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	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Meadow Nursing Home	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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to comprehensively assess for ability or safety and then care plan the self-administration of medication for 1 of 1 resident (R36) observed to have medication prepared by staff and then left with him to take on his own. Findings include: R36's admission Minimum Data Set (MDS) assessment dated [DATE], identified R36 had intact cognition. Diagnoses included disorder of the circulatory system, aneurysm of iliac artery and lower extremity and chronic obstructive pulmonary disease (COPD). R36's care plan with last review date 9/3/25, identified R36 admitted to the facility on [DATE]. A focus for altered respiratory status was identified with difficult breathing at times. Interventions included to administer medications and puffers as ordered. However, the care plan lacked any evidence R36 had been assessed or approved to administer nebulized medications independently. On 9/9/25, at 3:33 p.m., licensed practical nurse (LPN)-A prepared R36's medications for administration from a mobile cart in the hallway. LPN-A opened a box labeled Ipratropium 0.5 milligrams (mg) and albuterol sulfate 5 mg inhalation solution and removed one plastic vial of the medication. R36's corresponding electronic medication administration record (MAR) present via computer on the mobile cart, directed to inhale orally via nebulizer four time per day for COPD. LPN-A entered R36's room and poured the vial of medication into R36's nebulizer medication chamber, turned on the nebulizer machine and handed R36 the nebulizer mouthpiece to begin inhaling. LPN-A instructed R36 to ring if he had any trouble and exited the room. LPN-A returned to the medication cart and signed off the medication as administered. R36's medical record lacked evidence R36 was comprehensively assessed for safety with the self-administration of his nebulized medications. During interview on 9/9/25, at 3:56 p.m. LPN-A stated R36 administered his nebulized medications independently. LPN-A stated she also worked night shift and R36 had three different nebulized medications ordered to be administered during the night. Night shift nurse just brought all three of the ordered nebulizer medications to R36 and left them in his room for him to administer one after the other on his own. The nurse would check back with him later, when they brought in his oral medications, to ensure he had administered all of them. R36 was capable of bringing the nebulizer to his mouth and administering the nebulized medication correctly or he would be able to tell the staff if he was having any issues. Typically, there would be a self-administration assessment completed to ensure it was safe for R36 to self-administer the medications. LPN-A had just assumed there had been an assessment completed. During interview on 9/10/25, at 4:00 p.m. registered nurse (RN)-A stated she was responsible for completing resident assessments, including an assessment for ability and safety of resident to self-administer medications. RN-A stated R36 was high functioning and capable of administering his nebulized medications, however, she had not completed a formal assessment and order for the self-administration of the medications. She had not been aware he was doing the nebulized medications independently and so the assessment had been missed. When interviewed on 9/10/25, at 4:30 p.m. the director of nursing (DON) stated if a resident requested to self-administer medications it was the facility's policy to complete a self-administration of medication assessment to ensure they could do so correctly and safely, then it would be noted on the MAR and care planned. The facility's undated policy Self Administration of Medications identified on admission the resident would be asked if they would like to self-administer any medication. If the response was affirmative, the resident would need to demonstrate the ability, cognitively, physically and visually to safely complete the task. When a resident requested to self-administer medications, they would be assessed to determine the ability to do so safely for themselves and other residents. The assessment would be completed by a member of the interdisciplinary team using the facility's assessment form. The resident would need to demonstrate the ability to administer the medication, know the name of the medications, what it was used for, the main side effects of the medication. The resident would also need to be able to physically and visually complete the task.

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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. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a defined perimeter mattress (DPM) was not used in a manner to restrain residents while in bed for 1 of 3 residents (R14) reviewed for restraints. Findings include:R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 had a severe cognitive impairment, diagnoses that included bipolar disorder, epilepsy, and vascular dementia and identified R14 used an other restraint while in bed daily.R14's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 1/31/25, identified R14 had impaired cognitive function/impaired thought processes related to dementia. R14's cognitive assessment indicated severe impairment. R14 was able to make her needs known and was understood and understood others.R124's Behavioral Symptoms CAA dated 1/31/25, identified R14 had a potential to demonstrate behaviors related to vascular dementia, bipolar disorders, a history of depression with psychosis, and a generalized anxiety disorder. Behaviors noted during look back period: resistive to cares, hitting out at staff, not wanting to get up in the morning or have breakfast. Staff were directed to provide redirection; leave R14, if safe, and return later; meet R14's needs with toiletings, food, drink, and repositioning and continue to observe. However, the CAA failed to identify R14's DPM and/or interventions used prior to implementing a DPM.R14's care plan reviewed 7/23/25, identified R14 was at high risk for falls related to history stroke with weakness, vascular dementia with forgetfulness, hypertension, history of dizziness, and, at times, R14 was unaware of safety needs, confusion, gait/balance problems. R14 had a history of recurrent falls related to self-transfers and needed to be frequently reminded to ring for assist related to history of not ringing call light for staff assist. R14 needed staff assist with transfers, bed mobility, toileting, and other activities of daily living every day. Staff were directed R14 used a DPM on R14's bed and mats on the floor for safety related to history of self-transfers with falls in the past while in bed. R14's bed should be in low position. When R14 swung her legs out of bed, R14 was ready to get up. Staff assist with mechanical stand-up lift for transfers R14 was unable to walk. Review need for any restraints on annual and/or comprehensive assessments.R14's medical record failed to identify a restraint assessment.R14's physician order dated 11/8/22, identified R14 used assistive devices: 2 short side rails on top left and right DPM mattress with mats on the floor by R14's bed for safety. However, the physician order failed to identify a medical need for a restraint.During an observation on 9/8/25 at 7:13 p.m., R14 was lying in bed on her right side towards wall. A DPM was on R14'a bed and a mat was lying on the floor next to R14's bed.During an observation on 9/9/25 at 1:30 p.m., R14 was lying in bed on her back. A lap blanket was covering to her chest. R14 had her eyes closed and had rhythmic deep breathing. R14 was lowered to the floor with a DPM and a mat on the floor next to Rl14's bed.During an interview on 9/9/25 at 3:20 p.m., licensed practical nurse (LPN)-C stated R14 hadn't tried to get out of her wheelchair on her own in a in a long time. Sometimes, R14 would try to get out of her bed but R14 had a mattress with a lip on it so R14 just could get her feet out but that was it. R14 hadn't done that in a really long time either. R14 used to be more active, but not anymore. Like I said, R10 had that lip on her mattress and can't get out of it.During an interview on 9/9/25 at 3:25 p.m., nursing assistant (NA)-A R14 was usually chill and calm. R15 has her bad days sometimes. R14 would refuse to get up and wanted to fuss. That was about it. R14 would sit up at the side of the bed but that was it. R14 was unable to get out of bed because of the DPM. NA-A could not recall the last time R14 had a fall from bed.During an interview on 9/9/25 at 4:07 p.m., the social work designee (SSD) stated nursing performed the restraint assessments every quarter and annually. SSD stated R14 did not utilize a restraint that SSD was aware of. During an interview on 9/9/25 at 4:10 p.m., RN-B stated R14 used a DPM on her bed. R14 had the DPM before RN-B started working at the facility. R14's physician signed the restraint order for the DPM and the DPM was implemented in the fall of 2019. RN-B stated she did not know if a restraint assessment had been completed for R14, but RN-B knew R14 needed the DPM because R14 could no longer walk and would try to get out of bed and fall. RN-B stated she has walked past R14's room and R14 had her feet sticking out of her bed. RN-B would know that's when it was time to get R14 up. RN-B stated R14 did use a low bed with a mat on the floor so the likelihood of injury from a fall was slight, however, RN-B continued to state R14 required a DPM to prevent R14 from getting out of bed.During an interview on 9/10/25 at 3:02 p.m., RN-B stated, in 2018, R14 had a low bed with mats on the floor, a bed alarm and poor cognition so a DPM was the safest alternative for R14 because R14 was climbing out of bed. But that was a long time ago. RN-B stated, in RN-B's opinion, R14 could fall and injure herself. R14 had not

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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** Based on observation, interview and document review, the facility failed to ensure interventions for safe transfers were implemented for 1 of 5 residents (R23) observed during staff assisted transfers. Findings include:R23's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment. R23 required maximal assistance with transfers and ambulation. Diagnoses included depression, hypertension, osteoporosis, osteoarthritis, muscle weakness, and low back pain. R23's care plan with review date 8/20/25, identified R23 had a self-care performance deficit and a goal was listed to maintain her current level of function in all activities of daily living (ADLs) and mobility. Interventions included to transfer with maximal assist of one and a full wheeled walker with all transfers and to ambulate with moderate assist of one with FWW, gait belt and wheelchair to follow in the hallways. On 9/9/25, at 2:30 p.m. R23 was observed seated in her wheelchair in a common area near the nurse's station. Nursing assistant (NA)-A approached R23 and wheeled her wheelchair next to a nearby recliner, locking the wheelchair brakes. NA-A directed R23 to lift her arms up in the air then NA-A wrapped her arms around R23 just below her armpits. NA-A lifted R23 into a standing position, pivoted her toward the recliner and then sat R23 down into the recliner. A gait belt to assist with the resident transfer was not used. When interviewed on 9/9/23, at 2:35 p.m. NA-A stated it had been such a close transfer, and she would not use a gait belt to transfer a resident when the transfer was so close and did not require steps. NA-A would definitely use a gait belt when walking with a resident. When NA-A had assisted R23 to sit in the recliner, it was such a close transfer, so she just grabbed her around her torso and helped her stand and into the recliner. The wheelchair and recliner had been so close that no gait belt was required. NA-A stated she did not think it would bother R23 to raise her arms and be transferred in that manner. During interview on 9/9/23, at 3:14 p.m. licensed practical nurse (LPN)-A stated staff always transferred R23 with a gait belt and assist of one. Even if it was a close transfer, a gait belt would be required. Any resident that needed any type of staff assistance would need to have a gait belt on for the transfer.During interview on 9/10/23, at 4:30 p.m. the director of nursing (DON) stated any time staff assisted a resident to transfer, they were to use a gait belt. Any resident that needed assistance with transfers needed a gait belt and all the staff were aware of that. NA-A should have used a gait belt when transferring R23. Not using a gait belt and grabbing her around the torso to transfer could have injured R23's shoulders or caused her pain. There would have been nothing to grab a hold of, if R23 were to have started to fall during the transfer. The facility policy Wheelchair Transfer dated 1/3/23, directed staff to apply a gait/transfer belt around the resident's waist. Stand in front of the resident and position self to ensure safety of self and resident during transfer. Staff were to grasp the transfer belt at the resident's side with an underhand grasp. On count of three gradually assist resident to a standing position while continuing to grasp the transfer belt. Assist the resident to pivot and lower the resident into the chair. Remove the transfer belt.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a physician order for indwelling urinary catheter for 1 of 1 residents (R21) reviewed for urinary catheter. Findings include:R21's significant change Minimum Data Set (MDS) dated [DATE], identified R21 had a moderate cognitive impairment and diagnoses that included obstructive and reflux uropathy (a blockage in the urinary tract making it difficult to urinate), dementia, and benign prostatic hyperplasia (BPH) (an enlarged prostate). R21 used an indwelling urinary catheter.R21's physician order dated 6/8/22, directed to change foley catheter every 90 days. However, the physician order failed to identify type or size of urinary catheter.R21's care plan revised 12/27/23, identified R21 used an indwelling urinary catheter for obstructive uropathy and BPH. R21 required staff assistance with catheter care and emptying of the urinary bag. R21 used a 16 French (fr) urinary catheter with a 10 milliliter (ml) balloon.During an observation on 9/10/25 at 7:38 a.m., nursing assistant (NA)-B provided catheter care to R21.During an interview on 9/10/25 at 10:30 a.m., registered nurse (RN)-B provided a stock 14 fr urinary catheter with a 30 ml balloon. RN-B stated she would only put in 10 ml of saline into the balloon to match R21's order because it wasn't putting in more saline than what the balloon would hold. RN-B then stated R21's urinary catheter physician order was in R21's care plan, however, the care plan was not a physician order. But that's how staff knew what size to use.During an interview on 9/10/25 at 10:59 a.m., the director of nursing (DON) stated staff were expected to follow the physician orders for urinary catheters and to enter the order into the electronic medical record (EMR) in the physician orders. The care plan was an extension of the order, so all staff were aware how to care for the catheter. When the catheter was changed, nursing was expected to document type and size, how much saline was removed, how much saline was used, was the balloon intact etc. A full description of the procedure. The DON also stated using a 30 ml balloon with only 10 cc of saline was not following the order because the 30 ml balloon would expand and not work accordingly.During a telephone interview on 9/10/25 at 2:16 p.m., nurse practitioner (NP)-A stated R21's urinary catheter should be changed every 90 days due to an increased risk and history of urinary tract infection. However, staff should have an order for foley catheter 16 fr. with a 10 ml balloon and were expected to follow physician order.The facility policy Prevent of Catheter Associated UTIs revised 5/15/23, identified the urinary catheter insertion procedure but failed to identify the need for a physician order.

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F 0711 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a complete medical record was maintained to include the physician progress notes during routine visits for 4 of 14 residents (R2, R10, R32, R39) reviewed in the sample .Findings include:R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 was cognitively intact and had diagnoses that included atrial fibrillation (irregular heartbeat), major depressive disorder, morbid obesity and lymphedema (tissue swelling).R2's medical record identified an Order Summary Report signed by R2's physician and dated 9/3/24. However, R2's medical record failed to identify a physician progress note dated 9/3/24.A facility list was provided and identified the following residents had missing signed visit notes.R10's quarterly MDS dated [DATE], identified R10 had a moderate cognitive impairment and diagnoses that included cerebral palsy, epilepsy, and morbid obesity.R10's medical record failed to identify a physician progress note dated 6/11/25.R32's comprehensive MDS dated [DATE], identified R32 had a moderate cognitive impairment and diagnoses that included Alzheimer's disease, type 2 diabetes, and dementia.R32's medical record failed to identify a physician progress note dated 6/11/25.R39's quarterly MDS dated [DATE], identified R39 had a moderate cognitive impairment and diagnoses that included hypertension, insomnia, weakness, and osteoarthritis.R39's medical record failed to identify a physician progress noted dated 8/1/25.During an interview on 9/10/25 at 1:44 p.m., licensed practical nurse (LPN)-D stated she was responsible for the facility's medical records. LPN-D provided a word document containing a physician progress note for R2 dated 9/3/24. LPN-D stated R2's physician had recently resigned from her former clinic and did not have access to the medical record to document anything into R2's medical record. LPN-D called R2's physician that morning to remind the physician there were missing physician progress notes and the notes needed to be completed. Whenever a medical provider made rounds at the facility, LPN-D would provide a list of residents that needed evaluation and would wait for the completed physician progress note. Once received, LPN-D would ensure the physician progress note was scanned into the resident medical record. LPN-D stated the physician visit had been conducted more than a year prior, but R2's physician kept handwritten notes for review. From those notes, R2's physician was able to type the physician progress note the morning of 9/10/25. LPN-D stated she frequently reminds physicians of missing notes verbally but does not document any type of reminder. It's more of a frustration. At that time, LPN-D provided a list of residents with missing documentation and stated she had never formally brought the concern to administration.During an interview with the director of nursing (DON) and the administrator on 9/10/25 at 4:07 p.m., the administrator stated she was aware R2's physician had some missing documentation out there but was unaware of how long it had been occurring or how extensive. The administrator stated this concern should have been brought forward timelier, within 3 months, so reminders could be documented, and the facility could ensure all resident medical records were complete. The facility policy Physician Visits revised 1/4/23, identified during routine visits, the physician must:a. Review the resident's total program of care, including medications and treatment, at each visit required.b. Write, sign and date progress notes at each visit.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure long term residents received routine physician visits consistently every 60 days as required for 1 of 5 residents (R2) reviewed for unnecessary medications. Findings include:R2's quarterly Minimum Data Set (MDS) dated [DATE], identified R2 was cognitively intact and had diagnoses that included atrial fibrillation (irregular heartbeat), major depressive disorder, morbid obesity and lymphedema (tissue swelling).R2's medical record identified R2 was evaluated by a medical provider on 8/13/24, 11/19/24, 1/14/25, 2/26/25, 4/15/25, 6/11/25 and 8/29/25.During an interview on 9/10/25 at 1:44 p.m., licensed practical nurse (LPN)-D stated she was responsible to ensure residents were evaluated by a medical provider every 60 days. R2 was not seen timely and LPN-D stated she did not have an explanation why. LPN-D stated she keeps a handwritten schedule every month with the provider schedules, and which residents needed evaluation. However, LPN-D disposed of the handwritten schedule after the provider visit was complete. During an interview with the director of nursing (DON) and the administrator on 9/10/25 at 4:07 p.m., the DON stated staff were expected to ensure residents were evaluated by a medical provider every 60 days. This should have been tracked and brought forward to administration. The facility policy Physician Visits revised 1/4/23, identified the resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least every 60 thereafter, a physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Physician orders must be signed and dated at every routine visit.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders which resulted in a medication error rate 9.09% (percent) for 1 of 7 residents (R11) observed to receive mediations during the survey.Findings include:R11's Order Summary Report, dated 8/28/25, identified R11's current physician-ordered medications and treatments. This included an order for potassium chloride extended release 10 milliequivalent (meq) by mouth two times per day, and vitamin D3 25 micrograms (mcg) give two tablets by mouth in the morning, both with start dates 8/26/25. On 9/10/25, at 9:23 a.m. registered nurse (RN)-B prepared R11's medications at a mobile medication cart in the hallway by the nurses' station. RN-B reviewed R11's electronic Medication Administration Record (MAR) which outlined the same order for potassium and vitamin D3 as listed on R11's Order Summary Report (dated 8/26/25). However, RN-B removed an opened bottle of potassium chloride 10 meq tablets and placed two tablets into the medication cup with R11's other oral medications. RN-B then removed an opened bottle of vitamin D3 25 mcg and placed one tablet into the medication cup with R11's other oral medications. RN-B removed an opened bottle of oxybutynin 5 milligram (mg) tablets and placed one tablet into the medication cup with R11's other oral medications. RN-A placed the non-gel or capsule medications into a separate medication cup and started to place the medications into the pill crusher. RN-B was stopped by the surveyor (SA) and asked to review all medications she had prepared to ensure the SA had recorded the medications correctly. Apon review of the medications, RN-B took out a potassium tablet, stating R11 was only supposed to have one tablet and not the two tablets that were prepared and RN-B retrieved the open vitamin D3 bottle and placed an additional vit D3 tablet into R11's prepared medication cup, stating R11 was supposed to receive two tablets of vitamin D3 and not just the one tablet that had been prepared. RN-B then proceeded to crush the medications that could be crushed and put the crushed medications into a cup with vanilla pudding. RN-B took the crushed medications, and other prepared medications and brought them to R11's room where she administered the prepared medications. Immediately following R11's current physician orders were reviewed. R11's Order Summary Report dated 8/28/25, did not include an order for the medication oxybutynin. During interview on 9/10/25, at 10:00 a.m. RN-B stated she is not sure if she would have caught the incorrect doses of potassium and vitamin D3 if the SA had not stopped and asked to review, she may have. RN-B agreed she would have crushed all the crushable tablets and not be able to identify them once they were crushed if the SA had not stopped her to review them, which would have then been administered to R11. RN-B reviewed the medication bottles in the medication cart and observed R11 did have an opened bottle of oxybutynin 5 mg tablets in her drawer. RN-B stated she must have prepared one tablet in with the other medications for R11 in error. RN-B stated she had been nervous and working too quickly in preparing R11's medications that morning and should have slowed down and reviewed and compared the medications to R11's MAR more closely. RN-B stated she had filled out a medication error report form for the medication error of administering the oxybutynin medication without a current order. When interviewed on 9/10/25, at 4:30 p.m. the director of nursing (DON) stated she expected staff to read resident's MAR's closely and to check it with the medication bottles and double check to prevent medication errors. Staff were to follow the seven rights of medication administration guidelines. The facility policy Medication Administration, dated 5/25/23, directed staff to compare medicine listed on the residents MAR with label on the medication container when taking the medication from the cart, when removing the medication from the container and when returning the medication to the cart for three checks. Staff were to follow the eight rights of medication pass. Right patient, right medication, right dose, right time, right route, right documentation, right reason and right response. Staff were not to administer a medication if it was not listed on the residents MAR, and to check with the charge nurse or unit manager.

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	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Meadow Nursing Home	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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	09/10/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to perform timely tracking and trending of potential infectious symptoms to prevent the spread of transmissible organisms in a timely and ongoing manner; including a failure to implement timely transmission-based precautions (TBP) and testing for respiratory illness according to the Centers for Disease Control (CDC) for 3 of 3 residents (R10, R21, R39) who were displaying COVID-19 symptoms.Findings include:The facility NON-COVID Illness tracker dated August 2025, identified the following: unit, resident name, room number, infection type, body of infection, diagnostics, treatment, transmission-based precautions and illness resolution. The tracker also identified the following: On 8/2/25, R39 exhibited a runny nose, cough, and slight sore throat. R39's rapid antigen COVID-19 test was negative and R39 with provided comfort for his symptoms. However, the tracker failed to identify if R39 had a confirmatory negative rapid antigen test and/or was placed into transmission-based precautions until the confirmatory test was collected. On 828/25, R21 exhibited dry heaves, fatigue, runny nose, and cough. R21's rapid antigen COVID-19 test was negative and R21 with provided comfort for his symptoms. However, the tracker failed to identify if R21 had a confirmatory negative rapid antigen test and/or was placed into transmission-based precautions until the confirmatory test was collected. On 8/31/25, R10 exhibited cough, congestion, and sore throat. R10's rapid antigen COVID-19 test was negative and R10 with provided comfort for his symptoms. However, the tracker failed to identify if R10 had a confirmatory negative rapid antigen test and/or was placed into transmission-based precautions until the confirmatory test was collected.R39's quarterly Minimum Data Set (MDS) dated [DATE], identified R39 had a moderate cognitive impairment and diagnoses that included heart failure.R39's nursing progress notes identified the following: On 8/28/25 at 9:05 a.m., R39 was observed to be sitting in his wheelchair by the medication cart, R39 had a runny nose with clear drainage. This staff asked R39 how he was feeling R39 and stated, I don't feel good. R39 complained of runny nose with clear nasal drainage, productive cough with grey phlegm and a slight sore throat. R39 denied having a headache or body aches. Lungs were auscultated (listened to) and were clear throughout. Rapid COVID-19 antigen test completed and R39 tested negative for COVID-19. However, the note failed to identify if R39 was placed into transmission-based precautions until a confirmatory rapid antigen test was collected. On 8/29/25 at 11:05 a.m., R39 was complaining of cold symptoms. R39 had a congested, loose, productive cough that R39 said he could give a sputum sample of, if needed. Gave R39 a cup to expectorate into so staff can see what sputum looks like. Lungs were clear, R39 had a loud murmur. On 8/30/25 at 9:58 a.m., R39's rapid COVID-19 antigen test performed, and results were negative. R39 to continue to remain in room until temp was within normal limits, however, the note failed to identify if R39 was in transmission-based precautions. R21's comprehensive MDS dated [DATE], identified R21 had a mild cognitive impairment and diagnoses that included peripheral vascular disease, dementia and chronic kidney disease.R21's nursing progress notes identified the following: On 8/28/25 at 8:40 a.m., staff reported R21 had dry heaves that morning. R21 was alert and sitting up at the side of his bed, R21 stated I don't feel good. R21 complained of feeling tired, runny nose with clear nasal drainage, and of a productive cough. R21 stated he was able to cough up yellowish phlegm. R21 denied having a headache, sore throat or body aches. Rapid COVID-19 test completed and R21 tested negative for COVID-19. Will continue to monitor. On 8/29/25 at 11:39 a.m., R21 had been weak, easily fatigued, and noted confusion. Vitals: temperature 97.6 degrees F, pulse 64, respirations 22, and oxygen saturations 96% on room air. However, R21's bp was low- 85/59 auto, 80/62 manual. Encouraged R21 to drink fluids and monitored for continued concerns. When R21 got back to his room, R21 needed moderate assist of 1 to transfer from wheelchair to recliner. At 1:50 p.m., R21 participated in a small group game of rummy in the activity room with activity staff. At 1:54 p.m., R21 attended church in the activity room. At 3:11 p.m., R21 came to activity room this afternoon for ice cream cone social with other residents and staff. On 8/30/25 at 10:17 a.m., R21's rapid COVID-19 antigen test performed, and results were negative R10's quarterly MDS dated [DATE], identified R10 had a moderate cognitive impairment and diagnoses that included cerebral palsy, epilepsy, and morbid obesity.R10's nursing progress notes identified the following: On 8/31/25 at 7:57 a.m., R10 was showing signs of cough, congestion, and a dry/sore throat. A rapid COVID-19 antigen test which was negative and R10 did not have a fever at this time. However, the note failed to identify if R10 was placed into transmission-based precautions until a confirmatory test could be collected. At 4:14 p.m., R10 complained of congestion; Lungs