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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5PP5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00847

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245333**
2.STATE VENDOR OR MEDICAID NO.
(L2) **138740500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRFAX COMMUNITY HOME**
(L4) **300 TENTH AVENUE SOUTHEAST**
(L5) **FAIRFAX, MN** (L6) **55332**

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 **12/13/2013** (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)
12/31

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 1/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/06/2014 (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
08/01/1986
(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
01/22/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5333

Fairfax Community Home was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on October 30, 2013. On December 13, 2013, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction. On December 18, 2013 the Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on October 30, 2013, effective December 6, 2013.

Refer to the CMS-2567B for both health and life safety code. The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number: 24-5333

March 7, 2014

Ms. Judith Sandmann, Administrator
Fairfax Community Home
300 Tenth Avenue Southeast
Fairfax, Minnesota 55332

Dear Ms. Sandmann:

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 December 6, 2013, the above facility is certified for:

50 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 - 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 Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245333	A. Building B. Wing	12/13/2013

Name of Facility	Street Address, City, State, Zip Code
FAIRFAX COMMUNITY HOME	300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 12/06/2013	ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 12/06/2013	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 12/06/2013
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 12/06/2013	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 12/06/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	14022	1-21-14	18623	12/13/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
10/30/2013	YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245333	01 - MAIN BUILDING	12/18/2013

Name of Facility	Street Address, City, State, Zip Code
FAIRFAX COMMUNITY HOME	300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	11/18/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By 16022	Date: 1/21/14	Signature of Surveyor: 22373	Date: 12-18-13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/31/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245333	A. Building 01 - MAIN BUILDING B. Wing	12/18/2013

Name of Facility	Street Address, City, State, Zip Code
FAIRFAX COMMUNITY HOME	300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	11/18/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 10/31/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 21, 2014

Ms. Judith Sandmann, Administrator
Fairfax Community Home
300 Tenth Avenue Southeast
Fairfax, MN 55332

RE: Project Number S5333023

Dear Ms. Sandmann:

On November 14, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 30, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 13, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 18, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 30, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 6, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 30, 2013, effective December 6, 2013 and therefore remedies outlined in our letter to you dated November 14, 2013, will not be imposed. Your request for a continuing waiver involving the deficiency cited under K0067 at the time of the October 31, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Telephone: 651-201-3792 Fax: 651-201-3790

Enclosure

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5PP5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00847

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245333**
2.STATE VENDOR OR MEDICAID NO.
(L2) **138740500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRFAX COMMUNITY HOME**
(L4) **300 TENTH AVENUE SOUTHEAST**
(L5) **FAIRFAX, MN** (L6) **55332**

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 **10/30/2013** (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)
12/31

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sandra Nelson, HFE NE II 12/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 01/17/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
08/01/1986
(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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5333

At the time of the standard survey completed October 31, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that were not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7562

November 14, 2013

Ms. Judith Sandmann, Administrator
Fairfax Community Home
300 Tenth Avenue Southeast
Fairfax, Minnesota 55332

RE: Project Number S5333023

Dear Ms. Sandmann:

On October 31, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 9, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 9, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 30, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 April 30, 2014 (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 Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
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
	245333	A. BUILDING _____ B. WING _____	10/30/2013

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FAIRFAX COMMUNITY HOME	300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332

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F 000	INITIAL COMMENTS The facility's plan of correction (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 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	See Attached	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	See Attached All Completiion date are 12/6/2013	

12-3-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Landmann	ADMINISTRATOR	11-26-13

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

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F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free from unnecessary medications for 5 of 6 (R23, R38, R22, R12, R26). R23 received Ambien (a hypnotic medication commonly used short term, less than 14 days, for insomnia) from 1/8/13 to 10/29/13, without clinical justification for its extended use as directed by the manufacturer's recommendations. The Diagnoses List from the care plan dated 1/3/13, indicated R23's diagnoses included but were not limited to insomnia and a left femur fracture that required surgical repair. During interview on 10/28/13, at 12:30 p.m. R23 stated he slept well at night, has taken a sleeping pill for a long time and added that he, "needs," a sleeping pill to fall asleep. R23 stated that he liked to lay down in bed at 6:30 p.m. fell asleep around 8:30 p.m. and woke up between 6:00 a.m. to 7:30 a.m. During interview on 10/28/13, at 9:43 a.m. the director of nursing (DON) and registered nurse (RN)-B verified R23 received Ambien 5 milligrams (mg) for insomnia since 1/8/13. DON confirmed no sleep assessment or study was completed prior to starting or continuing the use of the Ambien and should have been. DON and RN stated R23 tried Halcion (a hypnotic medication used for insomnia) when he was first admitted. DON reported R23 had side effects from the	F 329		

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F 329	Continued From page 2 Halcion so it was changed to Ambien. DON reported the facility had not address or assessed the underlying cause of R23's insomnia, therefore, did not know if any non-pharmacological interventions were appropriate. DON verified she thought the pharmacist (P)-A would address if there was a medication being used inappropriately and P-A had not made such recommendations. During interview 10/30/13, at 12:35 p.m. the facility's consulting P-A stated Ambien should be used no longer than 14 days due to the side effects of the medication, which include addiction. P-A reported he reviewed R23's medications on a monthly basis and confirmed that during these reviews he had not identified R23 received Ambien since 1/13. P-A stated if he knew the Ambien was ordered he would have recommended to discontinued or changed to a more appropriate long term sleeping agent and that a proper assessment be completed to address the underlying factors for the insomnia. Physician Fax Sheet from the facility to medical doctor (MD)-A dated 12/24/12, noted, "Resident stated he has been having trouble sleeping and denies pain. He request that you be consulted about medication to help him sleep." Physician Order Sheet and Progress Note dated 12/24/13, indicated the physician ordered Halcion 0.25 mg, one tab before bed as needed for insomnia. No sleep assessment was completed at this time to determine the underlying factors for the inability to sleep. On 1/8/13, the Physician Order Sheet and Progress Note identified that the Halcion 0.25 mg was discontinued and R23 was to start Ambien	F 329		

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F 329	Continued From page 3 10 mg for insomnia. The Physician Progress Note dated 1/8/13, indicated R23 feels he needs something for sleep due to difficulty falling asleep. The Progress Note identified R23 was on Halcion, appeared drowsy and directed to discontinue the Halcion and start Ambien 10 mg every night before bed as needed. On 2/3/13, at 3:15 a.m. a Nursing Progress Note noted R23 had Ambien 10 mg at bed time and slept four hours, with middle of the night awakening. The note indicated R23 threw off his protect heel boots, blankets, pillows onto the floor. The note identified R23 was demanding of staff to put pillows and blankets back on the bed and had done this repeatedly. On 2/5/13, the Physician Order Sheet and Progress Note indicated to decrease the Ambien to 5 mg every 4 hours as needed. On 2/19/13, the Physician Order Sheet and Progress Note indicated to schedule the Ambien 5 mg daily before bed time. On 2/5/13, at 9:45 a.m. a Nursing Progress Note indicated MD-A reviewed R23's use of Ambien and indicated R23 insisted that he needs a, "sleeping pill." MD-A noted R23 was not always receiving this (sleeping pill) but has noted increased confusion at times when he takes this. It directed to read Nursing Progress Note from 2/3/13, and to decrease the Ambien to 5 mg as needed at that time. A Nursing Progress Note dated 2/19/13, at 11:00 a.m. directed to schedule Ambien 5 mg every four hours per resident request. The Physician Order Sheet and Progress Notes	F 329		

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F 329	Continued From page 4 from 2/19/13, to 10/22/13, identified R23 was to receive Ambien 5 mg at bed time daily. On 4/4/13, at 11:15 a.m. a Nursing Progress Note identified a quarterly care conference was held with resident and team. The note identified the scheduled Ambien was helping per resident. Fairfax Community Home Drug Regimen Review report completed by P-A dated 2/16/13, indicated to discontinue the as needed Halcion 0.25 mg, complete a sleep assessment if there is a sleep problem and check pain control post hip surgery. According to the Physician Order Sheet and Progress Note the Halcion was discontinued the prior month, and there was no recommendations made for the Ambien. The Psychoactive Medication Quarterly Evaluation dated 9/26/13, indicated that resident received Ambien 5 mg every night before bed due to inability to sleep at night. It identified resident did have Tylenol scheduled for pain and noted the insomnia appeared to be controlled. Review of the Medication Administration Record (MAR) from 1/8/13 to 10/30/13, indicated R23 received Ambien as ordered by the physician during that time, with the exception of a missed dose in October. In 2/13, the MAR indicated when the Ambien was as needed only from 2/5/13 to 2/19/13, the Ambien was administered 11 out of 14 days with no documentation for use of the as needed dose or results of the medications effectiveness. The Sleep Assessment policy and procedure dated 2010, indicated staff were to complete a sleep assessment on any resident who complains	F 329		

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F 329	Continued From page 5 of sleep issues. The Psychotherapeutic Medications Policy and procedure dated 2007, identified that an assessment would be performed prior to initiation of psychotherapeutic medication, quarterly, with change of condition and as needed (PRN). The policy identified that documentation must include a root cause analysis of behaviors, with identified target behaviors along with individualized interventions to support the use of the psychotherapeutic medication. R38 was not reviewed for adequate indication for use of an antianxiety medication and was not comprehensively assessed for insomnia prior to resuming an antidepressant medication (Elavil) used for sleep. R38 was admitted on 5/6/13, per the Admission Record. The quarterly Minimum Data Set (MDS) dated 8/13/13, included diagnoses of dementia, diabetes mellitus (DM) and anxiety disorder. R38 had a history of a closed head injury related to a fall in May 2013. The MDS indicated R38 had a Brief Interview of Mental Status (BIMS) score of four, indicating severe cognitive impairment. The patient health questionnaire (PHQ9) score was a zero and indicated R38 had no difficulty falling asleep, staying asleep or sleeping too much. The MDS indicated R38 had no behaviors. A Psychoactive Medication Quarterly Review dated 5/13/13, noted R38 was admitted on Ativan and will continue to monitor and assess if medication can be reduced. The Behavioral Symptoms Care Area	F 329		

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F 329	Continued From page 6 Assessment (CAA) dated 5/19/13, indicated R38 exhibited behaviors of wandering and was easily redirected. The CAA noted R38 was receiving Ativan for anxiety and Elavil for insomnia. The CAA indicated no referrals were needed. The social services/activities care plan dated 5/23/13, noted R38 was adjusting well to long term care and included an intervention to observe for signs of anxiety and approach in a calm reassuring manner and provide reassurance. The at risk for side effects from antidepressant and antianxiety medications care plan dated 5/23/13, included a goal of "will receive lowest effective dose and will not have side effects of medication." The care plan failed to identify any non-pharmacological interventions to be used for sleep and anxiety. The Admission History and Physical dated 5/5/13, noted R38 had fallen and struck the back of her head, sustaining a scalp hematoma without laceration. A Drug Regimen Review Report dated 5/13/13, noted Elavil was a "high risk drug" and suggested to do a sleep assessment to determine underlying cause of sleep problem and noted additive anticholinergic side effects probable with use of Elavil and Oxybutynin, avoid concurrent use in the elderly. Review of the Benzodiazepine/Anxiolytic Drug Monitor for May 2013 through September 2013, revealed a description of behaviors to be managed of anxiety, pacing and fidgeting. The behaviors were noted to have occurred in May 2013 on the first two days after admission only, did not occur at all in June 2013, occurred on the	F 329		

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F 329	Continued From page 7	F 329		

night shift only from July 20 through July 25, 2013 and occurred from August 2 through August 7, 2013, only, and did not occur in September 2013. A side effect of confusion was noted in May 2013 through August 2013.

Review of the Hypnotic Drug Monitor for May 2013 through September 2013, revealed R38 was being monitored for the use of Halcion (a hypnotic medication) which had been discontinued in June 2013 and not Elavil which was being administered. From May through September 2013, R38 was noted to have no sleep disturbance noted on all nights with the exception of five nights in July, and three nights in August.

A physician progress note dated 6/4/13, noted R38 had been in the facility for a month and " has adjusted nicely."

A Drug Regimen Review Report dated 6/21/13, noted Elavil produces strong anticholinergic effect and concurrent use with Oxybutynin should be avoided.

An Interdisciplinary Progress Notes dated 7/25/13, noted R38 had increased restlessness, anxiety, fidgeting and pacing especially at night and noted R38 needed to void and was unable to find a bathroom.

R38 had falls on 8/3/13, with a bruise to the left side of the head and neck and on 10/7/13, with a large bruise to the left hip.

The Care Plan Conference Summary dated 8/21/13, noted the Elavil had been discontinued on 7/9/13 and did not note any change in sleep

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F 329	Continued From page 8 patterns or anxiety noted. An Interdisciplinary Progress Notes dated 9/8/13, noted R38 complained of the room spinning when getting up from a chair and was found to have a low blood pressure of 96/50. Although the Hypnotic Drug Monitor noted R38 had no sleep disturbance noted on all but three nights from 8/1/13-9/3/13, the physician progress note dated 9/3/13, indicated R38 had not been sleeping well since off the Elavil and ordered to restart the Elavil at bedtime. Review of the September 2013 MAR revealed R38 received Ativan (a medication used to treat anxiety) 0.5 mg three times daily, Elavil (used for sleep) 25 mg every bedtime and Oxybutynin (used to treat symptoms of overactive bladder) 10 mg. The Elavil was discontinued on 7/9/13 and was restarted on 9/3/13. When interviewed on 10/30/13, at 8:59 a.m. licensed practical nurse (LPN)-C stated R38 was usually pretty good when sitting out in the dayroom and did not exhibit any behaviors. When interviewed on 10/30/13, at 9:03 a.m. RN-B stated non-pharmacological interventions were tracked for PRN medications only and would expect them to be included on a resident's care plan. RN-B stated she would expect nurses to document in the progress notes or a flow sheet if a resident was up at night. When interviewed on 10/30/13, at 9:08 a.m. LPN-A (the activities/social service staff) stated she was not involved in resident behaviors. When interviewed on 10/30/13, at 9:12 a.m. nursing assistant (NA)-B stated R38 was calm all	F 329		

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F 329	Continued From page 9 the time and didn't have sleep disturbance the nights she worked. The DON was interviewed on 10/30/13, at 9:15 a.m. and stated she was unable to provide any additional information for R38 and R38 "should have been locked at for a gradual dose reduction of Ativan." When interviewed on 10/30/13, at 12:44 p.m. the DON stated if a sleep assessment was done for R38 it would be in the chart and she was 90% sure one was not done. A sleep assessment was not provided for R38. P-A was interviewed on 10/30/13, at 12:34 p.m. and stated he had not recommended a dose reduction of Ativan for R38 and would do so in December. P-A stated R38's Elavil was for back pain not insomnia and thought the facility did not know the indication for use. The facility Psychotherapeutic Medications policy dated 2007, directed "A resident will not receive psychotherapeutic medications unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's target behavioral disturbance. A psychotherapeutic medication will be defined as any medication which is prescribed for the purpose of modifying mood and/or behavior." The Sleep Assessment Policy and Procedure dated 2010, directed to complete a sleep assessment on any resident who complains of sleep issues, interview resident and representative to identify causal factors for sleeplessness and develop an individualized plan for assistance with sleep hygiene based on the	F 329		

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F 329	Continued From page 10 assessment. R22 was admitted with diagnosis of Parkinson's disease, diabetes mellitus type II, hypertension, atrial fibrillation (an irregular heartbeat), and cardiomegaly. The facility failed to ensure adequate indication for Seroquel for Resident R22. In addition, the facility continued to provide Macrobid/nitrofurantoin/Macrodantin (an antibiotic) despite adverse consequences (worsening kidney function). Seroquel: R22 was observed on 10/27/13, at 4:00 p.m. the observed to be very sleepy. On 10/28/13, at 9:18 a.m. R22 was awake and talkative. On 10/29/13, at 8:29 a.m. R22 was eating breakfast and asking a nurse when he would have his medications, the nurse responded in a minute. At 8:30 a.m. she delivered the medications to his table. The care plan dated 6/13/12, indicated use of anti-psychotropic medications which was Seroquel for hallucinations. The medical record lacked evidence of R22 ever having hallucinations. The MDS dated 8/1/13, revealed a BIMS of 9 which indicated moderate cognitive impairment. On 8/25/13, at 12:00 p.m. the consultant pharmacist recommended to discontinue the Seroquel for hallucinations at bedtime, because the resident was on Sinemet (a medication for Parkinson's disease which may cause hallucinations). The recommendation further stated: "Can Seroquel be discontinued or held?"	F 329		

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F 329	Continued From page 11 The physician's reply stated, "Continue same meds [medications]." The reply lacked evidence of the justification and indication for the continued Seroquel use. P-A was interviewed on 10/30/13, at 12:56 p.m. and verified R22 continued to receive Seroquel despite no evidence to support hallucinations. Macrobid: R22 had abnormal kidney function tests and continued to receive Macrobid for urinary tract infections without justification. R22 was prescribed Macrobid 50 mg on 7/10/12. The 9/20/12, P-A recommended to stop Macrobid due to impaired glomerular filtration rate (GFR) was accepted and signed by the primary doctor on 10/2/12. The recommendation indicated: "Product selection: Macrobid 100 mg bid [twice a day] was ordered for a UTI [urinary tract infection] in this 86 year old with a GFR of 42. Macrobid will not reach sufficient concentrations in the urinary tract when GFR is below 60. Macrobid elderly: use is not recommended due to potential for renal impairment; alternative agents [are] preferred. The pharmacy consultant notice indicated use in the elderly, particularly females receiving long-term prophylaxis for recurrent UTIs, has been associated with an increased risk of hepatic [liver] and pulmonary [lung] toxicity, and peripheral neuropathy [nerve pain in the arms and legs]. Avoid or use extreme caution when prescribing to elderly patients, particularly those with decreased renal function. Monitor closely for toxicities." The laboratory results were reviewed from 5/23/12, going forward and the following was	F 329		

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F 329	Continued From page 12 noted: - On 5/23/12, blood urea nitrogen (BUN-test measures the amount of nitrogen in your blood that comes from the waste product urea with 16 to 20 mg being within normal range) was elevated at 40, Creatinine (Cr-a test that measures kidney function and normal range is 0.6 to 1.2 mg per deciliter (dL) in adult males and 0.5 to 1.1 milligrams per deciliter in adult females) elevated at 1.21, Bun/Creatinine ratio elevated at 33.1 (A normal BUN:Creatinine ratio is 15:1, according to "Renal Pathophysiology." When the ratio approaches 20:1, it suggests a problem with blood flow to the kidney. Alternatively, a BUN: Creatinine ratio of 10:1 suggests an intrinsic renal disease). R22 was again ordered Macrobid 50 mg by mouth every day for maintenance dose on 7/2/13. - On 8/14/13, laboratory results of BUN elevated at 36, Creatinine elevated at 1.40, Bun/Cr ratio elevated 25.7. R22 still remained on the Macrobid medication. Despite the compromised kidney function laboratory results, R22 continued to receive the Macrobid without justification from the physician. P-A was interviewed on 10/30/13, at 12:56 p.m. P-A verified R22 continued to receive Seroquel despite no evidence to support hallucinations and verified R22 received Macrobid 50 mg every morning with breakfast despite the compromised kidney labs, and the pharmacy recommendation to stop the medication. P-A stated he just rewrote the recommendation to stop Seroquel for October 2013, but stated if the doctor would write Sinemet induced hallucinations as an indication for Seroquel, that would be an adequate indication for use; but they would not stop it and "I just keep	F 329		

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F 329	Continued From page 13 saying that I can't find documentation for hallucinations." P-A further stated that he just wrote recommendation to stop Macrobid due to worsening kidney function in October 2013, but that recommendation was not yet on the medical record, and verified that he had failed to identify the Macrobid as potentially harmful related to baseline kidney laboratory values from July of 2013 to October of 2013. R12 was admitted to the facility with diagnoses of congestive heart failure and valvular heart disease, atrial fibrillation, anemia, dementia, and hypertension per the Admission Record dated 6/13/12. R12 had impaired kidney function and received Macrobid which would not reach sufficient therapeutic levels due to compromised kidney function. R12's care plan dated 6/25/12, included bladder incontinence secondary to some function loss of control and a history of UTI episodes with increased weakness, check every two hours during waking hours, if resident needs to toilet, every two hour and as needed toileting on the night shift. R12 wore pads during the day and pull ups at night. Assist of one to two staff to help with peri-care. R12 does occasionally use her call light to ask for help, she does not use it reliably, tabs monitor on bed and wheelchair to alert staff of self-transfer attempts. Encourage fluids, and antibiotics as ordered. The 9/20/12, P-A recommended to stop Macrobid due to impaired GFR was accepted and signed by the primary doctor on 10/2/12. The recommendation indicated: "Product selection: Macrobid 100 bid was ordered for a UTI in this 89	F 329		

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F 329	Continued From page 14 year old with a GFR of 42. Macrobid will not reach sufficient concentrations in the urinary tract when GFR is below 60. Macrobid elderly: use is not recommended due to potential for renal impairment; alternative agents [are] preferred. P-A's notice indicated Use in the elderly, particularly females receiving long-term prophylaxis for recurrent UTIs, has been associated with an increased risk of hepatic and pulmonary toxicity, and peripheral neuropathy. Avoid or use extreme caution when prescribing to elderly patients, particularly those with decreased renal function. Monitor closely for toxicities." The physician's orders were reviewed from 4/9/13, going forward and the following was noted: - On 4/9/13, Macrobid 100 mg twice a day for ten days was ordered for a urinary tract infection. - On 5/28/13, Augmentin (an antibiotic) 875 mg twice a day for ten days was ordered for a urinary tract infection. - On 6/14/13, Bactrim DS (an antibiotic) twice a day for 10 days was ordered for a urinary tract infection. - On 7/1/13, Macrobid 100 mg twice a day for 10 days. - On 7/2/13, Macrodantin 50 mg tabs every day after finishing Macrobid 100 mg twice a day, and Macrobid 50 mg every day was ordered to start 7/12/13, and remained in effect through the survey. R12's laboratory results were reviewed from 10/2/12, going forward and the following was observed. - On 10/2/12, the BUN was 28, the Creatinine was 1.2, and the GRF was 42. - On 6/12/13, laboratory results of Creatinine	F 329		

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F 329	Continued From page 15 1.14, estimated glomerular filtration rate (EGFR) 45 (moderately decreased EGFR). - On 6/27/13, BUN 26, Creatinine 1.60, EGFR 30 (moderately decreased) On 10/29/13, at 9:20 a.m. an interview with LPN-X on the use of Macrobid for a resident in known renal failure and prior consultant pharmacy recommendation to stop the use of Macrobid due to impaired GFR. The conversation was joined by DON and MDS coordinator. - At 10:00 a.m. The DON and case manager verified that Macrobid should not be given to renal compromised patients, and that the R12 remained on the medication from July 2 to the current date. On 10/29/13, at 3:15 p.m. the DON verified that the order for Macrodantin was not transcribed correctly, and Macrobid 50 mg everyday continued for a renal compromised resident with worsening Creatinine and GFR according to lab values, and no evidence of consultant pharmacy addressing after 10/2/2012. The policy on Psychotropic medications - Use of dated 2007 (from the Pathway Health Services Manual "A Culture of Safety." Indicated each resident will have failed behavioral programming and/or environmental changes. Each psychotropic med with have physician orders that include: name and strength, route of administration, frequency of administration, supporting diagnosis, target behaviors (if applicable) and individualized interventions. Prior to administration of an antipsychotic medication, the following must be documented. "Documentation must include a root cause analysis of behaviors. An appropriate supporting	F 329		

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F 329	Continued From page 16 diagnosis and behavioral symptom being treated There will be at least one measureable target behavior identified, which will be monitored every shift on the target behavior flow sheet (and identified in the informed consent form. Target behaviors and individualized interventions will be reviewed at a minimum quarterly with a change in condition and PRN with IDT [interdisciplinary] team." R26 diagnoses include acute cerebrovascular accident (CVA), history of atrial fibrillation, Deep venous thrombosis (DVT), hemiplegia, and transient ischemic attack (TIA) obtained from the undated Admission Record sheet. R26 had physician orders to receive Aspirin (an anti-inflammatory used to prevent heart attack), Plavix (used to prevent blood clots) and Coumadin (to treat blood clots and to lower the chance of blood clots forming in your body all together). R26 continued to receive the three anti-coagulants without justification. R26's quarterly MDS dated 9/9/13, indicated resident had received an anticoagulant in the last seven days of the assessment period. During review of R26's Physician's Orders dated 10/15/13, R26 received 1.5 mg of Coumadin every day, Aspirin 81 mg every day and Plavix 75 mg every day. The pharmacy medication regimen reports were reviewed from 8/23/12, going forward and the following was noted: - On 8/23/12, the Fairfax Community Home Drug Regimen Review Report P-A had indicated "DRUG NEED: PLAVIX 75 WITH ASA AND COUMADIN. VERY HIGH BLEEDING RISK	F 329		

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F 329	Continued From page 17 WITH THIS COMBO. COUMADIN AND ASA SHOULD SUFFICE FOR ANTICOAGULATION AND ANTIPLATELET." This recommendation was signed and dated by the attending physician "D/C [discontinue] Plavix" on 9/25/12. - On 4/21/13, the Fairfax Community Home Drug Regimen Review Report P-A indicated "REVIEW NEED FOR PLAVIX 75 MG WITH ASA 81 MG IN A PERSON ANTICHOAGULATED ON WARFARIN. THE ASA SHOULD SUFFICE WITH THE WARFARIN. CAN THE PLAVIX BE DISCONTINUED TO REDUCE BLEEDING RISK?" The recommendation was signed by the attending physician on 4/30/13, and on the space above the signature, was noted "Plavix D/C on 9/25/13-restarted on 10/31/13 per family request due to [d/t] possible TIA's (rolling out of bed x [times] 2 & not remembering)." - On 9/24/13, the Fairfax Community Home Drug Regimen Review Report annual laboratory (Lab) work P-A noted some of the medications R26 received which included Aspirin, Coumadin and Plavix all listed and the physician had signed and dated the report on 10/1/13, indicating the lab work was scheduled for 10/9/13. In further review of R26's signed Physician Orders from October 2012 through October 2013, and Medication Administration Record sheets from January 2013 through October 2013 revealed R26 was and received the Plavix the whole time even during the time physician stated he had discontinued the medication. On 10/30/13, at 12:40 p.m. during a telephone interview, P-A stated R26 using all the medications at the same time would be beneficial for the R26 as they do act a little differently in the pharmacological action but it was the physician's	F 329		

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F 329	Continued From page 18 responsibility to state the clinical justifiaction for the resident to continue using all the three medications that are in the same class. P-A further stated R26 had a history atrial fibrillation, DVT, TIA's and CVA and thought R26 had undiagnosed coronary artery disease but overall clinically there was a high risk of bleeding when all three medications are used at the same time. On 10/30/13, at 12:52 p.m. during a telephone interview with the physician he stated he did not remember talking to family regarding restarting the medication. He further stated if the pharmacist had recommended discontinuing the medication he had discontinued it and did not have a recollection he had written an order to restart the medication back again as noted in the facility drug regimen report signed 4/30/13. Additionally, the physician stated if medication was contraindicated, but resident was still using it, the clinical use would be documented in the resident chart which as to why R26 was taking all the three medications. In regards to the dates on the 4/30/13, drug regimen report he neither was able to explain why the dates were off. The medical record lacked evidence of the judtification for the three anticoagulants usage. The facility Orders for Anticoagulants policy dated 10/21/13, lacked information on the benefits and risks associated with using multiple blood thinners, anticoagulants, and when resident had a clinical indication to use all medications where it would be documented by the attending physician.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334	See Attached	

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F 334	Continued From page 19 that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal	F 334		

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F 334	Continued From page 20 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain information regarding residents pneumococcal immunization status for 2 of 5 (R49, R7) residents reviewed for immunizations. Findings include: R49 admitted on 10/2/13, had no pneumococcal information identified in his chart to determine whether or not he had been immunized or need to be immunized.	F 334		

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F 334	Continued From page 21 R7 was admitted on 10/3/13. The Resident Tuberculosis and Surveillance and Immunization Record dated 10/3/13, identified no pneumococcal information identified in his chart to determine whether or not he had been immunized or need to be immunized. On 10/29/13 at 2:26 p.m. director of nursing (DON) verified that pneumococcal immunization information was not obtained for R7 or R49 since admission. DON reviewed the Admission Check which indicated the pneumococcal information was not received for R49. The facility Pneumovax Vaccine policy dated 2010, indicated that all new admissions would be screened and given a Pneumovax vaccine unless specifically ordered otherwise by primary physician. The policy noted that a record of vaccination would be placed in the resident's medical record and in their vaccination record.	F 334		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428	See Attached	

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F 428	Continued From page 22 Based on interview and document review, the facility failed to ensure residents were free from unnecessary medications for 3 of 6 (R23, R38, R12). R23's Ambien (a hypnotic medication commonly used short term, less than 14 days, for insomnia) was used from 1/8/13 to current, and the pharmacist did not identify or report irregularities. During interview on 10/28/13, at 12:30 p.m. R23 stated he slept well at night, has taken a sleeping pill for a long time and added that he, "needs," a sleeping pill to fall asleep. R23 stated that he liked to lay down in bed at 6:30 p.m. fell asleep around 8:30 p.m. and woke up between 6:00 a.m. to 7:30 a.m. Physician Fax Sheet from the facility to medical doctor (MD)-A dated 12/24/12, noted, "Resident stated he has been having trouble sleeping and denies pain. He request that you be consulted about medication to help him sleep. "Physician Order Sheet and Progress Note dated 12/24/12, indicated the physician ordered Halcion 0.25 milligrams (mg), one tab before bed as needed for insomnia. No sleep assessment was completed at that time to determine the underlying factors for the inability to sleep. On 1/8/13, the Physician Order Sheet and Progress Note identified that the Halcion 0.25 mg was discontinued and R23 was to start Ambien 10 mg for insomnia. The Physician Progress Note dated 1/8/13, indicated R23 feels he needs something for sleep due to difficulty falling asleep. The Progress Note identified R23 was on Halcion, appeared drowsy and directed to discontinue the Halcion and start Ambien 10 mg	F 428		

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F 428	Continued From page 23 every night before bed as needed. On 2/3/13, at 3:15 a.m. a Nursing Progress Note noted R23 had Ambien 10 mg at bed time and slept four hours, with middle of the night awakening. The note indicated R23 threw off his protect heel boots, blankets, pillows onto the floor. The note identified R23 was demanding of staff to put pillows and blankets back on the bed and had done that repeatedly. On 2/5/13, the Physician Order Sheet and Progress Note indicated to decrease the Ambien to 5 mg every four hours as needed (PRN). On 2/19/13, the Physician Order Sheet and Progress Note indicated to schedule the Ambien 5 mg daily before bed time. On 2/5/13, at 9:45 a.m. a Nursing Progress Note indicated MD-A reviewed R23's use of Ambien and indicated R23 insisted that he needs a, "sleeping pill." MD-A noted R23 was not always receiving the (sleeping pill) but has noted increased confusion at times when he takes that. It directed to read Nursing Progress Note from 2/3/13, and to decrease the Ambien to 5 mg as needed at that time. A Nursing Progress Note dated 2/19/13, at 11:00 a.m. directed to schedule Ambien 5 mg every four hours per resident request. The Physician Order Sheet and Progress Notes from 2/19/13, to 10/22/13, identified R23 was to receive Ambien 5 mg at bed time daily. On 4/4/13, at 11:15 a.m. a Nursing Progress Note identified a quarterly care conference was held with resident and team. The note identified the	F 428		

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F 428	Continued From page 24 scheduled Ambien was helping per resident. Fairfax Community Home Drug Regimen Review report completed by pharamcist (P)-A dated 2/16/13, indicated to discontinue the as needed Halcion 0.25 mg, complete a sleep assessment if there is a sleep problem and check pain control post hip surgery. According to the Physician Order Sheet and Progress Note the Halcion was discontinued the prior month, and there was no recommendations made for the Ambien. R23's Monthly Drug Review Documentation Form for Fairfax Nursing Home identified P-A reviewed R23's medications on 2/16/13, 3/19/13, 4/41/13, 5/13/13, 6/21/13, 7/15/13, 8/26/13, 9/24/13, and 10/21/13, with no recommendations related to the extended use of Ambien. The Psychoactive Medication Quarterly Evaluation dated 9/26/13, indicated that resident received Ambien 5 mg every night before bed due to inability to sleep at night. It identified resident did have Tylenol scheduled for pain and noted the insomnia appeared to be controlled. Review of the Medication Administration Record (MAR) from 1/8/13 to 10/30/13, indicated R23 received Ambien as ordered by the physician during that time, with the exception of a missed dose in October. In 2/13, the MAR indicated when the Ambien was as needed only from 2/5/13 to 2/19/13, the Ambien was administered 11 out of 14 days with no documentation for use of the as needed dose or results of the medications effectiveness. During interview on 10/28/13, at 9:43 a.m. the director of nursing (DON) and registered nurse	F 428		

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F 428	Continued From page 25 (RN)-B verified R23 received Ambien 5 mg for insomnia since 1/8/13. DON confirmed no sleep assessment or study was completed prior to starting or continuing the use of the Ambien and should have been. DON and RN stated R23 tried Halcion (a hypnotic medication used for insomnia) when he was first admitted. DON reported R23 had side effects from the Halcion so it was changed to Ambien. DON reported the facility had not address or assessed the underlying cause of R23's insomnia, therefore, did not know if any non-pharmacological interventions were appropriate. DON verified she thought P-A would address if there was a medication being used inappropriately and P-A had not made such recommendations. During interview 10/30/13, at 12:35 p.m. P-A stated Ambien should be used no longer than 14 days due to the side effects of the medication, which include addiction. P-A reported he reviewed R23's medications on a monthly basis and confirmed that during these reviews he had not identified R23 received Ambien since 1/13. P-A stated if he knew the Ambien was ordered he would have recommended to discontinued or changed to a more appropriate long term sleeping agent and that a proper assessment be completed to address the underlying factors for the insomnia. R38's Ativan (an antianxiety medication) was not reviewed for adequate indication for use and in the presence of potential adverse consequences and failed to identify Elavil (an antidepressant medication) was restarted without adequate indication and with the potential for a serious drug	F 428		

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F 428	Continued From page 26 interaction with concurrent use of Oxybutynin (a medication used to control the urinary bladder). R38 was admitted on 5/6/13. The quarterly Minimum Data Set (MDS) dated 8/13/13, included diagnoses of dementia, diabetes mellitus (DM) and anxiety disorder. R38 had a history of a closed head injury related to a fall in May 2013. The MDS indicated R38 had a Brief Interview of Mental Status (BIMS) score of four, indicating severe cognitive impairment. The patient health questionnaire (PHQ9) score was a zero and indicated R38 had no difficulty falling asleep, staying asleep or sleeping too much. The MDS indicated R38 had no behaviors. The Behavioral Symptoms Care Area Assessment (CAA) dated 5/19/13, indicated R38 exhibited behaviors of wandering and was easily redirected. The CAA noted R38 was receiving Ativan for anxiety and Elavil for insomnia. The CAA indicated no referrals were needed. A Psychoactive Medication Quarterly Review dated 5/13/13, noted R38 was admitted on Ativan and will continue to monitor and assess if medication can be reduced. The social services/activities care plan dated 5/23/13, noted R38 was adjusting well to long term care and included an intervention to observe for signs of anxiety and approach in a calm reassuring manner and provide reassurance. The at risk for side effects from antidepressant and antianxiety medications care plan dated 5/23/13, included a goal of "will receive lowest effective dose and will not have side effects of medication." The care plan failed to identify any non-pharmacological interventions to be used for	F 428		

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F 428	Continued From page 27 sleep and anxiety. Review of the September 2013 MAR revealed R38 received Ativan 0.5 mg three times daily, Elavil 25 mg every bedtime and Oxybutynin 10 mg. The Elavil was discontinued on 7/9/13 and was restarted on 9/3/13. Review of the Benzodiazepine/Anxiolytic Drug Monitor for May 2013 through September 2013, revealed a description of behaviors to be managed of anxiety, pacing and fidgeting. The behaviors were noted to have occurred in May on the first two days after admission only, did not occur at all in June, occurred on the night shift only from July 20 through July 25, occurred from August 2nd through August 7th only, and did not occur in September 2013. A side effect of confusion was noted in May through August 2013. Review of the Hypnotic Drug Monitor for May 2013 through September 2013, revealed R38 was being monitored for the use of Halcion which had been discontinued in May 2013 and not Elavil which was being administered. From May through September 2013, R38 was noted to have no sleep disturbance noted on all nights with the exception of five nights in July 2013, and three nights in August 2013. The Admission History and Physical dated 5/5/13, noted R38 had fallen and struck the back of her head, sustaining a scalp hematoma without laceration. A physician progress note dated 6/4/13, noted R38 had been in the facility for a month and "has adjusted nicely."	F 428		

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F 428	Continued From page 28 A Drug Regimen Review Report dated 5/13/13, noted Elavil was a "high risk drug" and suggested to do a sleep assessment to determine underlying cause of sleep problem and noted additive anticholinergic side effects probable with use of Elavil and Oxybutynin, avoid concurrent use in the elderly. A Drug Regimen Review Report dated 6/21/13, noted Elavil produced strong anticholinergic effect and concurrent use with Oxybutynin should be avoided. An Interdisciplinary Progress Notes dated 7/25/13, noted R38 had increased restlessness, anxiety, fidgeting and pacing especially at night and noted R38 needed to void and was unable to find a bathroom. R38 had falls on 8/3/13, with a bruise to the left side of the head and neck and on 10/7/13, with a large bruise to the left hip. The Care Plan Conference Summary dated 8/21/13, noted the Elavil had been discontinued on 7/9/13, and did not note any change in sleep patterns or anxiety noted. An Interdisciplinary Progress Notes dated 9/8/13, noted R38 complained of the room spinning when getting up from a chair and was found to have a low blood pressure of 96/50. Although the Hypnotic Drug Monitor noted R38 had no sleep disturbance noted on all but three nights from 8/1/13 through 9/3/13, the physician progress note dated 9/3/13, indicated R38 had not been sleeping well since off the Elavil and ordered to restart the Elavil at bedtime.	F 428		

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F 428	Continued From page 29 When interviewed on 10/30/13, at 8:59 a.m. licensed practical nurse (LPN)-C stated R38 was usually pretty good when sitting out in the dayroom and did not exhibit any behaviors. When interviewed on 10/30/13, at 9:03 a.m. RN-B stated non-pharmacological interventions were tracked for PRN medications only and would expect them to be included on a resident's care plan. RN-B stated she would expect nurses to document in the progress notes or a flow sheet if a resident was up at night. When interviewed on 10/30/13, at 9:08 a.m. LPN-A (the activities/social service staff) stated she was not involved in resident behaviors. When interviewed on 10/30/13, at 9:12 a.m. nursing assistant (NA)-B stated R38 was calm all the time and did not have sleep disturbance the nights she worked. The DON was interviewed on 10/30/13, at 9:15 a.m. and stated she was unable to provide any additional information for R38 and R38 "should have been locked at for a gradual dose reduction of Ativan." When interviewed on 10/30/13, at 12:44 p.m. the DON stated if a sleep assessment was done for R38 it would be in the chart and she was 90% sure one was not done. A sleep assessment was not provided for R38. P-A was interviewed on 10/30/13, at 12:34 p.m. and stated he had not recommended a dose reduction of Ativan for R38 and would do so in December 2013. P-A stated R38's Elavil as for	F 428		

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F 428	Continued From page 30 back pain not insomnia and thought the facility did not know the indication for use. R12 was admitted to the facility with diagnoses of congestive heart failure and valvular heart disease, atrial fibrillation (irregular heart beat), anemia, dementia, and hypertension per the Admission Record dated 6/13/12. R12 had impaired kidney function and received Macrodantin which would not reach sufficient therapeutic levels due to the compromised kidney function. P-A was not aware of the Macrodantin (Macrobid an antibiotic) order. R12's care plan dated 6/25/12, included bladder incontinence secondary to some function loss of control and a history of urinary tract infection (UTI) episodes with increased weakness, check every two hours during waking hours, if resident needs to toilet, every two hour and as needed toileting on the night shift. R12 wore pads during the day and pull ups at night. Assist of one to two staff to help with peri-care. R12 does occasionally use her call light to ask for help, she does not use it reliably, tabs monitor on bed and wheelchair to alert staff of self-transfer attempts. Encourage fluids, and antibiotics as ordered. The 9/20/12, consultant pharmacist recommendation to stop Macrobid due to impaired glomerular filtration rate (GFR) was accepted and signed by the primary doctor on 10/2/12. The recommendation indicated: "Product selection: Macrobid 100 mg bid [twice a day] was ordered for a UTI in this 89 year old with a GFR of 42. Macrobid will not reach sufficient concentrations in the urinary tract when GFR is below 60. Macrobid elderly: use is not	F 428		

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F 428	Continued From page 31 recommended due to potential for renal impairment; alternative agents (are) preferred. The pharmacy consultant notice indicated use in the elderly, particularly females receiving long-term prophylaxis for recurrent UTIs, has been associated with an increased risk of hepatic [liver] and pulmonary [lung] toxicity, and peripheral neuropathy [nerve pain in the arms and legs]. Avoid or use extreme caution when prescribing to elderly patients, particularly those with decreased renal function. Monitor closely for toxicities." The physician's orders were reviewed from 4/9/13, going forward and the following was noted: - On 4/9/13, Macrobid 100 mg twice a day for ten days was ordered for a urinary tract infection. - On 5/28/13, Augmentin (an antibiotic) 875 mg twice a day for ten days was ordered for a urinary tract infection. - On 6/14/13, Bactrim DS (an antibiotic) twice a day for 10 days was ordered for a urinary tract infection. - On 7/1/13, Macrobid 100 mg twice a day for 10 days. - On 7/2/13, Macrodantin 50 mg tabs every day after finishing Macrobid 100 mg twice a day, and Macrobid 50 mg every day was ordered to start 7/12/13, and remained in effect through the survey. R12's laboratory results were reviewed from 10/2/12, going forward and the following was observed. - On 10/2/12, the BUN was 28, the Creatinine was 1.2, and the GRF was 42. - On 6/12/13, laboratory results of Creatinine 1.14, estimated glomerular filtration rate (EGFR)	F 428		

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F 428	Continued From page 32 45 (moderately decreased EGFR). - On 6/27/13, BUN 26, Creatinine 1.60, EGFR 30 (moderately decreased) - On 10/31/13, there was no chnage in the EGFR. On 10/29/13, at 9:20 a.m. an interview with LPN-X on the use of Macrobid for a resident in known renal failure and prior consultant pharmacy recommendation to stop the use of Macrobid due to impaired GFR. The conversation was joined by DON and MDS coordinator. At 10:00 a.m. the DON and case manager verified that Macrobid should not be given to renal compromised patients, and that the R12 remained on the medication from 7/2/13, to the current date of 10/29/13. On 10/29/13, at 3:15 p.m. the DON verified the order for Macrodantin was not transcribed correctly, Macrobid 50 mg everyday continued for a renal compromised resident with worsening Creatinine and GFR according to lab values was not addressed, and no evidence of consultant pharmacy addressing the Macrodantin after 7/2/13. On 10/30/13, at 12:00 p.m. P-A stated he was not aware the Macrobid had been restarted for R12 on 7/2/13, and would recommend Macrobid be stopped due to impaired kidney function.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431	See Attached	

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F 431	Continued From page 33 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications and fluids were disposed of when expired and failed to store urine specimens in a separate specimen refrigerator/container. In addition, there were seven ice bags stored in the medication refrigerator. This had the ability to affect all 5 residents (R46, R4, R1, R22, R2) who had their	F 431		

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F 431	Continued From page 34 medication stored in the refrigerator and any resident(s) who may receive stock refrigerated medications. Findings include: Expired medication: R46 received expired Tuberculin (a skin test medication (TST) for tuberculosis) on 10/17/13, which may give a false negative result. R46 was admitted 10/17/13, with diagnosis of anemia, diabetes mellitus, and high blood pressure. The admission Minimum Data Set (MDS) indicated a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The Storage of Medications policy dated 4/19/12, indicated: "3. No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed. ..... Refrigerator storage: On 10/30/13, the medication refrigerator contained Tuberculin opened 9/2/13, a laboratory urine specimen for R31, seven ice bags, and two CoaguChek tests (a self-laboratory test to check how thin the blood is). Also noted in the refrigerator was Lemon flavored nectar thickened water dated and opened 9/26/13, a box of stock 325 milligrams (mg) Aspirin suppository (used for fever) dated 10/28/13, stock bisacodyl suppositories (used for constipation) dated delivered 9/19/13, three unopened stock Novolog insulin (fast acting insulin to control blood sugar) vials, one unopened stock Novolin insulin three, unopened Lantus insulin (long acting insulin to	F 431		

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F 431	Continued From page 35 control blood sugar), two unopened Fluvirin (flu vaccine)stock supply. One unopened Levemir insulin (long acting insulin to control blood sugar) flex pen for R4, Novolog opened 10/10/13 for R1, Lantus insulin for R22, Novolin insulin for R2, opened 10/25/13, unopened Novolin for R2, and Novolog 70/30 insulin for R2 opened 10/21/13, On 10/31/13, at 8:30 a.m. licensed practical nurse (LPN)-Z opened the medication storage, she was not aware that TST testing expired 28 days after opening, and was not aware lab specimens could not be stored with medications. -At 8:45 a.m. LPN-Y, stated all the insulin was kept in the fridge, even those currently in use, the facility policy was to do the glucometer and then go get the insulin dosing from the medication room. -at 8:49 a.m. the director of nursing (DON) stated the expired Tuberculin was because they were not able to get any TST testing vials in this part of the state, they had worked with the pharm consultant and she believed he had contacted Minnesota Department of Health (MDH). In addition the DON was not aware that lab urine specimens could not be stored in the medication refrigerator. The Storage of Medications policy dated 4/19/12, indicated: "3. No discontinued, outdated, or deteriorated medications are available for use in this facility. All such medications are destroyed. ..... 8. Medications requiring refrigeration must be stored in the refrigerator located in the drug room at the nurses' station. The facility policy lacked a statement of storing laboratory specimens separately, and a statement stating food must be stored separately had been removed (crossed	F 431		

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F 431	Continued From page 36 out) from the policy."	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	See Attached	

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F 441	Continued From page 37	F 441		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility did not have an infection control program that had outcome or process surveillance, monitoring of infections, antibiotic usage trending or data analysis of the documented infections of individual residents. In addition, the facility did not have a process in place for trending staff illness to help prevent the development of infections and disease these had the potential to affect all 33 residents living in the facility.

Findings include:

On 10/28/13, at 3:23 p.m. the director of nursing (DON) was asked about who was in charge of the infection control program, the DON reported she was assigned the task today. DON confirmed there had been no outcome or process surveillance, monitoring of infections, antibiotic usage trending, or data analysis of the documented infections of individual residents.

At 3:48 p.m. DON stated she found the system the facility used to use but it had fallen to wayside, confirming no program was in place since 2011. The facility had not designated an infection preventionist (IP) to serve as the coordinator of an Infection Prevention and Control Program.

The facility utilized clinical flow sheets/infection control for all residents identified with infections in the facility related to URI, UTI, Skin, Eye and Ear. No further evaluation was completed with this

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F 441	Continued From page 38 information. No antibiotic trending was completed to determine if facility was over utilizing antibiotics. On 10/29/13, at 2:37 p.m. the DON stated the staff illnesses were recorded with symptoms but no one reviewed this data regarding trends, at least not formally.	F 441		

F Tag 329 Unnecessary Drugs

It is the policy of Fairfax Community Home that each resident's drug regimen is free from unnecessary drugs.

An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above. 2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that: (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	Pharmacy Consultant Review was completed on November 18th, 2013. He reviewed all medication orders. (See Tag 428 for current Pharmacy review.) For resident R-23 primary physician was consulted regarding residents use of Ambien, on 10/31/13 primary physician discontinued this medication and prescribed Elavil 25mg PO q HS for Dx of Depression. For Resident R-38- care plan will be reviewed for non-pharmacological interventions to, which will be added as deemed appropriate. Consultant pharmacist suggestions will be reviewed by primary physician by 12/06/13, including titrating Elavil. Ativan was decreased from TID to BID, 11/05/13. For Resident R-22- Consulting pharmacist recommendations to hold Seroquel until further documentation either proving or disproving medication need is decided. On 11/19/13 resident was taken to ER for increased confusion and lethargy. Orders received to stop Macrobid and start Levaquin 250mg PO daily, which primary physician changed orders on 11/21/13 to DC Levaquin and start Ceftin 250mg BID X 10 days. Consulting pharmacist recommendations will be discussed with primary physician by 12/06/13. For Resident R-12- Consulting pharmacist recommendations will be reviewed with primary physician by 12/06/13. For Resident R-26- Consulting pharmacist recommendations will be reviewed with primary physician by 12/06/13, primary physician ordered Plavix to be Dc'd effective 11/21/13.
How will you identify other residents having the potential to be affected by the same deficient practice and what	For other residents who may be affected by this practice a comprehensive record review was completed regarding unnecessary medications by consulting pharmacist on Nov 18, 2013.

corrective action will be taken?	
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	Recommendations related to unnecessary medications will be reviewed by the interdisciplinary team on 11/26/13. Staff members will be trained as it relates to their respective roles and responsibilities on 11/26 and 11/27/2013.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Unnecessary medication audits or audits of anti-anxiety medication administration with symptoms and/or non pharmacological interventions will be completed weekly for two weeks and randomly monthly for three months, utilizing the MDS and Care Conference quarterly scheduled to ensure continued compliance.The results will be reported to the QA/QI Committee for review and further recommendation.
Who is responsible for this plan of correction?	The Director of Nursing or designee Case Manager will be responsible for compliance. Date of Correction: 12/6/13.

F Tag 334 Influenza and Pneumococcal Immunizations

It is the policy of Fairfax Community Home to develop policies and procedures that ensure that—(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization due to medical contraindications or refusal.

Fairfax Community Home has policies and procedures that ensure that –(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative received education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R-49- Resident was interviewed in addition to interview with his spouse and nurses notes were updated to reflect the information regarding his pneumococcal vaccine. For resident R-7- Resident was given the influenza vaccine as soon as the consent was signed by her responsible party. Vaccine received 10/22/13. Pneumococcal vaccine information will be current in the residents chart by 12/06/13.
How will you identify other residents having the potential to be affected by the same deficient	For other residents who may be affected by this practice, medical records will be reviewed to ensure compliance.

practice and what corrective action will be taken?	
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy and procedure for Vaccination of Residents was reviewed and revised by the interdisciplinary team on 11/18/13. Staff members will be trained as it relates to their respective roles and responsibilities regarding the vaccinations of residents. QAA Committee met on November 18, 2013, and reviewed the policy and procedures and assisted with retraining of the Interdisciplinary Team.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Audits of the vaccinations of newly admitted residents and residents returning from hospitalization will be conducted weekly for two weeks and with each new admit or readmit for three months to ensure continued compliance. The results will be reported to the QA/QI Committee for review and further recommendation.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/06/2013.

F Tag 428 Drug Regimen Review

It is the policy of Fairfax Community Home that the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For resident R-23, Resident R-38 and Resident R-12 – please refer to corrections under tag 329 for the above deficiencies.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For other residents who may be affected by this practice a record review will be completed by pharmacy consultant. Residents with pharmacy concerns will be identified by chart review and/or drug regimen review. After review, physicians will be notified of the pharmacy consultant recommendations for consideration.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy for Pharmacy Services Overview and Medication Regimen Reviews was reviewed by the interdisciplinary team on 11/18/2013. Staff members will be trained as it relates to their respective roles and responsibilities regarding the policy and procedures on pharmacy consultant. QAA Committee Medical Director and Consultant Pharmacist reviewed the above policies, made any recommendations, and assisted with retraining of interdisciplinary team on 11/18/2013.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Drug regimen review audits will be completed weekly for four weeks, and then monthly for three months, and to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations.
Who is responsible for this plan of correction?	The Director of Nursing or designee Case Manager will be responsible for compliance.

	Date of Correction: 12/06/2013.

F Tag 431 Drug Records, Label/Store Drugs and Biologicals

It is the policy of Fairfax Community Home to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For resident R-46- Resident was given a new 2 step mantoux series as soon as TB serum was available. Residents R4, R1, B22 and R2 were not affected by this. For these residents who could have been affected, ice bags will be stored in a non medication refrigerator. A different refrigerator has been designated for storage of non medical. Ice Bags will be stored in a separate freezer. Our policy regarding storage of lab specimens has been updated.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For other residents who may be affected by this practice a medication process review was completed regarding Storage of Medications, Discarding and Destroying Medications. Education will be provided for staff members regarding this medication process on November 26 and or November 27, 2013. The pharmacy consultant reviewed the Storage of Medications Storage Policy with the Director of Nursing and Medical Director at the QAA meeting on November 18, 2013. The pharmacy consultant will be contacted regarding any other concerns, findings and or recommendations.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy and procedure for medication storage, discarding and destroying was reviewed with retraining for the interdisciplinary team. A meeting was conducted on November 18, 2013, with the consulting pharmacist to review the protocols for storage and disposition of medications. A review of these policies by the Medical Director was completed to ensure current standards of practice are in place.

How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Refrigerator audits will be done weekly for four weeks and random monthly thereafter to ensure compliance.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/06/2013.

F Tag 441 Infection Control, Prevent Spread, Linens

It is the policy of Fairfax Community Home to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	Our facility has re-established our infection control tracking and trending log for both residents and employees. The infection control program will be reviewed and revised to include outcome or process surveillance, monitoring of infections, and antibiotic usage trending and data analysis of the documented infections of individual residents. This facility will also develop a process for trending staff illness to help prevent the development of infections and disease that may affect our residents. The Director of Nursing is designated as the infection preventionist to serve as the coordinator of the Infection Prevention and Control Program.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Residents are reviewed daily for changes in condition and symptoms of infection. Infections will be reported to the designated facility Infection Preventionist (DON). The Preventionist (DON) will trend and analysis the data regarding resident infections, antibiotic usage of residents and staff illness. Results will be shared with the weekly Interdisciplinary Team meeting. Trending of resident infections, antibiotic usage of residents and staff illness trending will be reviewed quarterly with the medical director and consulting pharmacist.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy and procedure for Reporting communicable Diseases, Surveillance of Infections, Outbreak of Communicable Diseases, Compliance Rounds will be reviewed and retraining for the interdisciplinary team. A review of these concerns and process changes was discussed at the QAA meeting on November 18, 2013, with the Medical Director, Consultant Pharmacist and Interdisciplinary Team.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is	Audits will be completed weekly for four weeks and monthly for three months to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations.

achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 12/06/2013.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245333	A. BUILDING 01 - MAIN BUILDING B. WING _____	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX COMMUNITY HOME	300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332

(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
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

DC: 12-9-13

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 FORM 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.

EXIT: 10-30-13

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 31, 2013. At the time of this survey, Fairfax Community Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

POC ok w/AW for K67 FS 12-13-13

RECEIVED
NOV 22 2013
DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Hardeman	ADMINISTRATOR	11/21/13

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 By eMail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Fairfax Community Home was constructed as follows: The original building was constructed in 1965 and is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction. The nursing home is separated from an assisted living facility by a two-hour fire wall assembly. Also, the 1965 building of Type II(111) construction is separated from the 1995 addition of Type V(111) construction by a two-hour fire wall assembly. The facility has a fire alarm system with smoke detection at smoke barrier doors and all spaces open to the corridors, which is monitored for automatic fire department notification. The facility also has single-station, battery-operated smoke	K 000		

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K 000	Continued From page 2 detection in all Resident Rooms. The facility has a capacity of 50 beds and had a census of 38 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire sprinkler system in accordance with the provisions at NFPA 101 (2000) Chapter 19 and NFPA 13 (1999). In a fire emergency, this deficient practice could adversely affect 50 of 50 residents, staff and visitors. FINDINGS INCLUDE: On 10/31/2013 at 1:35 PM, observation revealed the water pressure gauge on the fire sprinkler system riser was marked with the date 6/08. In a subsequent interview with facility staff, it was confirmed this was the most recent date the gauge had been replaced, and no documentation could be provided verifying the fire sprinkler system gauge had been recalibrated or replaced within the previous five (5) years. This deficient practice was not in accordance with the requirements at NFPA 25 (1998 edition) Chapter 2, Section 2-3.2.	K 062	K062 The water pressure gauge on the fire sprinkler system was replaced on 11/18/13 by Tyco Simplex Grinnell. Completion Date: 11/18/13 Maintenance Orlin Kiecker is Responsible.	

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K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based upon observation and a staff interview, it was determined that the facility's general ventilating and air conditioning system (HVAC) was not installed in accordance with NFPA 101 (2000), Chapter 19, Section 19.5.2.1 and NFPA 90A (1999). In a fire emergency, a noncompliant HVAC system could adversely affect 50 of 50 residents, staff and visitors. FINDINGS INCLUDE: On 10/31/2013 between 12:00 and 2:30 PM, observation revealed the ventilation system in the 1965 building utilized the egress corridors as the supply air for Resident Rooms. Specifically, each Resident Room toilet room was equipped with an exhaust fan. Further, there were one or more supply air diffusers in the corridors, however, there were no return or exhaust air diffusers in the corridors. Also, there were no supply or return air diffusers in the Resident Room bedrooms. As such, the make-up air for the Resident Room toilet room exhaust fans came mostly from the supply air system in the corridors. This arrangement was not in conformance with NFPA 99 (1999 edition) Chapter 2, Section 2-3.11.1 or with CMS Ref: S&C-06-18.	K 067	K067 The building Heating, Ventilation & Air Conditioning Equipment (HVAC) Does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum. Waiver Requested AW	

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	245333	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/31/2013**

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K 067	Continued From page 4 This finding was verified with the chief building engineer.	K 067		