



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 23, 2024

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

RE: CCN: 245545
Cycle Start Date: October 21, 2024

Dear Administrator:

On October 21, 2024, 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

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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:

Annette Winters, Regional Supervisor, Federal Rapid Response

Health Regulation Division

Minnesota Department of Health

625 Robert Street N

P.O. Box 64975

Saint Paul, Minnesota 55164-0975

Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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 January 21, 2025 (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 April 21, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 11/18/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2024
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NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>On 10/18/24 and 10/21/24, 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.</p> <p>The following complaints were reviewed H55459526C (MN107517) H55459523C (MN107481) As a result of the investigation a deficiency cited at F610.</p> <p>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.</p> <p>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.</p>	F 000		
F 610 SS=D	<p>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p>	F 610		10/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/30/2024

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

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F 610	<p>Continued From page 1</p> <p>§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:</p> <p>Based on interview and document review the facility failed to thoroughly investigate an allegation of neglect of care for 1 of 3 residents (R1) reviewed for safety during staff assisted transfers with a mechanical stand device.</p> <p>Findings include:</p> <p>R1's Admission Record identified an admission date of 1/17/22. Diagnosis included multiple fractures of pelvis, osteoarthritis in left hip and disorder of bone density.</p> <p>R1's significant change Minimum Data Set (MDS) dated 8/23/24 identified intact cognition. The MDS indicated R1 had lower extremity impairment on both sides and was dependent on staff for transfers.</p> <p>Facility incident report dated 10/5/24, indicated staff nurse responded to a call and found R 1 on the bathroom floor with legs stretched forward and her back leaning against staff member's leg. When asked the nursing assistant (NA) stated she had been transferring R1 to the toilet when R1 slipped out of the harness strap and sat on the floor. NA- also stated R1 hit her head during the fall. R1 verbalized having pain in her head. R1 was unable to describe the details of the incident.</p>	F 610	<p>To ensure safe resident(s) mechanical lift transfers the facility's Transfer Policy was updated to include filing a VA report if a fall occurs when using the Hoyer or Stand-Up Lift, whether the fall results in an injury or not.</p> <p>Nursing staff were educated on the updated Transfer Policy to include the facility will file a report when there is a fall using the Hoyer or Stand-Up mechanical lift, whether the fall results in an injury or not.</p> <p>Nursing staff were re-educated on ensuring the correct lift and sling is used, and the harness sling and leg straps are in place and securely latched before initiating the transfer.</p> <p>Nursing staff were educated on the appropriate steps to initiate following a fall; cna to report the fall to the nurse, nurse to observe the resident for injury, initiate neuro checks and vital signs, if appropriate inform the physician following the resident's assessment, then arrange transfer to ER/Hospital for medical assessment if ordered, inform Director of</p>	

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F 610	<p>Continued From page 2</p> <p>R1's hospital history and physical notes dated 10/07/24, indicated she presented to the emergency department on 10/7/24 after a fall the previous day at the facility. The notes indicated R1 had landed on her left hip and hit her head on the toilet, was having difficult bearing weight and was more confused than usual. CT of left hip confirmed a non-displaced fracture of the acetabulum (the socket part of the hip joint).</p> <p>R1's care plan updated 10/18/24, identified acute and chronic pain arthritis and fall with pelvic fracture. The care plan indicated she required assist of one staff for transfer via mechanical stand device prior to fall with fracture.</p> <p>During interview on 11/18/24 at 11:54 a.m., R1 stated she remerged falling and said, "I just went whoosh." R1 stated she fell in her room and staff helped her get up. R1 stated had not fallen out of a machine and said, "could be I hit my head, I don't know."</p> <p>During interview on 11/18/24 at 1:07 p.m., NA-A stated she had put R1 in the mechanical stand and strapped the harness tight. NA-A stated when they got inside the bathroom R1 said she could not hold on anymore and let go of the machine and slipped through the harness. NA-A further stated she had used the medium sized sling and had used the leg straps. NA-A said after the incident occurred, staff received training on reporting a fall from a mechanical device.</p> <p>During interview on 10/18/24 at 1:56 p.m., the director of nursing (DON) stated she was not in the facility when R1 fell from the mechanical stand and said she had received a phone call</p>	F 610	<p>Nursing and family, nurse to inspect the sling and lift for malfunction. If the lift malfunctioned the nurse will remove the lift from service and inform maintenance. The maintenance director will inform the lift manufacturer of the lift malfunction.</p> <p>Nursing & Social Service will initiate the internal investigation checklist, conduct the internal investigation interviews with staff and resident, and filing the VA report as appropriate.</p> <p>Nursing staff were educated on following the resident's updated care plan and care card per therapy screening that resident is a 2-person full body sling Hoyer lift.</p> <p>Nurses were educated on the importance of timeliness of reporting an incident/injury to the Director of Nursing, Social Service Designee, Administrator and the VA reporting timelines.</p> <p>Therapy reviewed and updated all residents requiring transfers for appropriate lift and sling use.</p> <p>Maintenance checked all mechanical lifts for safety and routinely completes weekly maintenance checks on all mechanical lifts and maintains documentations of the checks.</p> <p>Therapy checked all full body Hoyer and Stand-Up slings for safety and or replacement. Therapy audit of slings found the need to replace a plastic locking male +female clasp and a Sara silicone</p>	

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F 610	<p>Continued From page 3</p> <p>several hours after the incident. The DON stated she had not looked at the harness following the incident to determine if the size was correct or if the harness was in good condition and said she hoped licensed practical nurse (LPN)-A had looked at them. The DON said the lift had not been inspected after the fall. The DON stated she only knew what was told to her and said she had been told R1 was just about to the toilet, and she raised her arms and slipped out of the sling.</p> <p>During interview on 10/1/24 at 2:00 p.m., physical therapist (PT)-A was asked what could cause a fall from a mechanical stand device. PT-A stated, "I suppose they could fall" if a resident's knees were not secure against the barrier, referring to the plate and the base of the machine that the knees of the resident rest against, or if the harness was not securely attached to the torso. PT-A stated if everything were hooked properly it would be almost impossible to fall out the mechanical stand.</p> <p>During interview on 10/18/24 at 2:15 p.m., LPN-A stated when he entered the room after R1 fell, she was seated on the floor and was propped up against NA-A's leg. LPN-A stated he asked R1 if she hit her head and she stated she had. LPN-A stated the lift was in the bathroom by the door. LPN-A said he had not inspected the lift or the harness.</p> <p>Facility policy Reporting of Mistreatment of Vulnerable Adults dated 8/20/24, indicated the social services designee will initiate the internal investigation checklist and conduct an internal investigation which will include staff and resident interviews.</p>	F 610	leg strap, both items were ordered from Arjo, total cost \$104.25.	



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Electronically delivered

October 23, 2024

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

Re: Event ID: M3ST11

Dear Administrator:

The above facility survey was completed on October 21, 2024 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00460	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2024
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NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 10/18/24 and 10/21/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H55459526C (MN107517)</p>	2 000		
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

10/30/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00460	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/21/2024
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NAME OF PROVIDER OR SUPPLIER FAIR MEADOW NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540
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2 000	Continued From page 1 H55459523C (MN107481) NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		