Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Fair Meadow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Garfield Avenue Southeast Fertile, MN 56540	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based observation, interview and document review, the facility failed to ensure a comprehensive reassessment was completed to ensure seat belt use was still warrented for identified medical symptoms; and failed to release the seatbelt according to care planned interventions for 1 of 1 residents (R9) reviewed for restraints. Findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE], identified R9 had a severe cognitive impairment, had diagnoses that included Alzheimer's disease, anxiety disorder, and psychotic disorder with delusions. R9 used a chair that prevented rising every day, and did not identify a trunk restraint. R9 used antipsychotic and antianxiety medications. R9's care plan revised 6/19/22, identified R9 required use of physical restraints: seat belt in a tilt-in-place wheelchair for positioning related to Alzheimer's dementia and R9 leaned forward in her wheelchair. Fall at home prior to admit with Fracture. R9 was continually reaching to her feet or leaning over in wheelchair attempting to fix her pants. R9 was a seamstress and did a lot of sewing for work. R9 continued to think she is sewing, [NAME] up her pants or picking up pins, etcetera. R9 had poor safety awareness. OT provided with new tilt and space type excessive leaning to be used as needed to assist with eating, hair cares, family visits. R9's family representative was aware. The care plan directed the following: - Discuss and record with R9/family/caregivers, the risks, and benefits of the restraint, when the restraints should be applied, routines while restrained and any concerns or issues regarding restraint use. - Ensure R9 was positioned correctly with proper body alignment while restraint was being used: seatbelt in wheelchair daily. Remove seatbelt with care, meals as able, one-on-one with staff, activities, toileting, etc. Fill out restraint release form every shift. - Seatbelt released with repositioning, 1:1 visit when calm, with toileting, when in bed and walking, etc. Document restraint use and release as per facility protocol. (continued on next page)

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.

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

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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

- Ensure valid consent on chart prior to initiating restraint.

- Evaluate/record continuing risks/benefits of restraint; alternatives to restraint, need for ongoing use, reason for restraint use. Staff were to chart time seatbelt was off.

- R9 needed a safe environment with adequate, glare-free light; floors that are even and free from spills or clutter; call light or alarm system; personal items within reach; bed in low position when locked.

- R9 needed opportunities for restraint-free time and physical activity daily. Walking, toileting, transfers in and out of bed to rest. When sleeping or not restless place in wheelchair, etc. Per restraint committee, R9 was to have an activity staff remove during 1:1 visit, document time off and how tolerated.

- R9 needed to have restraint applied daily. Seatbelt released: with repositioning, with 1:1 visit when calm, with toileting, when in bed, and walking, etc. Document restraint use and release as per facility protocol. Fill out restarting release form every shift. Family signed consent form. R9 used a tilt-in-space wheelchair with a footrest. Assure R9's hips were equally aligned in chair and all the way back. Calf pad placed over footrests when R9 was sitting up in her wheelchair. Do not turn your back on R9 if seat belt was off. Restraint reduction committee to look at ways to help reduce use of restraints and possible discontinue if able. Review quarterly/as needed. Nursing rehab to have her stretch daily on bed in therapy room. Try during activities to take seat belt off during 1:1 and observe closely as able and report skin breakdown.

- Monitor/document/report to MD PRN changes regarding effectiveness of restraint, less restrictive device, if appropriate; any negative or adverse effects noted, including decline in mood, change in behavior, decrease in ADL self-performance, decline in cognitive ability or communication, contracture formation, skin breakdown, signs/symptoms of delirium, falls/accidents/injuries, agitation and/or weakness.

The undated nurse aide care sheet, identified R9 used a seatbelt when in wheelchair but provided no other direction for staff, such as when it should be used and released.

R9's Order Summary Report dated 3/2/21, identified a physician order for Assistive Device: Seat belt on rocking wheelchair (agitation, hallucination, increased restless, leaning, falls) for resident safety. Shoulder strap as needed to help with proper positioning. Remove for care, toileting, 1-1 with staff.

R9's physician visit notes 10/10/23 through 7/17/24, failed to address R9's need for continued physical restraint.

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R9's Physical Restraint Elimination Assessment form dated 8/7/24, identified the following categories of evaluation: ambulation, weight bearing, sitting balance, ADLs (bathing dressing, grooming), physical limitations, orientation, comprehension, behavior/mood, activity participation and medication therapy. The form included the following scoring: 0-20 priority candidate, 21-35 good candidate and 35 plus poor candidate. R9 was complete bedrest/chairbound, non-weight bearing, leaned to the side, forward and backward, required total assist of two, had a history of falls, was legally blind, was disoriented to person place and time, was combative and severely agitated, unable to actively participate in activities and was currently taking antipsychotics. R9's score was 31 indicating R9 was a good candidate for restraint elimination. However, the assessment identified R9's score was good but R9 was not a candidate for restraint reduction or elimination program because R9 wore a seatbelt when sitting up in her wheelchair, video monitoring, used when R9 was in her room, with her bed in low position with a mat on the floor, but did not include supporting information to the frequency of the medical symptoms while seated in the chair warranting continued use without trialing a restraint reduction. R9 was legally blind with a diagnosis of Alzheimer's disease, delirium, psychotic disorder. R9 was unaware of safety or had poor safety awareness The assessment lacked the length of time the restraint is anticipated to be used to treat the medical symptom, the identification of who may apply the restraint, where and how the restraint is to be applied and used, the time and frequency the restraint should be released, and who may determine when the medical symptom has resolved in order to discontinue use of the restraint; the type of specific direct monitoring and supervision provided during the use of the restraint, including documentation of the monitoring; the identification of how the resident may request staff assistance and how needs will be met during use of the restraint, such as for re-positioning, hydration, meals, using the bathroom and hygiene; and the resident's record includes ongoing re-evaluation (based on supporting data) for the need for a restraint and is effective in treating the medical symptom.

R9's Behavior/Mood sheets identified the following:

- February 2024, R9 exhibited crying/weepy, taking off clothes, kicking, hitting, punching, picking at things not there, talking to herself, crawling out of bed, wakeful at night, hallucinating, difficulty with transfers, calling staff names, refusing cares, and screaming x 6. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair.

- March 2024, R9 exhibited crying/weeping and kicking, hitting, punching x 1. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair.

- April 2024, R9 exhibited no behaviors.

- May 2024, R9 exhibited taking clothes off x 2, throat punching during cares x 1, picking at things not there, talking to herself, crawling out of bed, and screaming x 1. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair.

- June 2024, R9 exhibited no behaviors.

- July 2024, kicking, hitting, punching, and calling staff names x 3. However, the documentation failed to identify behaviors exhibited while R9 was sitting in her wheelchair.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/25/24 at 1:14 p.m., family member (FM)-A stated R9 had a history of falls. R9 used a low bed with a mat on the floor and used a seatbelt when she was in her wheelchair. FM-A stated the seatbet was used so R9 couldn't fall out of her wheelchair and FM-A was ok with that because it kept R9 safe. During an observation on 8/25/24 at 5:22 p.m., R9's seatbelt was not released during the supper meal with nursing assistant (NA)-G seated immediately next to R9. - At 6:58 p.m., R9 continued to sit in her wheelchair in her room. R9's seatbelt was snuggly fastened over her waist. R9 was quiet, with her head hanging down and her eyes were closed. R9's hands were clasped and lying in her lap. - At 7:26 p.m., R9 continued to sit in her wheelchair with her seatbelt on. R9 exhibited no agitation and sat quietly upright in her wheelchair. On 8/26/24 at 9:22 a.m., NA-C and NA-F assisted R9 with morning cares. R9 was transferred from bed to her wheelchair using a full body mechanical lift. Once R9 was in the wheelchair, NA-F immediately fastened R9's seatbelt. R9 was cooperative with cares. NA-F stated R9 always used a seatbelt. All day, every day. Staff didn't do anything with it except buckle it, but staff did lay R9 down every 2 hours or so for a check and change. NA-F pushed R9's wheelchair to the common area by the front desk. R9 sat quietly upright in her wheelchair and exhibited no agitation or behaviors. - At 9:53 a.m., NA-F pushed R9's wheelchair to R9's room to assist R9 to eat breakfast. NA-F did not remove R9's seatbelt even though NA-F sat immediately next to R9. R9 sat quietly upright in her wheelchair while eating. R9 exhibited no agitation or behaviors. - At 9:54 a.m., NA-D entered the room and told NA-F she could assist R9 to eat. NA-D sat down next to R9 and began assisting R9 to eat but did not remove R9's seatbelt. R9 sat quietly eating and occasionally responded when spoken to. R9 exhibited no agitation or behaviors. - At 10:22 a.m., NA-D assisted R9 to activities. R9's seatbelt continued to remain fastened. R9 sat quietly upright in her wheelchair and exhibited to agitation or behaviors. During an observation on 8/26/24 at 4:14 p.m., NA-B and registered nurse (RN)-A assisted R9 from her bed to her wheelchair using a full body mechanical lift. Once R9 was in her wheelchair, RN-A immediately fastened R9's seatbelt and RN-A pushed R9's wheelchair to the common area by the front desk. R9 sat quietly, upright and responded well when others greeted her. R9 exhibited no agitation or behaviors. During an interview on 8/26/24 at 4:31 p.m., NA-B stated R9's seatbelt was a safety measure because R9 was always fidgeting. If R9 was in her wheelchair, R9 had to always have the seatbelt on. The seatbelt was to prevent R9 from falling in case staff couldn't see it. There was no time frame for removal of the seatbelt and there was no time when it wasn't needed. NA-B then stated the seatbelt was removed when staff laid her down to check for incontinence, but as soon as R9 was back in her wheelchair the seatbelt was put back on. - At 4:35 p.m., NA-B stated she had to change her answer because R9's seatbelt was checked every 30 minutes and removed every 2 hours. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot, remove a device in the same way the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. 3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. 4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. Using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in, bed; bed rail assessments done on admit, readmit, quarterly, & sig. changes. Some residents use bedrails for repositioning. b. Tucking sheets so tightly that a bed-bound resident cannot move. c. Placing a resident in a chair that prevents the resident from rising; and d. Placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising. 5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: a. Treat the medical symptom. b. Protect the resident's safety; and c. Help the resident attain the highest level of his/her physical or psychological well-being. 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. 7. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or resident representative. The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom). b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. 8. Orders for restraints will not be enforced for longer than twelve (12) hours unless the resident's condition requires continued treatment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on observation, interview, and record review the facility failed to comprehensively assess and develop interventions for safety while using a golf cart off campus for 1 of 1 (R23) resident reviewed for safe use of a motorized golf cart. Findings include: R23's quarterly Minimum Data Set (MDS) dated [DATE], identified R23 had moderate cognition and was independent or needed supervision with activities of daily living (ADL). R23 had upper extremity impairment on one side and no lower extremity impairment. R23's diagnoses included Parkinson's disease with dyskinesia (mild to severe uncontrolled muscle movements). R23's progress notes dated 2/26/24 through 8/27/24, identified multiple occasions of R23 independently leaving the facility on his golf cart and driving to appointments, town, the store, and other activities. The notes identified the resident kept his cell phone on his person, however, the notes failed to identify if R23 was safe while driving the golf cart. R23's medical record lacked an assessment for safe use of a motorized golf cart to include and evaluation and analysis of the the potential hazards and risks and eliminate them, if possible and, if not possible, reduce them as much as possible. R23's care plan dated 8/25/24, failed to identify a focus, goals, or interventions for safe use of a cart. On 8/25/24 at 1:37 p.m., R23 stated he drove his golf cart every day. R23 told the nurses when he was leaving, where he was going and the approximate time he would be returning. R23 also stated he brought his cell phone with him whenever he left the facility. On 8/27/24 at 8:39 a.m., nursing assistant (NA)-E stated R23 took his golf cart independently and was a very safe driver. NA-E stated she had ridden with R23 in the past and felt comfortable with his driving. On 8/27/24 at 8:45 a.m., activities aide (AA)-A stated R23 used a walker at the facility, was steady on his feet and needed very little assistance with ADL's. R23 had a motorized golf cart for the summer months, had a current drivers license, and drove the golf cart independently. R23 also brought his cell phone with him when he drove his cart and was able contact the facility if he needed anything. AA-A stated she had observed R23 driving the golf cart safely. On 8/27/24 at 8:50 a.m., the social services designee (SSD) stated R23 had the golf cart since his admission in 2021, and used the golf cart in the warmer months. The SSD stated she had not completed an assessment to determine if R23 was safe while using the golf cart, and was unable to find a previous assessment in R23's medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 9:00 a.m., AA-B entered the room and stated R23 had been driving his golf cart for many years and had assumed another staff member completed an assessment to determine if R23 could safely drive the golf cart. AA-B had not looked in his chart to ensure an assessment was there and had not completed one herself. Further, AA-B stated R23 had a drivers license and was supposed to complete an OT evaluation to drive his truck but the resident's family didn't want him driving the truck. The family approved the golf cart and R23 was satisfied driving the cart. An assessment to determine safe operation, including physical and cognitive ability including a safety plan was requested but not received from the facility. On 8/27/24 at 12:20 p.m., the assistant director of nursing (ADON) stated the facility had not assessed R23 for physical or mental ability for safe operation of and had not implemented interventions to ensure R23's safe return after leaving the facility or driving his golf cart. The facility did not have a policy regarding motorized golf cart use. The ADON stated R23 should be assessed at least yearly and as needed, and the golf cart use and safety plan should be added to the residents care plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to use personal protective equipment and follow hand hygeine guidelines for a resident known to have a multi-drug resistant organism (MDRO) for 1 of 1 residents (R5) reviewed for activities of daily living (ADLs). Findings include: The Centers for Disease Control and Prevention (CDC) Transmission-Based Precautions dated 4/3/24, identified Transmission-Based Precautions were the second tier of basic infection control and were used in addition to Standard Precautions for residents who may be infected or colonized with certain infectious agents for which additional precautions were needed to prevent infection transmission. Recommendations detailed the use of contact precautions for residents with known or suspected infections that represented an increased risk for contact transmission; wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment; and donning personal protective equipment (PPE) upon room entry and properly discarding before exiting the patient room is done to contain pathogens. R5's annual Minimum Data Set (MDS) dated [DATE], identified R5 had a moderate cognitive impairment, had diagnoses that included diabetes mellitus, and required extensive assistance with all care areas. R5's care plan revised 7/23/24, identified R5 had potential impairment to skin integrity related to rheumatoid arthritis, decreased mobility, arthritis, osteoporosis, diabetes, use of Coumadin (blood thinner), easily bruised, incontinence of bowels and bladder. The care plan directed staff to turn and reposition R5 every 2-3 hours, keep skin clean and dry, and to report changes to nursing. However, the care plan did not identify R5's contact precautions. The facility's undated, untitled care sheet, identified R5 required extensive to total assist with all care areas. R5 required a full body mechanical lift for transfers and daily preferences such as bedtime. However, the care sheet failed to identify if R5 had an infection and/or if R5 required transmission-based precautions. R5's nursing progress notes identified the following: - 8/11/24 at 2:37 p.m., R5 had a blister on the left side of her groin right under her labia (the major externally visible portions of the vulva). The blister had a white head with a red ring around it, no drainage noted, and R5 stated that it was not painful. - 8/13/24 at 3:28 p.m., on the left side of R5's labia was a 2 centimeter (cm) by 3 cm raised boil-like area, with thick drainage. R5 complained of tenderness with cares. Infection control nurse and primary registered nurse (RN) came to look at area well. R5 was placed on contact precautions. R5's physician notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER: Fair Meadow Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 Garfield Avenue Southeast Fertile, MN 56540	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/15/24 at 1:32 p.m., R5's left side of labia continued to be draining purulent drainage. Tender with cares. Thick core remained in center. Noted left buttock cheek/infragluteal fold (where buttock and upper thigh meets) noted a red induration area measured 1 cm. around. No head to it. Tender when touched. Will watch closely, chart and report. Reported to cart nurse, primary RN. R5's physician order dated 8/16/24 at 11:38 a.m., identified doxycycline 100 milligrams by mouth twice daily for 10 days. R5's wound culture dated 8/19/24, identified methicillin-resistant staphylococcus aureus (MRSA). The CDC's Appendix A: Type and Duration dated 8/26/24, identified Multidrug-resistant organisms (MDROs), infection or colonization e.g., MRSA (an infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections)) required contact and standard precautions. MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. During an observation on 8/25/24 at 6:54 p.m., R5 was sitting in her wheelchair in her room with a lap blanket covering to her waist. R5 was hollering out, come here. Signage on R5's room door identified R5 was on contact precautions and required a gown and gloves on entry. There was a 3-drawer plastic cart containing gowns, gloves, and masks next to her door. Nursing assistant (NA)-A entered R5's room without putting on a gown or gloves and was standing next to R5 with her wheelchair and blanket brushing against NA-A clothing. NA-A reassured R5 and stated it was still early to go to bed. R5 agreed and NA-A offered a drink of water. NA-A picked up an ice water glass from R5's overbed table and gave R5 a drink. NA-A placed the glass back on R5's overbed table and exited the room where NA-A then used hand sanitizer. During an interview on 8/25/24 at 7:41 p.m., NA-E stated R5 just started needing contact precautions due to that labia thing. Staff needed to wear a gown and gloves whenever staff were going to be in direct contact with R5. Like cares or whenever you're going to touch her. If staff were just dropping off linens and were not going to touch anything in R5's room, staff probably wouldn't need the gown or gloves but would need to either wash their hands or use hand sanitizer. If giving a drink of water, yes, staff needed to wear a gown or gloves to not get anything on their own clothes. During an interview on 8/25/24 at 7:43 p.m., NA-A stated a gown, and gloves was only needed if providing cares for R5. Otherwise, the gown and gloves were not needed. During an observation on 8/26/24 at 2:52 p.m., NA-F and NA-B entered R5's room after donning a gown, gloves, and mask. - At 2:53 p.m., NA-G rolled R5 to the right and removed R5's soiled brief. R5 had feces on her skin and NA-G proceeded to clean R5's skin with a disposable wipe. There was a circled area approximately 1 inch in diameter on R5's left infragluteal fold. The area was scabbed and without any covering. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 2:54 p.m., NA-G stated she was going to put salve on R5's bottom. NA-G removed her gloves and applied new gloves but did not wash her hands. NA-G obtained a tube of zinc oxide ointment and placed a small amount in her left gloved hand. NA-A smeared the ointment between R5's buttocks and folds then removed her left glove. NA-A did not wash her hands nor applied new gloves and proceeded to apply and fasten a clean brief to R5, pull up R5's pants and position R5 in bed. - At 2:56 p.m., NA-G gave R5 a drink of water. NA-B removed the gown and gloves and exited R5's room. In the hallway, NA-B used hand sanitizer. - At 2:58 p.m., NA-G removed her gloves, used hand sanitizer, then removed her gown. During an interview on 8/26/24 at 3:06 p.m., NA-B and NA-G stated they hadn't been doing contact precautions for R5 for maybe a week. NA-G stated they did not know why R5 needed precautions other than R5 had a boil her on bottom. NA-G and NA-B stated they did not know R5 had an infection nor what kind of infection it was. NA-G stated she did not wash her hands after removing the glove soiled with feces and worked with R5 without applying clean gloves. NA-B and NA-G reviewed the contact precautions sign and NA-G then stated, No one explained. During an interview on 8/26/24 at 3:09 p.m., licensed practical nurse (LPN)-A stated she would have to look up charting to know why R5 was on contact precautions. R5 had had multiple wounds in the past and R5 was being given an antibiotic for a boil in R5's groin and another boil on the back of R5's leg. Staff were applying warm packs to the areas, but there was no dressing covering. LPN-A stated she did not know if the areas were cultured or if the wounds were identified with a specific organism. Staff were directed to gown, gloves and mask when working with R5, so staff didn't take any germs out of the room with you. Staff were expected to wash their hands whenever going from clean to soiled to clean again. Staff were also expected to put on gloves whenever they were touching R5. Additionally, LPN-A stated she would tell staff to wash their hands with soap and water but to also use hand sanitizer afterward just to be safe. LPN-A stated they routinely say a culture was done, the person was started on an antibiotic and here you go. They don't tell us much other than that. During an interview on 8/27/24 at 10:53 a.m., registered nurse (RN)-A stated R5 had one area on the left groin that tested positive for MRSA. The wound was in progress of resolving. R5 was on contact precautions and staff were directed to gown up whenever entering R5 room. Staff should gown and glove even while providing a drink of water. Staff were expected to wash their hands or use hand sanitizer. Staff have had training on contact precautions during meetings, it was passed on during report and there should be information in the communication book. During an interview on 8/27/24 at 11:13 a.m., the assistant director of nursing (ADON) stated she was aware R5 tested positive for MRSA and R5 had been placed on contact precautions to prevent the spread of infection. Staff received education why R5 was on contact precautions and what PPE to wear especially during cares. The ADON stated the staff were expected to follow guidelines regarding all the types of precautions and it was the same for all who walked into R5's room. (continued on next page)

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	245545	A. Building B. Wing	08/27/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Infection Prevention and Control Program Policy and Procedure revised 5/12/23, identified hand hygiene was a primary means of preventing the transmission of infection. Hand hygiene was to be performed after removing gloves and after contact with a resident's mucuous membranes and bodily fluids and excretions. The policy and procedure also identified Transmission-Based Precautions were used for residents who were known to be or suspected of being infected or colonized with infectious agents, including pathogens that required addtional control measures to prevent transmission. Contact precautions included the following staff direction: - Contact precautions are intended to prevent transmission of nosocomial infections that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE. - Contact Precautions are often used in addition to Standard Precautions: - Acute infection with Methicillin-Resistant Staphylococcus Aureus (MRSA) or Vancomycin-Resistant Enterococcus (VRE). - Includes a gown and gloves upon entering (i.e., before making contact with the resident or resident's environment). - Prior to leaving the resident's room, the PPE is removed and hand hygiene is performed. - High Contact Care Activity Consists of: - Dressing - Bathing/Showering - Transferring - Providing Hygiene - Changing briefs or assisting with toileting - Wound care: any skin opening requiring a dressing

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948 Based on interview and document review, the facility failed to provide education on immunizations per Center for Disease Control and Prevention (CDC) guidance for 3 of 5 residents (R15, R22, R24) reviewed for immunizations. Findings include: R15's quarterly Minimum Data Set (MDS) dated [DATE] identified they were [AGE] years old with a diagnosis of a history of COVID-19. R15's immunization record dated 8/27/24, identified pneumococcal polysaccharide vaccine (PPSV23) was given on 7/18/05, and the pneumococcal conjugate vaccine (PCV13) on 4/6/16. R15's medical record did not include evidence R15 or R15's representative received education regarding pneumococcal vaccine booster and there was no indication R15 was offered the pneumococcal vaccine per CDC guidance. R22's significant change MDS dated [DATE], identified they were [AGE] years old with diagnosis of chronic pulmonary edema (fluid in the lungs). R22's immunization record dated 8/27/24, identified pneumococcal polysaccharide vaccine (PPSV23) was given on 10/10/13, and the pneumococcal conjugate vaccine (PCV13) on 9/30/15. R22's medical record did not include evidence R22 or R22's representative received education regarding pneumococcal vaccine booster and there was no indication R22 was offered the pneumococcal vaccine per CDC guidance. R36's quarterly MDS dated [DATE], identified they were [AGE] years old with a diagnosis of congestive heart failure. R36's immunization record dated 8/27/24, identified pneumococcal polysaccharide vaccine (PPSV23) was given on 2/13/12. There was no evidence R36 received or was offered the PCV13. R36's medical record did not include evidence R36 or R36's representative received education regarding pneumococcal vaccine booster and there was no indication R36 was offered the pneumococcal vaccine per CDC guidance. During an interview on 8/27/24 at 11:00 a.m., licensed practical nurse (LPN)-B, the infection preventionist, stated when residents come due for immunizations, she would notify the resident or their representative and notify provider and provide education as needed. LPN-B identified education regarding the PCV20 immunization was not sent to family or representative unless they asked about it. During an interview on 8/27/24 at 12:00 p.m. the director of nursing (DON) stated the resident, or their representative should have been educated about the PCV20 and documented in the resident's medical record. The expectation was the CDC guidance would be followed. The facility's Infection Prevention and Control Program policy dated 5/12/23, regarding pneumococcal vaccination documentation identified, resident or representative was provided education regarding the benefits and potential side effects of pneumococcal immunizations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CDC guidance dated 9/22/23, directed based on shared clinical decision-making (between resident/resident representative and provider) they need to decide whether to administer one dose of PCV20 at least 5 years after the last pneumococcal vaccination. This would have included providing education to the resident/resident representative.