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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K93D

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245545**
2.STATE VENDOR OR MEDICAID NO.
(L2) **804740500**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/22/2021** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, Unit Supervisor 09/02/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/15/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/15/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 28, 2021

CMS Certification Number (CCN): 245545

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 22, 2021 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 28, 2021

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

RE: CCN: 245545
Cycle Start Date: July 16, 2021

Dear Administrator:

On August 26, 2021, we notified you a remedy was imposed. On September 22, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 22, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 16, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 26, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 16, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 22, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: K93D

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00460

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

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(L3) **FAIR MEADOW NURSING HOME**
(L4) **300 GARFIELD AVENUE SOUTHEAST**
(L5) **FERTILE, MN** (L6) **56540**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/05/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Costello, HFE - NE II 09/02/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/15/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

August 26, 2021

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

RE: CCN: 245545
Cycle Start Date: July 16, 2021

Dear Administrator:

On July 26, 2021, we informed you that we may impose enforcement remedies.

On August 5, 2021, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) , as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 16, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 16, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 16, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 16, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Fair Meadow Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 16, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 16, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/2/21 through 8/5/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/2/21 through 8/5/21, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer	F 554		8/31/21

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

Electronically Signed | 08/30/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 1 medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety with self administration of medication for 1 of 1 residents (R30) who's medication was left to be administered by family. Findings include: R30's quarterly Minimum Data Set (MDS) dated 7/14/21, indicated R30 had severe cognitive impairment. Diagnoses included dementia, hypertension, edema, and dizziness. R30's care plan dated 7/21/21, indicated R30 had impaired cognitive function related to dementia and directed staff to administer medications as ordered for various diagnoses and to administer pain medications one half hour before treatments or care. R30's Order Summary Report dated 7/5/21, identified the following medication orders: Airborne multi-vitamin one tablet twice a day (BID) as needed (PRN) for allergies, amlodipine 10 milligrams (mg) in the morning, bisacodyl 5 mg every 24 hours as needed, cranberry-vitamin C 1500-100 mg one capsule in the morning, cyanocobalamin 1000 microgram (mcg) one tablet in the morning, gingko biloba 60 mg in the morning, ibuprofen 200 mg daily PRN for pain, furosemide 20 mg daily, Lyrica 75 mg in the evening, meclizine 12.5 mg in the evening, meclizine 25 mg two tablets in the morning, milk of magnesia 15 millimeters daily PRN,	F 554	R30 does not choose to self administer meds and it is not clinically appropriate for R30 to do so. The policy for self administration of meds was reviewed by DON. On 8/23/21 education was provided to all employees that work the med cart regarding the 8 rights of medication pass. The med pass policy was reviewed with nursing staff. Staff were instructed that R30□s daughter is not authorized to pass her mother□s meds. DON met with daughter and educated her on facility policy regarding med pass. Daughter was instructed and reminded that she is not authorized to give her mother meds. An audit was performed on all residents to assure assessment and physician orders for self administration are in place if clinically appropriate. Random audits will be completed on all shifts 2x/wk for 4 weeks, and 1x/wk for 2 weeks. QAA Committee updated on deficiency on 8/31/2021 and will monitor compliance with audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/05/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 2	F 554		

omeprazole 20 mg daily PRN, Osteo Bi-Flex one tablet BID, sennosides-docusate 8.6-50 mg BID, Tums 500 mg two tablets at bedtime, Tums 500 mg two tablets every 4 hours PRN, Tylenol 500 mg two tablets three times a day.

On 8/5/21, at 8:08 a.m. licensed practical nurse (LPN)-A was observed passing morning medications to residents. LPN-A took R30's medications cards and bottles from the medication cart and put the following medications into a medication cup: amlodipine 10 mg one tablet, cranberry-vitamin C 1500-100 mg one capsule, gingko biloba 60 mg one capsule, furosemide 20 mg 1 tablet, meclizine 12.5 mg two tablets, Bio-Flex one capsule and vitamin B12 1000 mg one cap.

- R30 was asleep upon LPN-A entering R30's room. LPN-A stated staff take the medications in to the resident's room and give them to the residents family member (FM)-A and FM-A administers the medications after the resident gets up for the day. FM-A was seated at a card table setup for puzzles in the room. LPN-A handed FM-A the medication cup with seven different medications and stated here are R30's medications. LPN-A exited R30's room to continue on with her medication pass. FM-A stated she always administered R30's medications in the morning after she had gotten up for the day, as she liked to take her time taking them.

R30's Self Administration of Medication form dated 8/13/18, indicated R30 did not choose to self administer her medications, nor did it include an assessment for FM-A's ability to administer R30's medications.

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	245545	A. BUILDING _____ B. WING _____	08/05/2021

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F 554	Continued From page 3 R30's Medication Administration Record (MAR) dated August 2021, identified each medication and what time it was to be administered. The facility nurses identified each medication as administered by inserting a check mark and their initials on the appropriate date of administration. LPN-A initialed she had administered the medications ordered on the morning of 8/5/21, at 8:00 a.m. The MAR did not identify R30 as self administering her medications or FM-A as administering the medications. Nor did the MAR identify at what time the medications were actually administered. When interviewed on 8/5/21, at 3:54 p.m. the director of nursing (DON) stated the nurse should not have left R30's medications with FM-A for FM-A to administer. he DON indicated this would be a problem as the nurse would not know if all the medications were administered and at what time they were administered. The facility policy Medication Administration, Medication Hold Parameters dated 7/19/21, directed staff to place medications into med cup, following the eight rights of medication pass. Identify resident prior to administration, offer appropriate amount of water, and stay with the resident until all medications are swallowed or taken correctly. A policy for self administration of medications was requested; however, was not received.	F 554		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F 636		8/31/21

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F 636	Continued From page 4	F 636		

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff

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F 636	Continued From page 5 members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a complete and comprehensive Minimum Data Set (MDS) assessment was completed at least annually for 1 of 13 residents (R135) reviewed in the final sample selection. Findings include: The Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual dated 10/1/20, identified the MDS as an assessment tool which facilities are required to use. The manual indicated the omnibus budget reconciliation act (OBRA) Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified	F 636	An annual MDS was initiated for R135 immediately and an ARD set for 8/09/21. MDS was submitted and accepted on 8/18/2021. MDS Coordinator collaborated with Point Click Care to place R135 back on the MDS scheduler with the PCC system. DON and MDS Coordinator reviewed policy regarding completion of individual comprehensive assessments. RN□s were educated on comprehensive assessments and timing. A 2 point check system was implemented and involves comparing a list of current residents and the list of last completed MDS and dates to the new upcoming MDS schedule with dates for annuals and quarterlies. Residents and dates are double checked to ensure nobody gets missed. On 8/31/21 the QAA Committee	

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F 636	Continued From page 6 nursing homes. Comprehensive MDS assessments must be completed on admission and annually and quarterly assessments, which are not comprehensive assessments, are to be used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators for the gradual onset of significant changes in resident status. R30's annual MDS dated 4/15/20, indicated R30 had several diagnoses which included heart failure, hypertension, arthritis, chronic obstructive pulmonary disease, anxiety and depression. R30 required extensive assistance with dressing, grooming, transfers and toileting. R30 was frequently incontinent of bladder and did not ambulate. R30's quarterly MDS dated 12/16/20, indicated R30 had several diagnoses which included heart failure, hypertension, arthritis, chronic obstructive pulmonary disease, anxiety and depression. R30 required extensive assistance with dressing, grooming, transfers and toileting. R30 was frequently incontinent of bladder and did not ambulate. The record lacked a required comprehensive assessment for March 2021. On 8/4/21, at 2:47 p.m. registered nurse (RN)-A stated the facility's MDS consultant RN-C and RN-B were responsible for filling out the MDS schedule. RN-A stated she was only able to find the quarterly MDS assessment that was done in December. The care section in R30's record indicated an assessment was due to be done in March 2021, but the record did not have a care plan or MDS after December 2020.	F 636	was made aware of the deficiency and will perform random audits to ensure compliance. Audits will be completed 2x/wk for 4 weeks, and 1x/wk for 2 weeks. (Even though the form 2567 repeatedly mentions R30, we are doing the plan of correction for R135.) QAA to decide if audits are to continue, increase or be discontinued.	

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F 636	Continued From page 7	F 636		

During telephone interview on 8/4/21, at 2:55 p.m. the MDS consultant RN-C stated she could not understand why R30 did not have a current MDS. R30 may have gotten removed from the MDS scheduler program on their computer system. RN-C stated the facility completed the MDS assessments on every resident in their facility and she did not know why or how R30 had gotten missed. R30 should have had an annual comprehensive MDS assessment done in March 2021.

On 8/5/21, at 2:16 p.m. the director of nursing (DON) stated they were not able to find an MDS for R30 after 12/16/20. R30's assessments had gotten missed for some reason. The facility setup R30 for an observation period in order to complete a comprehensive assessment as soon as possible.

The facility's policy Resident Assessment Instrument dated 5/15/20, indicated MDS schedules were defined by the RAI manual. There were specific schedules for opening the MDS, setting the assessment reference date and completion of the MDS according to the type of assessment. The MDS coordinator would determine the MDS schedule identifying all pertinent dates. The schedule would be routed to all interdisciplinary team members.

The facility's policy Patient Driven Payment Model (PDPM) Policy Procedure dated 5/15/20, indicated the facility would complete a comprehensive assessment of the resident's needs using the most recently updated RAI manual for the state. The facility would conduct a comprehensive assessment within fourteen days

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F 636	Continued From page 8 after admission, a significant change or not less than once every twelve months or within 366 days after the assessment reference date of the most recent comprehensive resident assessment.	F 636		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure required quarterly Minimum Data Set (MDS) assessment was completed for 1 of 13 residents (R135) reviewed in the final sample selection. Findings include: The Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual dated 10/1/20, identified the MDS as an assessment tool which facilities are required to use. The manual indicated the omnibus budget reconciliation act (OBRA) Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. Comprehensive MDS assessments must be completed on admission and annually and quarterly assessments, which are not comprehensive assessments, are to be used to track the resident's status between comprehensive assessments and to ensure	F 638	A comprehensive assessment was completed immediately for R135. MDS Coordinator collaborated with Point Click Care to place R135 back on the MDS scheduler with the PCC system. DON and MDS Coordinator reviewed policy regarding revision and accuracy of the quarterly assessment process. RN□s were educated on quarterly assessments and timing. A 2 point check system was implemented and involves comparing a list of current residents and the list of last completed MDS and dates to the new upcoming MDS schedule with dates for annuals and quarterlies. Residents and dates are double checked to ensure nobody gets missed. On 8/31/21 the QAA Committee was made aware of the deficiency and will perform random audits to ensure compliance. Audits will be completed 2x/wk for 4 weeks, and 1x/wk for 2 weeks. (Even though the form 2567 repeatedly mentions R30, we are doing the plan of correction for R135.) QAA to	8/31/21

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F 638	Continued From page 9 monitoring of critical indicators for the gradual onset of significant changes in resident status. R30's annual MDS dated 4/15/20, indicated R30 had several diagnoses which included heart failure, hypertension, arthritis, chronic obstructive pulmonary disease, anxiety and depression. R30 required extensive assistance with dressing, grooming, transfers and toileting. R30 was frequently incontinent of bladder and did not ambulate. R30's quarterly MDS dated 12/16/20, indicated R30 had several diagnoses which included heart failure, hypertension, arthritis, chronic obstructive pulmonary disease, anxiety and depression. R30 required extensive assistance with dressing, grooming, transfers and toileting. R30 was frequently incontinent of bladder and did not ambulate. The medical record lacked any further MDS assessments as required. The record lacked a required annual comprehensive MDS assessment in March 2021 and then the subsequent quarterly MDS assessment due in June 2021. On 8/4/21, at 2:47 p.m. registered nurse (RN)-A stated the facility's MDS consultant RN-C and RN-B were responsible for filling out the MDS schedule. RN-A was only able to find the quarterly MDS assessment that was done in December. The care section in R30's record indicated an assessment was due to be done in March 2021, but the record did not have a MDS completed after December 2020. During telephone interview on 8/4/21, at 2:55 p.m.	F 638	decide if audits are to continue, increase or be discontinued.	

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F 638	Continued From page 10	F 638		

the MDS consultant, RN-C stated she could not understand why R30 did not have a current MDS. R30 may have gotten removed from the MDS scheduler program on their computer system. The facility completed MDS assessments on every resident in their facility and she did not know why or how R30 had gotten missed. R30 should have had an annual comprehensive MDS done in March 2021 as well as a quarterly MDS in June 2021. RN-C verified the MDS's were not done.

On 8/5/21, at 2:16 p.m. the director of nursing (DON) stated they were not able to find an MDS for R30 after the one completed on 12/16/20. R30's assessments were missed for some reason. The facility setup R30 for an observation period in order to complete a comprehensive assessment as soon as possible.

The facility's policy Patient Driven Payment Model (PDPM) Policy Procedure dated 5/15/20, indicated the facility would complete a quarterly review of each resident would be conducted at least every three months or within 92 days unless a significant change assessment had been completed in that time.

The facility's policy Resident Assessment Instrument dated 5/15/20, indicated MDS schedules were defined by the RAI manual. There were specific schedules for opening the MDS, setting the assessment reference date and completion of the MDS according to the type of assessment. The MDS coordinator would determine the MDS schedule identifying all pertinent dates. The schedule would be routed to all interdisciplinary team members.

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F 686	Continued From page 11	F 686		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 1 resident (R7) reviewed who were at risk for pressure ulcers. Findings include: R7's quarterly Minimum Data Set (MDS) dated 5/19/21, indicated he had intact cognition and required extensive assistance with bed mobility, dressing, toileting and total assistance with transfers. R7 was at risk for developing pressure ulcers and had a pressure relieving device on his bed and in his chair. The MDS did not identify a current pressure ulcer and did not identify if R7 was on a turning and repositioning schedule. R7's care plan dated 5/26/21, identified a potential risk for impairment in skin integrity related to his cerebrovascular accident and left	F 686	R7□s care sheet indicates he is to be turned and repositioned every two hours. The care plan was updated to reflect this, as he is at risk for skin breakdown. R7 does not have a current pressure ulcer but continues at risk for developing one. In order to protect all residents in similar situations, the DON and skin nurse reviewed all resident□s charts to assure they are receiving the necessary treatment for prevention and to promote healing of pressure ulcers. Care plans were updated as necessary to include repositioning at appropriate intervals for each resident as appropriate. Education is scheduled for 9/21/21 for nursing staff on the timeliness of repositioning, what constitutes a change in position, and the reasons residents are placed on a turning and repositioning	9/21/21

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F 686	Continued From page 12 hemiparesis, as well as acute and chronic pain related to cervical disc degeneration. Staff were directed to turn and reposition R7 every two hours and it helped alleviate his pain. On 8/4/21, from 7:00 a.m. through 9:50 a.m. R7 was continuously observed and the following observation and interviews were obtained: -At 7:00 a.m. R7 was lying in his bed on his back. R7 was awake and stated he was not up yet for his breakfast. R7 stated he had been laying on his back for at least three hours and his lower back was really hurting due to laying in the same position for so long. -At 8:43 a.m. R7's position had remained unchanged. He had started to call out softly for help. He did not use his call light. -At 8:52 a.m. R7's position remained unchanged. He continued to call out softly for staff. -At 8:55 a.m. nursing assistant (NA)-C entered R7's room in response to his call light. NA-C informed R7 she would get him his breakfast. R7 requested to go to the dining room for breakfast. NA-C notified R7 he was assist of two to transfer and she would have to get some help. R7 responded he needed to be moved, as he had been lying on his back for at least three hours. NA-C asked R7 if he would mind waiting five minutes and she would come back with help and assist him. R7 stated he guessed he would have to. R7's position remained unchanged. - At 9:11 a.m. R7's position remained unchanged. R7 stated it was going to feel so good to get moved.	F 686	schedule. Charge nurse on each shift is responsible to check the repositioning schedules to ensure they have been followed. DON or designee to conduct random audits to ensure appropriate care is being delivered to reduce the risk for pressure ulcer development. Audits will be completed 2x/wk for 4 weeks, and 1x/wk for 2 weeks. QAA Committee updated on deficiency on 8/31/2021 and will monitor compliance with audits.	

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F 686	Continued From page 13	F 686		

- At 9:18 a.m. R7's position remained unchanged. His call light remained on and no staff had entered his room.

- At 9:23 a.m. NA-B entered R7's room with R7's breakfast tray. NA-B raised the head of the bed, placed a clothing protector on R7's chest and placed his breakfast tray in front of him. R7 requested to wash his hands in the sink. NA-B stated she would bring him a washcloth. R7 remained on his back with the head of the bed elevated as he ate his breakfast.

- At 9:36 a.m. an unidentified nurse entered R7's room and administered his medications. R7 continued to eat his breakfast, his position was unchanged.

- At 9:48 a.m. NA-B entered R7's room to remove his breakfast tray. R7 stated I have been in this position for to long. NA-B lowered the head of the bed to a flat position. She stated she thought R7 was on a every three hour turning and repositioning program. R7 commented to NA-B that he had been on his back for over three hours. NA-B informed R7 that the head of his bed had been elevated which was considered repositioning. R7 replied he had been on his back the entire time though. On request from surveyor, NA-B assisted R7 to turn on his left side and placed a pillow under his right hip.

During interview on 8/4/21, at 11:45 a.m. NA-C stated she needed to help another resident and was unable to go back to R7 but she had told someone that he had requested to get up for breakfast. She was not sure of the name of the person she had told. R7 had told NA-C he had

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F 686	Continued From page 14	F 686		

not been moved all morning but she was unable to assist him because he was a two person assist. After review of R7's care sheet , NA-C stated R7 was last repositioned at 7:00 a.m. She had not assisted with the repositioning at that time and thought maybe NA-B had done so..

When interviewed on 8/4/21, at 11:53 a.m. NA-B stated she shifted R7 ' s weight by pulling on his draw sheet around 7:00 a.m.; however, he remained positioned on his back. NA-B did not get his weight off of his back but if he had wanted to be turned, she would have done so.

On 8/5/21, at 9:45 a.m. NA-A indicated repositioning residents meant to off load their weight if they were sitting or to turn them to a side lying position if a resident were lying on their back in bed. NA-A stated R7 needed assistance to turn and reposition and was on a two hour repositioning schedule.

During interview on 8/5/21, at 9:48 a.m. registered nurse (RN)-A stated turn and reposition meant to turn side to side when in bed. Shifting a residents weight in bed or raising the head of the bed did not represent turning and repositioning.

When interviewed on 8/5/21, at 2:22 p.m. the director of nursing (DON) stated shifting a resident's weight or raising the head of the bed was not considered turning or repositioning. It was unfortunate R7 did not get turned and repositioned off of his back on 8/4/21. Staff should be going in to resident rooms and doing a full repositioning and off loading as directed by the resident's care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	08/05/2021

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

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F 686	Continued From page 15 The facility's policy Repositioning/Turning, dated 4/3/20, indicated repositioning was critical for a resident who was immobile or dependent on staff for repositioning. The policy detailed the steps needed to reposition a resident when in bed. Steps included to check the residents care plan to determine resident specific positioning needs, use two people if applicable, and place the resident in a comfortable position in accordance with the resident's individualized care plan.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a therapy recommended restorative program was completed as ordered for 1 of 1 residents (R7) reviewed for range of motion.	F 688	R7□s rehab program was reviewed. Due to resident request to stay in bed more frequently, R7□s program was updated to include bed exercises on days he doesn□t want to go out for rehab therapy.	8/31/21

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	245545	A. BUILDING _____ B. WING _____	08/05/2021

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F 688	Continued From page 16 Findings include: R7's quarterly Minimum Data Set (MDS) dated 5/19/21, indicated R7 had intact cognition with no behaviors of resisting or refusing care. R7 required extensive assistance with dressing, grooming, toileting and bathing. R7 was unable to ambulate and range of motion was impaired on one side. Diagnosis included hemiplegia (paralysis on one side) following cerebral infarction (an area of necrotic tissue in the brain) affecting left non-dominant side R7's activites of daily living (ADL) Care Area Assessment dated 9/15/20, inentified a goal for R7 to maintain his current level of function with bed mobility, transfers, dressing and toilet use. R7's care plan dated 5/26/21, identified R7 had a flaccid left side due to hemiplegia. Physical and occupational therapy were to evaluate and treat as needed. A rehabilitation nursing program was offered three to six times per week for active range of motion (AROM) on the omnicycle, AROM on right leg and right upper extremity and passive range of motion (PROM) on left leg and shoulder. PROM was also to be offered on R7's neck along with ultra sound as directed by his primary physician and therapy for pain relieve related to chronic pain from cervical disc degeneration. R7's nursing rehabilitation program documentation dated 7/7/21 through 8/5/21, identified 6 of 25 opportunities to exercise with the rehabilitation nursing program were patient refused, 1 of 25 opportunities was due to rehab aide was unable to see him and 15 out of 25	F 688	R7 was educated on the benefits of performing the program more regularly to improve his mobility and decrease his pain. Therapy aides were educated on charting appropriately to indicate whether the resident refused or was unavailable. On days he refuses, bed exercises will be offered to prevent decrease in ROM. Rehab Coordinator and therapy department reviewed programming in place for all residents in need for ROM or at risk for decline. Programs were updated as necessary. RN□s and Rehab Coordinator to assess all residents on admission and as needed to identify and develop a program to include ROM if necessary. Rehab Coordinator or Designee will perform audits 2x/wk for 4 weeks, and 1x/wk for 2 weeks to ensure accurate charting and program completion. QAA committee updated on 8/31/21 and will monitor compliance with audits.	

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F 688	Continued From page 17	F 688		

opportunities to exercise were documented as not applicable (NA). The remaining 3 of 25 opportunities did not have documentation recorded.

On 8/4/21, at 8:57 a.m. R7 stated he had aches and pains but they do not bother him all the time. It only hurt when he did not move for a long time. His neck hurt liked "the dickens" but when they massaged his shoulders and put ointment on it, the pain improves. Therapy had a massager that looked like a hair dryer and that really helped his pain. Therapy used the massager about one time per week and the effect would last for a couple of days. R7 indicated his back pain improved when he moved around more and his pain increased when he did not.

On 8/5/21, at 9:45 a.m. nurses aide (NA)-A stated rehab nursing and therapy do all resident exercises. NA-A thought R7 went to therapy for exercise.

When interviewed via telephone on 8/5/21, at 9:48 a.m. rehab aide (RA)-A stated they coded NA when exercises and rehab therapy was not offered to the resident that day.

During interview on 8/5/21, at 9:48 a.m. registered nurse (RN)-A indicated the rehabilitation nursing program documentation showed R7 had only been offered rehab nursing eight times in the month of July and the document was blank on all the other days. She did not know how it could be determined whether R7 was being offered exercise or if R7 refused and the services were offered.

During joint interview with the director of nursing

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

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F 688	Continued From page 18	F 688		

(DON) and rehab aide (RT)-A via telephone on 8/5/21, at 2:26 p.m. RT-A stated they put three to six times per week on all the rehab resident's care plans. R20's rehab documentation recorded NA for 15 out of 25 opportunities for rehab AROM and PROM exercises. RT-A indicated the rehab aides did all their charting in the point of care chart. If NA was marked under the pain task it meant ROM exercises were not offered to the resident and the rehab aides did not get to the resident that day. The DON indicated it was unfortunate R7 was not offered rehabilitative nursing more frequently.

The facility policy Nursing Rehab Program dated 6/23/20, indicated restorative nursing care promotes resident's highest level of independence with range of motion and activities of daily living. The MDS coordinator would provide oversight to the program to ensure the restorative interventions were being implemented as planned. The rehab coordinator would document at a minimum quarterly the program evaluation indicating the progress, lack of progress, and changes to the restorative care plan during the assessment review dated and as needed.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 26, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: K93D11

Dear Administrator:

The above facility was surveyed on August 2, 2021 through August 5, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/05/2021

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/2/21 through 8/5/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.	2 540		8/31/21

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2 540	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a complete and comprehensive Minimum Data Set (MDS) assessment was completed at least annually for 1 of 13 residents (R135) reviewed in the final sample selection. Findings include: The Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual dated 10/1/20, identified the MDS as an assessment tool which facilities are required to use. The manual indicated the omnibus budget reconciliation act (OBRA) Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. Comprehensive MDS assessments must be completed on admission and annually and quarterly assessments, which are not comprehensive assessments, are to be used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators for the gradual onset of significant changes in resident status. R30's annual MDS dated 4/15/20, indicated R30 had several diagnoses which included heart failure, hypertension, arthritis, chronic obstructive pulmonary disease, anxiety and depression. R30 required extensive assistance with dressing, grooming, transfers and toileting. R30 was frequently incontinent of bladder and did not ambulate.	2 540	Corrected.	

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2 540	Continued From page 4 R30's quarterly MDS dated 12/16/20, indicated R30 had several diagnoses which included heart failure, hypertension, arthritis, chronic obstructive pulmonary disease, anxiety and depression. R30 required extensive assistance with dressing, grooming, transfers and toileting. R30 was frequently incontinent of bladder and did not ambulate. The record lacked a required comprehensive assessment for March 2021. On 8/4/21, at 2:47 p.m. registered nurse (RN)-A stated the facility's MDS consultant RN-C and RN-B were responsible for filling out the MDS schedule. RN-A stated she was only able to find the quarterly MDS assessment that was done in December. The care section in R30's record indicated an assessment was due to be done in March 2021, but the record did not have a care plan or MDS after December 2020. During telephone interview on 8/4/21, at 2:55 p.m. the MDS consultant RN-C stated she could not understand why R30 did not have a current MDS. R30 may have gotten removed from the MDS scheduler program on their computer system. RN-C stated the facility completed the MDS assessments on every resident in their facility and she did not know why or how R30 had gotten missed. R30 should have had an annual comprehensive MDS assessment done in March 2021. On 8/5/21, at 2:16 p.m. the director of nursing (DON) stated they were not able to find an MDS for R30 after 12/16/20. R30's assessments had gotten missed for some reason. The facility setup R30 for an observation period in order to complete a comprehensive assessment as soon	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 540	Continued From page 5 as possible. The facility's policy Resident Assessment Instrument dated 5/15/20, indicated MDS schedules were defined by the RAI manual. There were specific schedules for opening the MDS, setting the assessment reference date and completion of the MDS according to the type of assessment. The MDS coordinator would determine the MDS schedule identifying all pertinent dates. The schedule would be routed to all interdisciplinary team members. The facility's policy Patient Driven Payment Model (PDPM) Policy Procedure dated 5/15/20, indicated the facility would complete a comprehensive assessment of the resident's needs using the most recently updated RAI manual for the state. The facility would conduct a comprehensive assessment within fourteen days after admission, a significant change or not less than once every twelve months or within 366 days after the assessment reference date of the most recent comprehensive resident assessment. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review policy and provide education for staff regarding completion of an individualized comprehensive resident assessment including care area assessments for admission, annual and significant changes. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 550	Continued From page 6	2 550		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure required quarterly Minimum Data Set (MDS) assessment was completed for 1 of 13 residents (R135) reviewed in the final sample selection. Findings include: The Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual dated 10/1/20, identified the MDS as an assessment tool which facilities are required to use. The manual indicated the omnibus budget reconciliation act (OBRA) Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. Comprehensive MDS assessments must be completed on admission and annually and quarterly assessments, which are not comprehensive assessments, are to be used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators for the gradual onset of significant changes in resident status. R30's annual MDS dated 4/15/20, indicated R30	2 550	Corrected.	8/31/21

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	00460	A. BUILDING: _____ B. WING _____	08/05/2021

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

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2 550	Continued From page 7 had several diagnoses which included heart failure, hypertension, arthritis, chronic obstructive pulmonary disease, anxiety and depression. R30 required extensive assistance with dressing, grooming, transfers and toileting. R30 was frequently incontinent of bladder and did not ambulate. R30's quarterly MDS dated 12/16/20, indicated R30 had several diagnoses which included heart failure, hypertension, arthritis, chronic obstructive pulmonary disease, anxiety and depression. R30 required extensive assistance with dressing, grooming, transfers and toileting. R30 was frequently incontinent of bladder and did not ambulate. The medical record lacked any further MDS assessments as required. The record lacked a required annual comprehensive MDS assessment in March 2021 and then the subsequent quarterly MDS assessment due in June 2021. On 8/4/21, at 2:47 p.m. registered nurse (RN)-A stated the facility's MDS consultant RN-C and RN-B were responsible for filling out the MDS schedule. RN-A was only able to find the quarterly MDS assessment that was done in December. The care section in R30's record indicated an assessment was due to be done in March 2021, but the record did not have a MDS completed after December 2020. During telephone interview on 8/4/21, at 2:55 p.m. the MDS consultant, RN-C stated she could not understand why R30 did not have a current MDS. R30 may have gotten removed from the MDS scheduler program on their computer system. The facility completed MDS assessments on	2 550		

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2 550	Continued From page 8	2 550		

every resident in their facility and she did not know why or how R30 had gotten missed. R30 should have had an annual comprehensive MDS done in March 2021 as well as a quarterly MDS in June 2021. RN-C verified the MDS's were not done.

On 8/5/21, at 2:16 p.m. the director of nursing (DON) stated they were not able to find an MDS for R30 after the one completed on 12/16/20. R30's assessments were missed for some reason. The facility setup R30 for an observation period in order to complete a comprehensive assessment as soon as possible.

The facility's policy Patient Driven Payment Model (PDPM) Policy Procedure dated 5/15/20, indicated the facility would complete a quarterly review of each resident would be conducted at least every three months or within 92 days unless a significant change assessment had been completed in that time.

The facility's policy Resident Assessment Instrument dated 5/15/20, indicated MDS schedules were defined by the RAI manual. There were specific schedules for opening the MDS, setting the assessment reference date and completion of the MDS according to the type of assessment. The MDS coordinator would determine the MDS schedule identifying all pertinent dates. The schedule would be routed to all interdisciplinary team members.

SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise as necessary the policies and procedures regarding the revision and accuracy of the quarterly assessment process. The DON, or designee(s) could provide an in-service for all appropriate

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2 550	Continued From page 9 staff on these policies and procedures. The DON, or designee(s) could monitor to assure each resident with a quarterly assessment is accurate and revise. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a therapy recommended restorative program was completed as ordered for 1 of 1 residents (R7) reviewed for range of motion. Findings include: R7's quarterly Minimum Data Set (MDS) dated	2 890	Corrected	8/31/21

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2 890	Continued From page 10 5/19/21, indicated R7 had intact cognition with no behaviors of resisting or refusing care. R7 required extensive assistance with dressing, grooming, toileting and bathing. R7 was unable to ambulate and range of motion was impaired on one side. Diagnosis included hemiplegia (paralysis on one side) following cerebral infarction (an area of necrotic tissue in the brain) affecting left non-dominant side R7's activites of daily living (ADL) Care Area Assessment dated 9/15/20, inentified a goal for R7 to maintain his current level of function with bed mobility, transfers, dressing and toilet use. R7's care plan dated 5/26/21, identified R7 had a flaccid left side due to hemiplegia. Physical and occupational therapy were to evaluate and treat as needed. A rehabilitation nursing program was offered three to six times per week for active range of motion (AROM) on the omnicycle, AROM on right leg and right upper extremity and passive range of motion (PROM) on left leg and shoulder. PROM was also to be offered on R7's neck along with ultra sound as directed by his primary physician and therapy for pain relieve related to chronic pain from cervical disc degeneration. R7's nursing rehabilitation program documentation dated 7/7/21 through 8/5/21, identified 6 of 25 opportunities to exercise with the rehabilitation nursing program were patient refused, 1 of 25 opportunities was due to rehab aide was unable to see him and 15 out of 25 opportunities to exercise were documented as not applicable (NA). The remaining 3 of 25 opportunities did not have documentation recorded.	2 890		

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2 890	Continued From page 11 On 8/4/21, at 8:57 a.m. R7 stated he had aches and pains but they do not bother him all the time. It only hurt when he did not move for a long time. His neck hurt liked "the dickens" but when they massaged his shoulders and put ointment on it, the pain improves. Therapy had a massager that looked like a hair dryer and that really helped his pain. Therapy used the massager about one time per week and the effect would last for a couple of days. R7 indicated his back pain improved when he moved around more and his pain increased when he did not. On 8/5/21, at 9:45 a.m. nurses aide (NA)-A stated rehab nursing and therapy do all resident exercises. NA-A thought R7 went to therapy for exercise. When interviewed via telephone on 8/5/21, at 9:48 a.m. rehab aide (RA)-A stated they coded NA when exercises and rehab therapy was not offered to the resident that day. During interview on 8/5/21, at 9:48 a.m. registered nurse (RN)-A indicated the rehabilitation nursing program documentation showed R7 had only been offered rehab nursing eight times in the month of July and the document was blank on all the other days. She did not know how it could be determined whether R7 was being offered exercise or if R7 refused and the services were offered. During joint interview with the director of nursing (DON) and rehab aide (RT)-A via telephone on 8/5/21, at 2:26 p.m. RT-A stated they put three to six times per week on all the rehab resident's care plans. R20's rehab documentation recorded NA for 15 out of 25 opportunities for rehab AROM and PROM exercises. RT-A indicated the rehab	2 890		

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2 890	Continued From page 12 aides did all their charting in the point of care chart. If NA was marked under the pain task it meant ROM exercises were not offered to the resident and the rehab aides did not get to the resident that day. The DON indicated it was unfortunate R7 was not offered rehabilitative nursing more frequently. The facility policy Nursing Rehab Program dated 6/23/20, indicated restorative nursing care promotes resident's highest level of independence with range of motion and activities of daily living. The MDS coordinator would provide oversight to the program to ensure the restorative interventions were being implemented as planned. The rehab coordinator would document at a minimum quarterly the program evaluation indicating the progress, lack of progress, and changes to the restorative care plan during the assessment review dated and as needed. SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director	2 900		8/31/21

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2 900	Continued From page 13 of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 1 resident (R7) reviewed who were at risk for pressure ulcers. Findings include: R7's quarterly Minimum Data Set (MDS) dated 5/19/21, indicated he had intact cognition and required extensive assistance with bed mobility, dressing, toileting and total assistance with transfers. R7 was at risk for developing pressure ulcers and had a pressure relieving device on his bed and in his chair. The MDS did not identify a current pressure ulcer and did not identify if R7 was on a turning and repositioning schedule. R7's care plan dated 5/26/21, identified a potential risk for impairment in skin integrity related to his cerebrovascular accident and left hemiparesis, as well as acute and chronic pain related to cervical disc degeneration. Staff were	2 900	Corrected	

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2 900	Continued From page 14 directed to turn and reposition R7 every two hours and it helped alleviate his pain. On 8/4/21, from 7:00 a.m. through 9:50 a.m. R7 was continuously observed and the following observation and interviews were obtained: -At 7:00 a.m. R7 was lying in his bed on his back. R7 was awake and stated he was not up yet for his breakfast. R7 stated he had been laying on his back for at least three hours and his lower back was really hurting due to laying in the same position for so long. -At 8:43 a.m. R7's position had remained unchanged. He had started to call out softly for help. He did not use his call light. -At 8:52 a.m. R7's position remained unchanged. He continued to call out softly for staff. -At 8:55 a.m. nursing assistant (NA)-C entered R7's room in response to his call light. NA-C informed R7 she would get him his breakfast. R7 requested to go to the dining room for breakfast. NA-C notified R7 he was assist of two to transfer and she would have to get some help. R7 responded he needed to be moved, as he had been lying on his back for at least three hours. NA-C asked R7 if he would mind waiting five minutes and she would come back with help and assist him. R7 stated he guessed he would have to. R7's position remained unchanged. - At 9:11 a.m. R7's position remained unchanged. R7 stated it was going to feel so good to get moved. - At 9:18 a.m. R7's position remained unchanged. His call light remained on and no staff had	2 900		

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2 900	Continued From page 15 entered his room. - At 9:23 a.m. NA-B entered R7's room with R7's breakfast tray. NA-B raised the head of the bed, placed a clothing protector on R7's chest and placed his breakfast tray in front of him. R7 requested to wash his hands in the sink. NA-B stated she would bring him a washcloth. R7 remained on his back with the head of the bed elevated as he ate his breakfast. - At 9:36 a.m. an unidentified nurse entered R7's room and administered his medications. R7 continued to eat his breakfast, his position was unchanged. - At 9:48 a.m. NA-B entered R7's room to remove his breakfast tray. R7 stated I have been in this position for to long. NA-B lowered the head of the bed to a flat position. She stated she thought R7 was on a every three hour turning and repositioning program. R7 commented to NA-B that he had been on his back for over three hours. NA-B informed R7 that the head of his bed had been elevated which was considered repositioning. R7 replied he had been on his back the entire time though. On request from surveyor, NA-B assisted R7 to turn on his left side and placed a pillow under his right hip. During interview on 8/4/21, at 11:45 a.m. NA-C stated she needed to help another resident and was unable to go back to R7 but she had told someone that he had requested to get up for breakfast. She was not sure of the name of the person she had told. R7 had told NA-C he had not been moved all morning but she was unable to assist him because he was a two person assist. After review of R7's care sheet , NA-C stated R7 was last repositioned at 7:00 a.m. She	2 900		

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2 900	Continued From page 16 had not assisted with the repositioning at that time and thought maybe NA-B had done so.. When interviewed on 8/4/21, at 11:53 a.m. NA-B stated she shifted R7 ' s weight by pulling on his draw sheet around 7:00 a.m.; however, he remained positioned on his back. NA-B did not get his weight off of his back but if he had wanted to be turned, she would have done so. On 8/5/21, at 9:45 a.m. NA-A indicated repositioning residents meant to off load their weight if they were sitting or to turn them to a side lying position if a resident were lying on their back in bed. NA-A stated R7 needed assistance to turn and reposition and was on a two hour repositioning schedule. During interview on 8/5/21, at 9:48 a.m. registered nurse (RN)-A stated turn and reposition meant to turn side to side when in bed. Shifting a residents weight in bed or raising the head of the bed did not represent turning and repositioning. When interviewed on 8/5/21, at 2:22 p.m. the director of nursing (DON) stated shifting a resident's weight or raising the head of the bed was not considered turning or repositioning. It was unfortunate R7 did not get turned and repositioned off of his back on 8/4/21. Staff should be going in to resident rooms and doing a full repositioning and off loading as directed by the resident's care plan. The facility's policy Repositioning/Turning, dated 4/3/20, indicated repositioning was critical for a resident who was immobile or dependent on staff for repositioning. The policy detailed the steps needed to reposition a resident when in bed.	2 900		

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2 900	Continued From page 17 Steps included to check the residents care plan to determine resident specific positioning needs, use two people if applicable, and place the resident in a comfortable position in accordance with the resident's individualized care plan. SUGGESTED METHOD OF CORRECTION: The DON or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing, and to promote healing of pressure ulcers. The DON or designee could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety with self administration of medication for 1 of 1 residents (R30) who's medication was left to be administered by family. Findings include:	21565	Corrected	8/31/21

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R30's quarterly Minimum Data Set (MDS) dated 7/14/21, indicated R30 had severe cognitive impairment. Diagnoses included dementia, hypertension, edema, and dizziness.

R30's care plan dated 7/21/21, indicated R30 had impaired cognitive function related to dementia and directed staff to administer medications as ordered for various diagnoses and to administer pain medications one half hour before treatments or care.

R30's Order Summary Report dated 7/5/21, identified the following medication orders: Airborne multi-vitamin one tablet twice a day (BID) as needed (PRN) for allergies, amlodipine 10 milligrams (mg) in the morning, bisacodyl 5 mg every 24 hours as needed, cranberry-vitamin C 1500-100 mg one capsule in the morning, cyanocobalamin 1000 microgram (mcg) one tablet in the morning, gingko biloba 60 mg in the morning, ibuprofen 200 mg daily PRN for pain, furosemide 20 mg daily, Lyrica 75 mg in the evening, meclizine 12.5 mg in the evening, meclizine 25 mg two tablets in the morning, milk of magnesia 15 millimeters daily PRN, omeprazole 20 mg daily PRN, Osteo Bi-Flex one tablet BID, sennosides-docusate 8.6-50 mg BID, Tums 500 mg two tablets at bedtime, Tums 500 mg two tablets every 4 hours PRN, Tylenol 500 mg two tablets three times a day.

On 8/5/21, at 8:08 a.m. licensed practical nurse (LPN)-A was observed passing morning medications to residents. LPN-A took R30's medications cards and bottles from the medication cart and put the following medications into a medication cup: amlodipine 10 mg one tablet, cranberry-vitamin C 1500-100 mg one

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capsule, gingko biloba 60 mg one capsule, furosemide 20 mg 1 tablet, meclizine 12.5 mg two tablets, Bio-Flex one capsule and vitamin B12 1000 mg one cap.

- R30 was asleep upon LPN-A entering R30's room. LPN-A stated staff take the medications in to the resident's room and give them to the residents family member (FM)-A and FM-A administers the medications after the resident gets up for the day. FM-A was seated at a card table setup for puzzles in the room. LPN-A handed FM-A the medication cup with seven different medications and stated here are R30's medications. LPN-A exited R30's room to continue on with her medication pass. FM-A stated she always administered R30's medications in the morning after she had gotten up for the day, as she liked to take her time taking them.

R30's Self Administration of Medication form dated 8/13/18, indicated R30 did not choose to self administer her medications, nor did it include an assessment for FM-A's ability to administer R30's medications.

R30's Medication Administration Record (MAR) dated August 2021, identified each medication and what time it was to be administered. The facility nurses identified each medication as administered by inserting a check mark and their initials on the appropriate date of administration. LPN-A initialed she had administered the medications ordered on the morning of 8/5/21, at 8:00 a.m. The MAR did not identify R30 as self administering her medications or FM-A as administering the medications. Nor did the MAR identify at what time the medications were actually administered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00460	A. BUILDING: _____ B. WING _____	08/05/2021

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

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21565	Continued From page 20 When interviewed on 8/5/21, at 3:54 p.m. the director of nursing (DON) stated the nurse should not have left R30's medications with FM-A for FM-A to administer. he DON indicated this would be a problem as the nurse would not know if all the medications were administered and at what time they were administered. The facility policy Medication Administration, Medication Hold Parameters dated 7/19/21, directed staff to place medications into med cup, following the eight rights of medication pass. Identify resident prior to administration, offer appropriate amount of water, and stay with the resident until all medications are swallowed or taken correctly. A policy for self administration of medications was requested; however, was not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could review with staff current policies to ensure residents who are self administering medication had been assessed and were appropriate to administer their own medication, along with a physicians order for administration. The DON could audit resident to ensure assessment, and physician orders for self administration were in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		

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	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Fair Meadow Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 Edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/27/2021

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

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Inspected as one building: Fair Meadow Nursing Home is a 1-story building, without a basement, and constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1972 the south wing was added to the original building and was determined to be of Type II (111) construction.	K 000		

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K 000	Continued From page 2 The south wing is separated with at least a 2 hour fire barrier from an apartment building. The facility is divided into 4 separate smoke zones by 30 minute fire barriers. The facility has a fire alarm system with smoke detection throughout the corridor system and in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" with automatic fire department notification. The building is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Automatic Sprinkler Systems with quick response heads. Hazardous areas have automatic fire detection that is on the fire alarm system. The facility has a capacity of 41 beds and had a census of 38 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has failed to ensure that 1 of 12 monthly test/inspections of battery operated emergency lights in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3.1.1 (1). This deficient	K 291	On 8/05/2021 a monthly inspection was conducted on all battery operated emergency lights in coordination with NFPA 101 Life Safety Code. The policy was updated to state testing will be conducted in 30 day intervals, rather than	8/6/21

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K 291	Continued From page 3 condition could have a widespread impact on the residents within the facility. Findings include: On 08/03/2021, at 12:42 PM, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was observed that the facility could not provide information or documentation for 1 of 12 monthly 30 second test/inspection for the battery powered emergency lights. This deficient condition was verified by the Maintenance Supervisor.	K 291	monthly. This monthly inspection will be scheduled for 20 day intervals to assure compliance, and will be scheduled by Maintenance Supervisor. The Nursing Home Administrator will conduct monthly audits at the end of each month to assure inspection completion.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.6.1.6. This deficient condition could have a widespread impact on the residents within the facility.	K 346	The fire alarm out of service policy was updated on 8-6-21 to include the 4 hour requirement in accordance with NFPA 101 Life Safety Code. The name and contact information for the current fire marshal was also added to the policy. Maintenance Supervisor will preform annual review of this policy to assure accurate information. Compliance	8/6/21

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K 346	Continued From page 4 Findings include: On 08/03/2021, at 12:06 PM, during a records review and an interview with a Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy. The current fire alarm system out of service policy stated that the fire watch would be enforced after 10 hours instead of the required 4 hours of the fire alarm system outage in a 24 hour period. This deficient condition was verified by the Maintenance Supervisor.	K 346	monitored by maintenance supervisor .	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could have a	K 901	The facility risk assessment could not be located at the time of inspection. On 8-4-21 the risk assessment was found, it had been completed on 6/2020, performed by previous Maintenance Supervisor. The current Maintenance	8/6/21

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K 901	Continued From page 5 widespread impact on the residents within the facility. Findings include: On 08/03/2021, at 1:06 PM, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. This deficient condition was verified by the Maintenance Supervisor.	K 901	Supervisor has included the assessment in the risk assessment binder. The location of these assessments were made known to maintenance assistance also. Maintenance Supervisor to review assessment annually.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated	K 914		8/19/21

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K 914	Continued From page 6 repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available fire drill documentation, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/03/2021, at 1:15 PM, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the current completion of the annual electrical outlet inspection and testing for the electrical outlets located in the resident rooms located throughout the facility. This deficient condition was verified by the Maintenance Supervisor.	K 914	Facility wide testing was conducted on all electrical outlets in resident rooms on 8-19-21. Completion was documented in Maintenance Policy Book 13. Maintenance Supervisor will assure annual inspection and documentation by scheduling this testing on the maintenance schedule. Compliance will be monitored by Maint Supervisor.	