom from Abuse, Neglect, and Exploitation dated 6/15/26, identified all resident sand or other person receiving services have the right to be free from any maltreatment, neglect, verbal or mental abuse, physical abuse, sexual abuse, corporal punishment, involuntary seclusion, or misappropriation of funds or property. The facility residents will not tolerate abuse from staff, family, volunteers, or any other persons. All facility staff are mandated reporters of abuse, and any suspected case will be appropriately investigated, reported, and responded to. Definition of injuries of unknown source: the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident. A mandated reporter is (each employee) who has reason to believe a VA is being or has been maltreated or has knowledge that a VA has sustained a physical injury which is not reasonably explained, shall immediately report to his/her immediate supervisor. Ensure that all alleged violations involving abuse, neglect exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the State Survey Agency and adult protection services where state law provides jurisdiction in long-term care facilities but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Unknown injury was defined as: an injury that is not related to a previously known incident or injury and probable cause is not identified.			F0609			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to thoroughly investigate an allegation of injury of unknown origin for 1 of 1 residents (R1) who was sent to the emergency department (ED) for evaluation for left leg swelling, bruising and complaints of pain. Findings include: R1's uarterly Minimum Data Set (MDS) dated 6/16/26, identified moderately impaired cognition without behaviors. R1 had impairment of lower bilateral extremities and used manual wheelchair for mobility. R1 required partial/moderate assistance with toileting hygiene, personal hygiene, sitting on side of bed to lying flat on bed, and substantial/maximal assistance to transfer from chair/bed to chair transfer. R1's diagnoses included anemia (low red blood count), congestive heart failure (CHF), and anxiety. R1's care plan dated 7/13/26, identified: Date initiated: 10/7/24, R1 was high risk for falls due to age related physical disability, decline in activities of daily living (ADLs) since admission, and gait/balance problems. Date revised: 10/23/24, Ensure R1 wore appropriate			F0610	F610 The facility failed to complete a thorough investigation of an injury of unknown origin involving R1's left ankle fracture, left lower leg bruising, swelling, tenderness, and pain. The investigation did not include timely interviews with all staff who transferred, repositioned, assessed, or cared for the residents during the relevant timeframe. Upon return from the hospital, the resident was in a CAM boot as ordered and transferred using a Hoyer lift to avoid unsafe weight-bearing and reduce risk of further injury. Nursing staff were notified of the residents updated transfer status and CAM boot usage after the resident returned from the hospital by the communication book and shift report however, it did not get added to the care plan/sheets. On 7/6/26, the care plan was updated to reflect the residents CAM boot and Hoyer lift usage. The SSD will review the policy with staff to clarify that injuries of unknown origin, unexplained bruising, fractures, or physical injuries not reasonably explained must be treated as reportable concerns and reported to the SSD immediately upon discovery. This will be completed within 7 days. Evidence of completion will include the policy review, staff sign-in sheet, and a Vulnerable Adult guideline. The SSD implemented a checklist for allegations, injuries of unknown origin, unexplained bruising, fractures, or suspected mistreatment. The checklist will require resident assessment, resident interview attempt, witness interviews, staff interviews from all shifts, medical record review, therapy review, NA documentation review, care plan review, equipment review, timeline, root cause analysis, and administrator review. This was completed on 7/28/2026. On July 7, 2026, a nursing meeting was held during which transfer training was discussed and a demonstration on safe patient handling techniques was provided. In addition, The Rehab Coordinator will educate staff on required number of staff assistance, use of gait belts, Hoyer lift use, stand-pivot transfers, commode transfers, bed mobility, and when to stop a transfer and request additional assistance on August 17th and 18th at the skills fair. Evidence of completion will include training rosters, skills competency checklists, and return demonstrations.		09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0610 SS = D	Continued from page 6 footwear, non-skid socks and shoes when nursing assistant (NA) ambulated or mobilized in wheelchair. Date revised: 10/23/24, Review information on past falls and attempt to determine cause of falls, record possible root causes, and remove any potential causes is possible. R1 was a vulnerable adult (VA) due to placement, diagnoses, and dependence. Staff were instructed to follow care plans to ensure safety and reviewed at care conferences quarterly and as need to identify changes in risk factors for abuse. Per facility abuse policy guidelines, report episodes of abuse to charge nurse, director of nursing (DON), social services designee (SSD), and administrator. Report to common entry report per policy if intervention or a VA report is needed. R1's progress notes dated 7/2/26, through 7/4/26, identified: 7/2/26 at 10:00 a.m., R1 had been having difficulty with transfers and became fearful. Attempted to stand with moderate assist of two staff and became resistant. Due to inconsistency, will be Hoyer (full body mechanical lift) for transfers to/from bed and recliner and assist of two to use grab bar and commode for toileting. 7/2/26 at 11:15 a.m., R1 had bruise to left outer calf and swollen ankle, tender to touch. Staff reported last evening and this morning she had been difficult to transfer. Bruise to calf may have been caused by bed frame during a transfer. Provider gave orders to transfer to local emergency department (ED) for x-ray of left knee and ankle. 7/2/26 at 4:53 p.m., Received update from ED physician, R1 was admitted to hospital with diagnoses of acute renal injury and left ankle fracture non-displaced (bone cracked but remained properly aligned). 7/4/26 at 1:49 p.m., R1 returned to facility at 11:20 a.m., R1 had a CAM boot (walking boot) to left ankle/foot and transferred via Hoyer lift. Staff interviews completed by the facility identified: 7/1/26, p.m., nursing assistant (NA) stated she sent male staff NA to R1 because she had to go help a resident that preferred to have no men. Later, certified occupational therapy assistant (COTA) and NA went to R1's room to boost her up in bed.			F0610	Continued from page 6 The DON or designee will audit all incidents involving bruising, swelling, pain, fracture, transfer-related injury, or injury of unknown origin two times per week for two weeks, then weekly for four weeks. Audits will verify that immediate resident safety measures were implemented; required notifications and reports were completed; interviews were completed with all involved staff and witnesses; the resident was interviewed or an attempt was documented; the medical record, therapy documentation, care plan, and assignment sheets were reviewed; and corrective actions were documented. The Rehab Coordinator or designee will complete transfer-observation audits for residents requiring two-person assist or mechanical lift use two times per week for two weeks, then weekly for four weeks, to verify staff follow the care plan and use safe transfer techniques. Any identified noncompliance will result in immediate coaching, re-education, competency validation, and progressive corrective action as appropriate. The QAPI Committee will review investigation audit results, transfer-observation audit results, staff education completion, resident safety outcomes, and any repeat events involving injuries of unknown origin or transfer-related concerns. The committee will determine whether additional system changes are needed, including revisions to policies, assignment sheets, care plan communication, therapy referral processes, incident reporting workflows, or staff competency requirements.		09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0610 SS = D	Continued from page 7 7/1/26, p.m. COTA stated male NA requested help with R1. She went to assist and observed R1 laying close to the edge of the bed. COTA asked male NA to leave the room and asked the other NA in the room how good are you are lifting? NA responded not good at all. COTA asked another NA to assist with R1's boost toward middle of the bed. R1 did not complain of leg pain, only back pain. 7/2/26, a.m., COTA was asked by nursing to screen R1 related to difficulty with transfers. R1 used omni cycle (powered exercise device intended for medical and therapeutic purposes), attempted to stand in hallway but was unable, stood for a minute and held onto parallel bars, then brought to room stood and walked with stand by assist (SBA) to her recliner. Later at 11:00 a.m., went to get R1 up for lunch and noted left ankle and outer left calf were swollen Facility internal incident report dated 7/2/26 at 11:15 a.m., R1 was noted to have a bruise on her left outer calf, swollen ankle and tender to touch. Trained medication assistant (TMA) reported this morning, last evening and this morning R1 had been difficult to transfer. Bruise to outer calf may have been caused by bed frame during a transfer. Intervention: screen was placed for R1's increased difficulty with transfers. R1 was presently doing a restorative nursing program working on transfers and ambulation. R1 was unable to give description. Immediate action taken orders given by provider for transfer to ED for evaluation and x-ray of left knee and ankle. R1 rated her ankle pain at 10 out of 10. Tylenol 650 milligrams (mg) was given by mouth. No injuries observed post incident. Mental status: oriented to person confused, weakness, and impaired memory. Predisposing situation factors: during transfer. Statements: no statements found. Emergency Department (ED) provider notes dated 7/2/26 at 2:08 p.m., identified R1 was sent from care facility with signs of trauma. The history is not exactly clear and did not match the physical examination. According to the facility nurse and therapist, R1 sustained bruises on her left breast with the use of the sit to stand device at the facility. R1 walked with the parallel bars by their report this morning and noticed swelling of the ankle later, no history of significant injury, noted R1 possibly bumped her leg on the bed or something during a transfer, but no fall was reported. R1's movement became increasingly difficult, and a Hoyer lift was used instead. ED provider spoke with podiatry MD, x-rays were reviewed and confirmed a fracture of the left ankle, agreed the boot for now and planned a follow-up in one week. Upon physical exam R1			F0610			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0610 SS = D	Continued from page 8 had edema, erythema (redness caused by increased blood flow), some ecchymosis (bruising caused by blood leaking from broken blood vessels into the subcutaneous tissue beneath the skin) on the left and right lower extremities. R1's primary provider medical doctor (MD) visit dated 7/7/26, identified R1 was seen for follow-up from her recent hospitalization for a malleolar fracture of unknown origin. R1 was a poor historian with dementia, and an accurate depiction of events leading up to the fracture could not be obtained. Staff noted bruising and swelling and sent R1 to ED for evaluation. R1 returned to facility with a CAM boot and hospital staff had used a Hoyer lift, avoiding weight bearing activities. Plan: continue CAM boot, use lift with cares, and follow up with podiatry. Interview on 7/13/26 at 1:25 p.m., nursing assistant (NA)-D stated she worked day shift on 7/2/26, night staff reported R1 had a hard standing/transferring to commode at 6:00 a.m. NA-D watched R1 transfer and noted she was hesitant to stand. NA-D asked the COTA to assess R1. The COTA changed R1's transfer status to a hoyer lift. R1 was then sent to hospital. NA-D stated she was not interviewed regarding R1's ankle fracture. Interview on 7/13/26 at 2:11 p.m., NA-E stated she transferred and walked R1 with two staff, three times on 7/1/26, in the morning. R1 did good except she got weak fast. R1 did not complain of ankle or leg pain during transfers or when walking. NA-E stated on 7/2/26, R1 walked a little bit, short steps from wheelchair to the commode with assist of two, R1 was weak and complained of knee pain. R1 did not fall during her shift and had bruises on her left lower leg. NA-E stated that she left for the day before R1 was sent to hospital. NA-E stated she was not interviewed regarding R1's left ankle fracture. Interview on 7/13/26 at 2:29 p.m., licensed practical nurse (LPN)-A stated R1 was alert, forgetful, and confused. R1 had difficulty with understanding how to turn and pivot when she stood up and usually complained of knee pain. R1 did not usually complaint of ankle pain. LPN-A stated she did not know how R1 fractured her ankle and was not interviewed regarding the injury. Interview on 7/13/26 at 4:20 p.m., NA-F stated she worked on 6/29/26, evening shift (2:00 p.m. to 10:15 p.m.). NA-F transferred R1 around 9:11 p.m. R1 was confused at night, with her confusing getting worse			F0610			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0610 SS = D	Continued from page 9 around supper time. R1 transferred with assist of two with a walker. NA-F would instruct R1 to take a few steps forward, so NA-F could place the commode behind her as R1 had a hard time moving her feet. NA-F stated on 6/29/26, no bruises were noted on R1’s lower legs, only a bruise on her knee. NA-F stated she was not interviewed regarding R1’s left ankle fracture. Interview on 7/14/26 at 8:54 a.m., medical director (MD) stated R1 had a diagnosis of osteoporosis and brittle bones. MD was not able to specify what may have caused R1's ankle fracture. MD stated it could have been something simple, and staff did not have knowledge of anything specific happening. R1 did not have a fall or any type of injury that occurred that the MD was aware of. R1’s medical history placed her at risk for this fracture more so than someone else, if her leg or foot had got caught she could have easily fractured it. MD stated R1’s bruising on her left abdominal side was presumed to be caused by the lift machine. Additionally, R1 was on Eliquis (anticoagulant) and therefore bruised easily. R1’s was pleasant, was unaware of what was going on around her and had impaired cognition. Interview on 7/14/26 at 11:37 a.m., occupational therapy assistant (COTA) stated she was the activity and rehab director. R1's cognition had slowly gotten worse, but was always moderately confused. On 6/29/26, R1 was screened due to bruising on left side/breast/underarm. R1 stood in the stand lift with the wide sling around her, was more resistive when she was in the stand lift, pushed backwards, and the sling slid upwards pulling on her left side. R1 was changed to stand pivot transfer to the commode. On 7/1/26, in the early evening, NA-A requested help, stated R1 laid on edge of the bed and would not allow him in her room. COTA stated she entered R1’s room and noted she was laying close to the bed railing and was visibility upset. COTA stated NA-A and NA-B had just assisted her to the commode then to the bed. COTA thought R1's leg may have been bumped on the bed frame during the transfer. COTA did not ask the NA's about the transfer but reported it to the nurse on the medication cart. COTA stated she was not aware if the staff knew R1 was fragile and/or on anticoagulants. On 7/2/26 at approximately 11:15 a.m., COTA noticed R1's outer left calf was bruised, R1's ankle was swollen and tender to touch. R1 was sent into ED and diagnosed with a left fractured ankle. Interview on 7/14/26 at 2:09 p.m. NA-B stated on 7/1/26 around 7:00 p.m., NA-A assisted her			F0610			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0610 SS = D	Continued from page 10 transferring R1 to the commode. R1 was in her wheelchair, the commode was located behind her, and a gait belt was applied. R1 stood up, the wheelchair was moved and the commode was pulled up behind her. R1’s feet would not move, her knees did not support her standing very long. R1's knees gave out and R1 was lowered down onto commode. R1 did not complain of pain. While R1 sat on commode, NA-A pulled her backwards across the floor without assist to the bedside, approximately five feet. NA-B stated together they transferred R1 to the edge of the bed. Once on the bed, R1's feet were not touching floor. NA-A placed one arm around R1's back and one arm underneath her knees then spun her entire body around quickly so that she laid on the very edge of the bed. R1's knees and feet remained off the bed. R1 screamed, "stop, stop," then started to cry, and seemed scared with how fast NA-A moved her. NA-B stated the movement was so fast and but R1 did not appear to hit any part of her legs/feet on the bed. NA-B stated she did not know how R1 fractured her ankle and was not interviewed. Interview on 7/15/26 at 2:00 a.m., NA-G stated they usually worked the overnight shift. On 7/1/26 in the early morning, R1 used the commode located next to her bed. She was transferred by a stand pivot with assist of two. R1 frequently had difficulty with standing and complained about not being able to move her feet. NA-G stated it was worse the morning of 7/1/26. NA-G stated were not interviewed regarding R1’s fractured ankle. Interview on 7/15/26 at 11:45 a.m., NA-C stated R1 was assist of two to get her onto and into bed. NA-C stated R1 was a larger sized resident, definately required two staff assist to transfer and to lay in bed. NA-C stated if one staff tried to get R1 into bed alone, it would have placed her at higher risk for injury. R1's legs/feet tended to drop down and often bumped on the bed or the mattress during transfers. On 7/1/26, between 9:00 p.m. and 9:30 p.m., NA-C was informed by NA-B, R1 was halfway off the bed and asked for assistance. When NA-C entered R1's room, she noted R1 laid on her back on the edge of the bed diagonally, the head of the bed was slightly elevated. R1's knees were bent at the edge of the mattress, and feet dangled off the bed. NA-C stated three staff boosted R1 up into the middle of bed. R1 panicked when repositioned. NA-C stated she was not interviewed about R1’s fractured ankle. Interview on 7/15/26 at 1:25 p.m., unit coordinator/registered nurse (RN)-A stated COTA			F0610			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0610 SS = D	Continued from page 11 had informed her in the morning on 7/2/26, R1's bruise on her left calf may have been caused by being hit on the bed frame during a transfer on 7/1/26, on evening shift. The COTA told RN-A, she went into R1's room in the evening on 7/1/26, R1 laid on the edge of the bed due to two staff, NA-A and NA-B, having a hard time getting her onto the bed and they needed to move R1 quickly. The following day, 7/2/26, R1 had a new bruise located on the outer side of the calf down to just above the ankle, and R1's left ankle was swollen and tender to touch. R1 requires assistance from two staff for bed mobility and it would not have been safe for one staff to move her from a sitting to a lying position in bed. One staff assisting with bed mobility placed R1 at higher risk for injury. RN-A stated it was unknown if NA-A and NA-B were interviewed regarding R1's fractured left ankle but it would have been important for them to be interviewed to find out what happened, provide necessary education, prevent it from occurring again, and maintain safety for the resident and staff. The facility should have completed an investigation and all staff that worked with her in the last week should have been interviewed prior to confirmation of the fracture of her ankle to help identify if something went wrong. RN-A stated on 7/2/26, when she observed R1's bruising of the left lower leg as well as R1's swollen and tender left ankle, RN-A did not ask her how it may have happened but should have. Even though R1 was not cognitively intact, she may have been able to give some information. Interview on 7/15/26 at 2:46 p.m., NA-A stated R1 had impaired cognition and required two staff assist to transfer/lay her down on the bed. NA-A stated he was asked to assist with R1's transfer on 7/1/26 at 7:00 p.m. NA-A placed R1's walker in front of her, held onto the gait belt, and together with NA-B, stood R1 up. NA-B pulled the commode behind R1, R1's clothes were adjusted, and she sat down on the commode. When finished, R1 stood up and NA-B completed peri cares. R1 was weak that day, unable to stand very long and was almost crying. R1 wanted to go to bed, and sat back down on commode. NA-A stated with the help of NA-B, he moved R1 over to the bedside while still on the commode. NA-A did not recall if the commode had wheels on it. R1 was positioned alongside the bed while still on the commode. NA-A stated NA-B stood behind the commode so she could hold onto R1 while she pivoted, and NA-A stood on R1's left side. NA-A grabbed the gait belt with both hands and NA-B grabbed the gait belt from behind. R1 stood up again, NA-B moved the commode away. The transfer was a real long pivot, R1 was unable to			F0610			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0610 SS = D	Continued from page 12 move her feet, she stood close to the bed and sat down. R1 was close to the edge of the bed when NA-A placed his right hand /arm on her back and his left hand was placed under both her legs. NA-B grabbed R1's legs/feet, turned her and laid her entire body down on the bed, including feet and legs. There were no concerns about safety or her legs being bumped on anything. "We planned to boost her up in bed but she [R1] got angry and told me to get out or she would punch me." NA-A stated he called for help and left the room when other staff arrived. NA-A stated he heard R1 had a fractured ankle and did not know what caused it. Interview on 7/15/26 at 4:27 p.m., DON stated R1 had moderate forgetfulness, impaired cognition and at risk for falls. R1 was unable to process to turn her feet when she stood up, unable to turn around, scared of the stand lift and anything that moved her around. Before R1 fractured her ankle she was assist of two, FWW, and commode. R1 was unable to respond to commands, staff were expected have two physical assistance when R1 transferred and to lay R1 in bed. R1 likely hit or bumped ankle/foot on bed frame, resulted in a bruise on the calf of left leg, and most likely occurred on 7/1/26, when her legs hung over the bed. COTA saw R1's back of the leg rested on the bed frame. R1 was on anticoagulants (blood thinners). R1 was able move forward but unable to turn. DON was unsure if it affected her ankle but could have caused R1 to have a fractured ankle. "We did not have a clue she had a fracture until an x-ray was done. We were unable to identify how it happened." DON stated she was made aware of R1's fractured left ankle on 7/2/26, in the afternoon. The DON did not suspect abuse or neglect but thought it was possibly from a transfer. There were no falls or her ankle hitting anything during a transfer that we were aware of. The DON stated the facility would have been expected to investigate the incident. Only R1 was interviewed and R1 thought she broke her ankle at church. Only two staff were interviewed. The investigation should have included review of medical records, NA charting, therapy notes, and assessments (all completed). A replay of the scenarios should have been completed if something was questioned. The DON stated their investigation include a review of polices (abuse and transfers), and education (safe transfers). It would have been important to interview the staff who transferred R1 to bed on 7/1/26, to get a full picture of what happened, to ensure they had the correct staff assistance during the transfer, and provide re-education if needed. The DON stated she was unsure if NAs on 7/1/26 used the appropriate number of staff and technique to assist R1 with bed			F0610			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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	
F0610 SS = D	Continued from page 13 mobility. Using the appropriate number of staff and technique would have prevented injuries. DON stated the 5-WHY Analysis Template was used to determine root cause of injuries: bruise to left calf on 7/1/26, R1 rested her legs on the bed frame, and did not have a bruise on the calf of her left leg until the following day. The facility identified this most likely was caused from this transfer. On 7/2/26, a left ankle fracture was confirmed by x-ray and MD determined due to R1's history of osteoporosis/decreased bone density, repetitive torsion (repetitive movement) and/or inability to turn foot, could have caused the fracture. Facility policy Vulnerable Adult (VA) Abuse Prohibition Plan, Freedom from Abuse, Neglect, and Exploitation dated 6/15/26, identified a mandated reporter who has reason to believe a VA is being or has been maltreated, or has knowledge that a VA had sustained a physical injury which is not reasonably explained, shall immediately report to his/her immediate supervisor and within two hours to the State Survey Agency and adult protection services where state law provides jurisdiction in long-term care facilities after the allegation is made. The facility's investigation is to be given to the administrator within five days. The person designated to perform the investigation will use the Resident Abuse Investigation Form attached to this policy (form was not attached). Each interview will be conducted separately in a private location. The individual conducting the investigation and other designated individuals will be at minimum: complete abuse form, review medical record to determine events leading up to the incident, interview the persons reporting the incident/witnesses to the incident/resident (as appropriate), and review all events leading up to the alleged incident.		F0610			09/23/2026	
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or		F0656	F656 The facility failed to update and implement the comprehensive care plan, Kardex, and care sheet for one resident reviewed for care plan updates and implementation following return from the hospital with a left ankle fracture, CAM boot orders, and weight-bearing restrictions. The resident's comprehensive care plan, Kardex, and resident care sheet were reviewed and updated to include current transfer status, left lower extremity weight-bearing restriction, CAM boot use when out of bed, removal of the CAM boot while resting in bed as ordered, use of Hoyer lift for transfers, fall-risk precautions, and related safety interventions on 7/6/2026.		09/23/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0656 SS = D	Continued from page 14 maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to update the care plan and implement care planned interventions for 1 of 3 residents (R1) reviewed for care plan updates and implementation. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/16/26, identified moderately impaired cognition without behaviors. R1 had impairment of lower bilateral extremities and used a manual wheelchair for mobility. R1 required partial/moderate assistance with toileting hygiene, personal hygiene, sitting on side of bed to lying flat on bed, substantial/maximal assistance to transfer from chair/bed to chair			F0656	Continued from page 14 The Director of Nursing or designee will review current residents who have returned from a hospital stay, experienced a significant change in condition, received new therapy recommendations, or have new orders for assistive devices, braces, boots, splints, transfer methods, or weight-bearing restrictions within the past 30 days. Any identified resident with incomplete or inconsistent care plan, Kardex, or care sheet information will have the record updated immediately and staff notified of the current interventions. Unit Coordinators, Infection Control Preventionist and the MDS Coordinator were educated on 7/29/2026 on the facility's Care Plans policy dated 3/10/26, including the requirement to review and revise care plans when a resident is readmitted from the hospital, experiences a significant change in condition, or receives new treatment or therapy recommendations. The charge nurse will verify, at the time of readmission or significant change, that care plan interventions match current physician orders, therapy recommendations, discharge instructions, and resident care sheets. Any conflicting weight-bearing orders or unclear instructions will be clarified with the provider and/or therapy department before staff implement the care. The Director of Nursing or designee will audit residents with hospital readmissions, significant changes in condition, new transfer requirements, weight-bearing restrictions, or assistive devices to ensure the care plan, Kardex, and care sheet are accurate and consistent. Audits will be completed weekly for two weeks, then monthly for two additional months. Audit findings will be reviewed by the Quality Assurance and Performance Improvement committee. Identified trends, concerns, or repeated noncompliance will result in additional education, process revision, and follow-up monitoring.		09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0656 SS = D	Continued from page 15 transfer, and walked 15 feet once standing in a corridor or similar space. R1’s diagnoses included anemia (low red blood count), congestive heart failure (CHF), and anxiety. Physician signed orders dated 7/7/26, identified: Circulation, Motor, and Sensation (CMS) two times a day (BID) left lower extremity (LLE), may remove boot when resting otherwise on at all other times, and must be on with all transfers. Review of R1’s care plan dated 7/13/26, identified: Ambulation, Transfers and Bed Mobility Initiated 12/10/24, revised 7/1/26, resolved 7/13/26, R1 required a walking program due to weakness in knees and staff and provided ambulation with front wheeled-walker (FWW), gait belt, and partial/moderate assistance of one staff member. Restorative Nursing Program offered 6-7 times per week. Ambulation with FWW, gait belt, and partial/moderate assistance of one staff member and wheelchair to follow provided for safety. Revised, R1 was dependent with assist of two for all bed mobility tasks. Initiated 7/1/26, resolved 7/13/26, Staff were directed to have provided directional cueing, monitor gait stability, endurance, utilize appropriate footwear, and observe all fall-prevention and safety precautions during ambulation. Revised 7/2/26, check and change at this time, dependent assist of two via hoyer lift (full body mechanical lift) for transfer/medium body sling, and walking on hold ambulated with therapy only. Revised 7/13/26, Walk: unable at this time. Passive range of motion (PROM) to left extremity, feet up on stool two-pound weight over knees and warm blanket for five minutes. Fall Risk Initiated 10/7/24. Ensure R1 wore appropriate footwear, non-skid socks and shoes when nursing assistant (NA) ambulated or mobilized in wheelchair. Revised: 10/23/24. Review information on past falls and attempt to determine cause of falls, record possible root causes, and remove any potential causes is possible.			F0656			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0656 SS = D	Continued from page 16 R1's care plan failed to include use of CAM boot (walking boot) to left ankle/foot following left ankle fracture as well as weight restrinctions. R1's care sheet received on 7/13/26, identified R1 was dependent and required assistance from two staff with hoyer lift with medium body sling, walking and locomotion on hold and only with therapy. Care sheet did not include/identify weight restrictions to left foot/leg and use of CAM boot when out of bed. R1's progress notes dated 7/2/26, through 7/4/26, identified: 7/2/26 at 10:00 a.m., R1 had been having difficulty with transfers and became fearful. Attempted to stand with moderate assist of two staff and became resistant. Due to inconsistency, will be Hoyer (full body mechanical lift) for transfers to/from bed and recliner and assist of two to use grab bar and commode for toileting. 7/2/26 at 11:15 a.m., R1 had bruise to left outer calf and swollen ankle, tender to touch. Staff reported last evening and this morning she had been difficult to transfer. Bruise to calf may have been caused by bed frame during a transfer. Provider gave orders to transfer to local emergency department (ED) for x-ray of left knee and ankle. 7/2/26 at 4:53 p.m., Received update from ED physician, R1 was admitted to hospital with diagnoses of acute renal injury and left ankle fracture non-displaced (bone cracked but remained properly aligned). 7/4/26 at 1:49 p.m., R1 returned to facility at 11:20 a.m., R1 had a CAM boot (walking boot) to left ankle/foot and transferred via hoyer lift. Hospital physical therapy initial evaluation and discharge dated 7/3/26 at 11:56 a.m., identified admitted to hospital on 7/2/26 at 2:09 p.m., with a diagnosis of closed fracture of left ankle, ecchymosis (bruising), acute kidney injury, and dehydration. Precautions: left ankle fracture, toe touch weight bearing (TTWB). No history of fall reported. Cognition: confused, unable to express concerns or rate pain, and cried out with pain and/or fear with movement of left rib/cage/lateral chest and left ankle. Right [sic] foot in ankle immobilizer boot. Functional limitations: bed mobility, sitting balance, fall risk and positioning. Recommendation: hoyer transfer for patient and staff safety, dependent upon staff for all functional			F0656			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0656 SS = D	Continued from page 17 movement. R1’s hospital discharge summary dated 7/4/26, identified she was admitted to hospital with a presumed fall. R1’s cognition impairment unfortunately made it difficult to remember how and when she fell. This was an unwitnessed fall that resulted in a closed fracture of the left medial malleolus, un-displaced with extensive bruising on the left side of her body congruent with the fall. Physical therapy recommended Hoyer lift. Nursing staff communication book dated 7/4/26, identified R1 returned from hospital, had a CAM boot to be worn at all times she is out of bed, can have off when she is in bed. Use hoyer for all transfers. Non-weight bearing at this time. R1’s primary provider medical doctor (MD) visit dated 7/7/26, identified R1 was seen for follow-up from her recent hospitalization for a malleolar fracture of unknown origin. R1 was a poor historian with dementia, and an accurate depiction of events leading up to the fracture could not be obtained. Staff noted bruising and swelling and sent R1 to ED for evaluation. R1 returned to facility with a CAM boot and hospital staff had used a Hoyer lift, avoiding weight bearing activities. Plan: continue CAM boot, use lift with cares, and follow up with podiatry. Physical therapy evaluation dated 7/7/26 at 8:38 p.m., identified R1 had total body weakness, deconditioning, range of motion (ROM) limitations, left ankle pain, and inability to stand, walk, or transfer efficiently due to pain and weight bearing precautions (non-weight (NWB) bearing left lower extremity (LLE)). R1’s precautions included fall risk, cognitive decline and NWB LLE. R1 was currently a hoyer lift due to NWB of the left lower extremity and not strong enough to transfer on just her right lower extremity. Occupational therapy evaluation dated 7/8/26 at 6:45 a.m., identified R1 presented for evaluation with the inability to stand with current NWB to LLE restriction in place following left ankle fracture and hospital stay. R1 had a decline in her ability to perform activities of daily living (ADLs), transfers, and was unable to ambulate. R1 rated her left ankle pain at 7 out of 10 with movement. Interview on 7/14/26 at 11:37 a.m., the occupational therapy assistant (COTA) stated she was responsible for updating the care plan sections: lift recliner, activity, and rehab when R1 returned from the			F0656			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0656 SS = D	Continued from page 18 hospital. The CAM boot was important to have on when up to prevent her ankle from moving, keep it stable and protect it. COTA stated she thought the nurse placed this in the care plan, Kardex, and care sheets, and verified it was not. COTA stated it would have been important so staff knew how to care for R1's ankle, helped promote healing and protected R1's ankle/foot. COTA stated R1's weight bearing restriction was difficult to clarify when she returned to facility. R1's hospital documents indicated three different weight bearing restrictions: toe touch, weight bearing as tolerated and non-weight bearing. Staff were expected transfer R1 with hooyer lift only and no ambulation. "[R1] was evaluated by our therapy department when she returned from the hospital. It was determined [R1] was to be non-weight bearing." COTA stated R1's care plan identified sit to stand: not at this time and hooyer lift: walking on hold. Non-weight bearing should have been added to R1's care plan, Kardex and care sheet so that staff had a better understanding/clarification of R1's abilities and restrictions. Interview on 7/14/26 at 2:09 p.m. NA-B stated she referred to the resident care sheet to identify how to care for the resident. NA-B stated she was unaware R1 was to have a CAM boot on her left ankle, was unsure what that would have been used for, and did not know R1 was non-weight bearing for the left ankle. NA-B state those interventions were listed on the care sheet. Interview on 7/15/26 at 1:25 p.m., unit coordinator/registered nurse (RN)-A stated R1's care plan should have been updated upon re-admission so staff were aware of the CAM boot and non-weight bearing to prevent further injury to R1's ankle. RN-A stated the interventions were not added to care plan, Kardex, or the care sheet. Interview on 7/15/26 at 2:00 a.m., NA-G stated R1 fractured her left ankle. NA-G stated R1 was to have a CAM boot on when up and off when in bed and was non-weight bearing on left leg. NA-G verified this information was not on the care sheet he used to take care of residents. NA-G stated he remembered hearing about the CAM boot and non-weight bearing restrictions in report. Interview on 7/15/26 at 4:27 p.m., the director of nursing (DON) stated when R1 returned from the hospital on 7/4/26, she had a weight restriction on her left foot/leg of toe touch in the hospital and instructions to use CAM boot. Facility therapy assessed R1 to be non-weight bearing and to use a			F0656			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
F0656 SS = D	Continued from page 19 hoyer lift for transfers. DON stated the weight restriction and the CAM boot should have been added to the care plan, Kardex, and care sheet as soon as R1 returned from the hospital so staff would have known how to transfer her, keep her ankle safe, and likely could have affected the healing process of the ankle if weight was placed on it. Facility policy dated 3/10/26, Care Plans identified the facility’s Care Planning/Interdisciplinary Team in coordination with the resident, his/her family, or representative, develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Assessments of residents are ongoing, and care plans are revised as information about the residents’ and condition changes. The team was responsible for the review and updating of care plans: a. when there has been a significant change in the residents’ condition, b. when the resident has been readmitted to the facility from a hospital stay, and c. at least quarterly.			F0656			09/23/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
20000	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: On 7/13/26, through 7/15/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed: H55453156C (3068352) with no licensing order issued.			20000			07/27/2026

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
20000	Continued from page 1 As result of the investigation a licensing order was issued at 0565 related to an incidental finding. 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.			20000			07/27/2026
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the			20565	The facility failed to update and implement the comprehensive care plan, Kardex, and care sheet for one resident reviewed for care plan updates and implementation following return from the hospital with a left ankle fracture, CAM boot orders, and weight-bearing restrictions. The resident's comprehensive care plan, Kardex, and resident care sheet were reviewed and updated to include current transfer status, left lower extremity weight-bearing restriction, CAM boot use when out of bed, removal of the CAM boot while		09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
20565	Continued from page 2 facility failed to update the care plan and implement care planned interventions for 1 of 3 residents (R1) reviewed for care plan updates and implementation. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/16/26, identified moderately impaired cognition without behaviors. R1 had impairment of lower bilateral extremities and used a manual wheelchair for mobility. R1 required partial/moderate assistance with toileting hygiene, personal hygiene, sitting on side of bed to lying flat on bed, substantial/maximal assistance to transfer from chair/bed to chair transfer, and walked 15 feet once standing in a corridor or similar space. R1's diagnoses included anemia (low red blood count), congestive heart failure (CHF), and anxiety. Physician signed orders dated 7/7/26, identified: Circulation, Motor, and Sensation (CMS) two times a day (BID) left lower extremity (LLE), may remove boot when resting otherwise on at all other times, and must be on with all transfers. Review of R1's care plan dated 7/13/26, identified: Ambulation, Transfers and Bed Mobility Initiated 12/10/24, revised 7/1/26, resolved 7/13/26, R1 required a walking program due to weakness in knees and staff and provided ambulation with front wheeled-walker (FWW), gait belt, and partial/moderate assistance of one staff member. Restorative Nursing Program offered 6-7 times per week. Ambulation with FWW, gait belt, and partial/moderate assistance of one staff member and wheelchair to follow provided for safety. Revised, R1 was dependent with assist of two for all bed mobility tasks. Initiated 7/1/26, resolved 7/13/26, Staff were directed to have provided directional cueing, monitor gait stability, endurance, utilize appropriate footwear, and observe all fall-prevention and safety precautions during ambulation. Revised 7/2/26, check and change at this time, dependent assist of two via hoyer lift (full body mechanical lift) for transfer/medium body sling, and walking on hold ambulated with therapy only. Revised 7/13/26, Walk: unable at this time. Passive range of motion (PROM) to left extremity, feet up on stool two-pound weight over knees and warm			20565	Continued from page 2 resting in bed as ordered, use of Hoyer lift for transfers, fall-risk precautions, and related safety interventions on 7/6/2026. The Director of Nursing or designee will review current residents who have returned from a hospital stay, experienced a significant change in condition, received new therapy recommendations, or have new orders for assistive devices, braces, boots, splints, transfer methods, or weight-bearing restrictions within the past 30 days. Any identified resident with incomplete or inconsistent care plan, Kardex, or care sheet information will have the record updated immediately and staff notified of the current interventions. Unit Coordinators, Infection Control Preventionist and the MDS Coordinator were educated on 7/29/2026 on the facility's Care Plans policy dated 3/10/26, including the requirement to review and revise care plans when a resident is readmitted from the hospital, experiences a significant change in condition, or receives new treatment or therapy recommendations. The charge nurse will verify, at the time of readmission or significant change, that care plan interventions match current physician orders, therapy recommendations, discharge instructions, and resident care sheets. Any conflicting weight-bearing orders or unclear instructions will be clarified with the provider and/or therapy department before staff implement the care. The Director of Nursing or designee will audit residents with hospital readmissions, significant changes in condition, new transfer requirements, weight-bearing restrictions, or assistive devices to ensure the care plan, Kardex, and care sheet are accurate and consistent. Audits will be completed weekly for two weeks, then monthly for two additional months. Audit findings will be reviewed by the Quality Assurance and Performance Improvement committee. Identified trends, concerns, or repeated noncompliance will result in additional education, process revision, and follow-up monitoring.		09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
20565	Continued from page 3 blanket for five minutes. Fall Risk Initiated 10/7/24. Ensure R1 wore appropriate footwear, non-skid socks and shoes when nursing assistant (NA) ambulated or mobilized in wheelchair. Revised: 10/23/24. Review information on past falls and attempt to determine cause of falls, record possible root causes, and remove any potential causes is possible. R1's care plan failed to include use of CAM boot (walking boot) to left ankle/foot following left ankle fracture as well as weight restrinctions. R1's care sheet received on 7/13/26, identified R1 was dependent and required assistance from two staff with hoyer lift with medium body sling, walking and locomotion on hold and only with therapy. Care sheet did not include/identify weight restrictions to left foot/leg and use of CAM boot when out of bed. R1's progress notes dated 7/2/26, through 7/4/26, identified: 7/2/26 at 10:00 a.m., R1 had been having difficulty with transfers and became fearful. Attempted to stand with moderate assist of two staff and became resistant. Due to inconsistency, will be Hoyer (full body mechanical lift) for transfers to/from bed and recliner and assist of two to use grab bar and commode for toileting. 7/2/26 at 11:15 a.m., R1 had bruise to left outer calf and swollen ankle, tender to touch. Staff reported last evening and this morning she had been difficult to transfer. Bruise to calf may have been caused by bed frame during a transfer. Provider gave orders to transfer to local emergency department (ED) for x-ray of left knee and ankle. 7/2/26 at 4:53 p.m., Received update from ED physician, R1 was admitted to hospital with diagnoses of acute renal injury and left ankle fracture non-displaced (bone cracked but remained properly aligned). 7/4/26 at 1:49 p.m., R1 returned to facility at 11:20 a.m., R1 had a CAM boot (walking boot) to left ankle/foot and transferred via hoyer lift. Hospital physical therapy initial evaluation and			20565			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
20565	Continued from page 4 discharge dated 7/3/26 at 11:56 a.m., identified admitted to hospital on 7/2/26 at 2:09 p.m., with a diagnosis of closed fracture of left ankle, ecchymosis (bruising), acute kidney injury, and dehydration. Precautions: left ankle fracture, toe touch weight bearing (TTWB). No history of fall reported. Cognition: confused, unable to express concerns or rate pain, and cried out with pain and/or fear with movement of left rib/cage/lateral chest and left ankle. Right [sic] foot in ankle immobilizer boot. Functional limitations: bed mobility, sitting balance, fall risk and positioning. Recommendation: hoyer transfer for patient and staff safety, dependent upon staff for all functional movement. R1's hospital discharge summary dated 7/4/26, identified she was admitted to hospital with a presumed fall. R1's cognition impairment unfortunately made it difficult to remember how and when she fell. This was an unwitnessed fall that resulted in a closed fracture of the left medial malleolus, un-displaced with extensive bruising on the left side of her body congruent with the fall. Physical therapy recommended Hoyer lift. Nursing staff communication book dated 7/4/26, identified R1 returned from hospital, had a CAM boot to be worn at all times she is out of bed, can have off when she is in bed. Use hoyer for all transfers. Non-weight bearing at this time. R1's primary provider medical doctor (MD) visit dated 7/7/26, identified R1 was seen for follow-up from her recent hospitalization for a malleolar fracture of unknown origin. R1 was a poor historian with dementia, and an accurate depiction of events leading up to the fracture could not be obtained. Staff noted bruising and swelling and sent R1 to ED for evaluation. R1 returned to facility with a CAM boot and hospital staff had used a Hoyer lift, avoiding weight bearing activities. Plan: continue CAM boot, use lift with cares, and follow up with podiatry. Physical therapy evaluation dated 7/7/26 at 8:38 p.m., identified R1 had total body weakness, deconditioning, range of motion (ROM) limitations, left ankle pain, and inability to stand, walk, or transfer efficiently due to pain and weight bearing precautions (non-weight (NWB) bearing left lower extremity (LLE)). R1's precautions included fall risk, cognitive decline and NWB LLE. R1 was currently a hoyer lift due to NWB of the left lower extremity and not strong enough to transfer on just her right lower extremity.			20565			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
20565	Continued from page 5 Occupational therapy evaluation dated 7/8/26 at 6:45 a.m., identified R1 presented for evaluation with the inability to stand with current NWB to LLE restriction in place following left ankle fracture and hospital stay. R1 had a decline in her ability to perform activities of daily living (ADLs), transfers, and was unable to ambulate. R1 rated her left ankle pain at 7 out of 10 with movement. Interview on 7/14/26 at 11:37 a.m., the occupational therapy assistant (COTA) stated she was responsible for updating the care plan sections: lift recliner, activity, and rehab when R1 returned from the hospital. The CAM boot was important to have on when up to prevent her ankle from moving, keep it stable and protect it. COTA stated she thought the nurse placed this in the care plan, Kardex, and care sheets, and verified it was not. COTA stated it would have been important so staff knew how to care for R1's ankle, helped promote healing and protected R1's ankle/foot. COTA stated R1's weight bearing restriction was difficult to clarify when she returned to facility. R1's hospital documents indicated three different weight bearing restrictions: toe touch, weight bearing as tolerated and non-weight bearing. Staff were expected transfer R1 with hooyer lift only and no ambulation. "[R1] was evaluated by our therapy department when she returned from the hospital. It was determined [R1] was to be non-weight bearing." COTA stated R1's care plan identified sit to stand: not at this time and hooyer lift: walking on hold. Non-weight bearing should have been added to R1's care plan, Kardex and care sheet so that staff had a better understanding/clarification of R1's abilities and restrictions. Interview on 7/14/26 at 2:09 p.m. NA-B stated she referred to the resident care sheet to identify how to care for the resident. NA-B stated she was unaware R1 was to have a CAM boot on her left ankle, was unsure what that would have been used for, and did not know R1 was non-weight bearing for the left ankle. NA-B state those interventions were listed on the care sheet. Interview on 7/15/26 at 1:25 p.m., unit coordinator/registered nurse (RN)-A stated R1's care plan should have been updated upon re-admission so staff were aware of the CAM boot and non-weight bearing to prevent further injury to R1's ankle. RN-A stated the interventions were not added to care plan, Kardex, or the care sheet. Interview on 7/15/26 at 2:00 a.m., NA-G stated R1			20565			09/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/15/2026	
NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST , FERTILE, Minnesota, 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
20565	Continued from page 6 fractured her left ankle. NA-G stated R1 was to have a CAM boot on when up and off when in bed and was non-weight bearing on left leg. NA-G verified this information was not on the care sheet he used to take care of residents. NA-G stated he remembered hearing about the CAM boot and non-weight bearing restrictions in report. Interview on 7/15/26 at 4:27 p.m., the director of nursing (DON) stated when R1 returned from the hospital on 7/4/26, she had a weight restriction on her left foot/leg of toe touch in the hospital and instructions to use CAM boot. Facility therapy assessed R1 to be non-weight bearing and to use a hoyer lift for transfers. DON stated the weight restriction and the CAM boot should have been added to the care plan, Kardex, and care sheet as soon as R1 returned from the hospital so staff would have known how to transfer her, keep her ankle safe, and likely could have affected the healing process of the ankle if weight was placed on it. Facility policy dated 3/10/26, Care Plans identified the facility’s Care Planning/Interdisciplinary Team in coordination with the resident, his/her family, or representative, develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Assessments of residents are ongoing, and care plans are revised as information about the residents’ and condition changes. The team was responsible for the review and updating of care plans: a. when there has been a significant change in the residents' condition, b. when the resident has been readmitted to the facility from a hospital stay, and c. at least quarterly. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review and/or revise policies and procedures to ensure care plans are updated, and implemented for residents who have weight bearing limits, require increased assistance and application of a walking boot to help protect a fracture and allow healing prevent. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.			20565			09/23/2026