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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5XY8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00103

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245344**
2.STATE VENDOR OR MEDICAID NO.
(L2) **134240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRVIEW CARE CENTER**
(L4) **702 10TH AVENUE NORTHWEST, PO BOX 10**
(L5) **DODGE CENTER, MN** (L6) **55927**

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 **03/30/2015** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 06/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/22/2015 (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
10/01/1986
(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
03/18/2015
(L33)

Posted 07/08/2015 Co.

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245344

June 22, 2015

Ms. Jane Sheeran, Administrator
Fairview Care Center
702 10th Avenue Northwest, PO Box 10
Dodge Center, Minnesota 55927

Dear Ms. Sheeran:

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 April 14, 2015 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 1, 2015

Ms. Jane Sheeran, Administrator
Fairview Care Center
702 10th Avenue Northwest, PO Box 10
Dodge Center, Minnesota 55927

RE: Project Number S5344025, FMS F5344025

Dear Ms. Sheeran:

On February 18, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 11, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 27, 2015 a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. On April 7, 2015, CMS forwarded the results of the Health FMS and notified you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

> Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 11, 2015 (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of April 7, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 11, 2015.

On March 30, 2015 the Minnesota Department of Health completed a Post Certification Revisit (PCR) and On March 21, 2015 the Minnesota Department of Public Safety completed a PCR of your facility to verify that your facility had achieved and maintained compliance with federal certification deficiencies

issued pursuant to a standard survey, completed on February 11, 2015 and the FMS Survey completed on March 27, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 11, 2015 and the FMS Survey completed on March 27, 2015, effective April 14, 2015 .

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the remedy outlined in their letter of April 7, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

> Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 11, 2015. be rescinded (42 CFR 488.417(b)).

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 11, 2015 is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 11, 2015, is to be rescinded.

In the CMS letter of March 27, 2015, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 11, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245344	A. Building B. Wing	3/30/2015

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST, PO BOX 10 DODGE CENTER, MN 55927

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 **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	**03/12/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	**03/12/2015**	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:
	GPN/kfd	06/01/2015	10160	03/30/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/11/2015

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
245344	A. Building B. Wing	5/26/2015

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST, PO BOX 10 DODGE CENTER, MN 55927

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 **F0323** Reg. # **483.25(h)** LSC	**04/14/2015**	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	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GPN/kfd	06/01/2015	01060	05/26/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 3/27/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245344	A. Building / B. Wing: 01 - MAIN BUILDING 01	3/21/2015

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST, PO BOX 10 DODGE CENTER, MN 55927

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 K0029	03/12/2015	ID Prefix Reg. # NFPA 101 LSC K0143	03/12/2015	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	06/01/2015	25822	03/21/2015
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?	YES	NO
2/11/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5XY8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00103

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245344**
2.STATE VENDOR OR MEDICAID NO.
(L2) **134240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRVIEW CARE CENTER**
(L4) **702 10TH AVENUE NORTHWEST, PO BOX 10**
(L5) **DODGE CENTER, MN** (L6) **55927**

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 **02/11/2015** (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 **55** (L18)

13.Total Certified Beds **55** (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
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 02/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/16/2015 (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
10/01/1986
(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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

February 18, 2015

Ms. Jane Sheeran, Administrator
Fairview Care Center
702 10th Avenue Northwest, PO Box 10
Dodge Center, Minnesota 55927

RE: Project Number S5344025 and H5344018
Dear Ms. Sheeran:

On February 11, 2015, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 11, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5344018 that was found to be unsubstantiated.

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>Electronic 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 March 23, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 May 11, 2015 (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 August 11, 2015 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
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
	245344	A. BUILDING _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER	**702 10TH AVENUE NORTHWEST, PO BOX 10 DODGE CENTER, MN 55927**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. This investigation of complaint H5344018 was completed and found to not be substantiated.	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time	F 156		3/12/15

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

Electronically Signed | 02/26/2015

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 156	Continued From page 1 of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy	F 156		

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F 156	Continued From page 2 groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the notice of provider noncoverage, or generic notice, upon discontinuation of Medicare part-A services for 4 of 4 residents (R67, R73, R71, 46) who meet the eligibility requirements to receive Medicare part-A. Findings Include: R67's Resident Admission Record indicated she had been admitted to the facility on 9/13/2014, on	F 156	Deficiency with ID Prefix Tag F156 shall be corrected. The facility shall provide the notice of provider noncoverage, or generic notice, upon discontinuation of Medicare Part A services. The four identified residents all discharged home. Staff responsible for ensuring the generic notice is provided have been reeducated on the guidelines for providing the form. The Administrator will monitor this Plan of Correction for compliance through audits of Medicare A resident financial files for	

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F 156	Continued From page 3 Medicare part-A services and discharged from the facility on 10/1/14. The Occupational Therapist Progress and Discharge summary dated 9/30/14 indicated R67 was discharged from occupational therapy on 9/30/14. The Stay By Reason Discharge Report showed R67 used 18 Medicare part-A days during her stay in the facility. R67 was not issued a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization by the facility. R73's Resident Admission Record indicated he had been admitted to the facility on 12/15/2014, on Medicare part-A services and discharged from the facility on 1/13/15. The Physical Therapist Progress and Discharge summary dated 1/12/15 indicated R73 was discharged from physical therapy on 1/12/15. The Stay By Reason Discharge Report showed R73 used 17 Medicare part-A days during his stay in the facility. R73 was not issued a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization by the facility. R71's Resident Admission Record indicated she had been admitted to the facility on 10/23/2014, on Medicare part-A services and discharged from the facility on 12/13/14. The Physical Therapist Progress and Discharge summary dated 12/12/14 indicated R71 was discharged from physical therapy on 12/12/14. The Stay By Reason Discharge Report showed R71 used 51 Medicare part-A days during her stay in the facility. R71 was not issued a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization by the facility.	F 156	inclusion of a copy of the Generic Notice upon discharge.	

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F 156	Continued From page 4 R46's Resident Admission Record indicated she had been admitted to the facility on 12/09/2014, on Medicare part-A services and discharged from the facility on 1/16/15. The Physical Therapist Progress and Discharge summary dated 1/15/15 indicated R46 was discharged from physical therapy on 1/15/15. The Stay By Reason Discharge Report showed R46 used 23 Medicare part-A days during her stay in the facility. R46 was not issued a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization by the facility. On 2/10/14 at 2:47 p.m. the accountant technician stated when residents discharge off of their Medicare part-A service when they chose to go home the facility does not provide Medicare denial notices. A policy was requested, but not provided by the facility.	F 156		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity during the dining experience for 9 of 13 residents (R16, R65, R34, R44, R57, R8, R81, R52, and R28)	F 241	Deficiency with ID Prefix Tag 241 shall be corrected. The facility shall promote dignity during the dining experience. Policies and Procedures addressing	3/12/15

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F 241	Continued From page 5 who were observed during meals. Findings include: LACK OF DIGNIFIED DINING ASSISTANCE AND ENVIRONMENT: R16 was identified by the facility to need assistance with eating but received no assistance for 18 minutes, after food was served. The facility identified R16 on the quarterly Minimum Data Set (MDS), an assessment dated 1/6/15, to have severe cognitive impairment, dementia, and required extensive assistance of one staff for eating. R16 ' s care plan, not dated, revealed a focus of mechanically altered diet related to cerebral vascular accident with right hemiplegia. Interventions included total assistance in eating, Sippy cups to aide in drinking fluids; honey thickened fluids, and pureed diet. R16 received the first plate of food served from the kitchen for supper on 2/9/15, at 5:55 p.m. R16 received pureed food was on a divided plate, bowl of purred fruit and thickened liquids. Nursing assistant (NA)-B sat with R16 and began to assist her to eat her pureed fruit. On 2/9/15, at 6:04 p.m., R16 was observed in the wheelchair holding an adaptive cup with thickened apple juice with eyes closed and head bowed. R16 had eaten all of the pureed fruit but the dinner plate of pureed food was uncovered and untouched by R16. At 6:10 p.m., R16 independently took a sip of thickened juice from the adaptive cup he had been holding in his hand.	F 241	timely and appropriate assistance for meals, use of terms of endearment or nicknames when addressing a resident and Dining Room Table Clearing/Cleaning have been reviewed and revised where necessary to ensure it addresses residents dignity. All staff will be reeducated on the Policy and Procedures pertinent to their position/department. The Director of Nursing and Dietary Manager will will randomly observe the Dining Rooms during meal times to ensure compliance with this plan of correction.	

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F 241	Continued From page 6 From 6:16 p.m. to 6:22 p.m. (six minutes) R16 was not assisted by staff to eat nor encouraged to eat his food. At 6:22 p.m. (six minutes) NA-B sat with R16 and assisted him to eat ice cream but did not offer him any food items on the dinner plate. At 6:40 p.m., NA-B left R16 to assist another resident in the dining room. The policy Feeding The Resident (Dependent Eating) dated 11/27/10 read, "Policy: 1. To assist the resident with feeding as necessary. 2. To provide adequate nutrition. Procedure: 8. Never make the resident feel that the meal must be hurried, make the meal pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident when possible." During interview on 2/11/15, at 11:10 a.m., certified dietary manager stated she expected staff to assist R16 with eating as he would accept food. USE OF TERMS OF ENDEARMENT WITHOUT PERMISSION FROM THE RESIDENT: During dining observations in the dining room during supper on 2/9/15, at 5:25 .p.m., 12 residents were seated at the tables and at various places in the meal eating process During observations at that time, registered nurse (RN)-A was heard to called R65, "Honey" and "Sweetie." At 5:55 p.m., dietary aide (DA)-A served a plate of food to R34 and called her "Honey." At 5:57 p.m., cook (C)-A called R44 "Boops" when conversing with her. At 6:04 p.m., C-A said to R57, "Here you go wild hair woman" as C-A gave R57 her plate of food. Also at 6:04 p.m. DA-A served R65 a plate of food and said, "Here you go hun."	F 241		

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F 241	Continued From page 7 During dining observations in the dining room, for the noon meal on 2/10/15, at 11:57 a.m., DA-B served a plate of food to R34, and stated, "There you go honey." At 11:58 a.m., DA-B stated to R8, "I'm going to scoot you up a little honey" before DA-B moved R8 closer to the table. During dining observations for breakfast on 2/11/15, at 7:42 a.m., nursing assistant (NA)-A stated, " (R8) (R8), take a bite of your toast sweetie." At 7:44 a.m., NA-A stated to R81, "How you doing sweetie?" At 7:46 a.m., NA-A stated to R44, "Are you all done honey?" R65, R34, R44, R57, R8, and R81 care plans were reviewed and no identification of use of nicknames was found. During interview on 2/11/15, at 11:10 a.m., certified dietary manager (CDM) stated she expected staff to not call residents by nicknames unless the residents have asked to be called a nick name. CDM stated she was not aware of any resident who wanted to be called by these nicknames used during the three meals observed. During interview on 2/11/15, at 11:43 a.m., director of nursing stated nicknames were alright to use if residents thought it was alright, as this was their home. Director of nursing stated she was not aware of any resident who had requested to be called the nicknames used during the three meals observed. Director of nursing verified she had not asked any resident if it was alright to call them by a nickname. During interview at that time, a facility policy for use of nicknames was requested, although none was provided. RESIDENTS WERE EATING AND STAFF STARTED TO CLEAN TABLES AROUND THEM:	F 241		

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F 241	Continued From page 8 During observations of the supper dining experience on 2/9/15, at 6:19 p.m., dietary aide (DA)-A placed one large gray bucket, two small pails, and one small clear plastic container onto the top shelf of a three shelf metal cart. At 6:26 p.m., DA-A moved the metal cart used to hold garbage from tables to a table R57 was still eating her meal of ice cream while DA-A began to remove soiled dishes, scrape foods into a bucket, pour liquids into a bucket, and stack soiled dishes on the cart. At 6:30 p.m., DA-A moved the metal cart to the next table, cleared the table and scraped foods where R28 was still eating. At 6:35 p.m., revealed DA-A moved the cart to the next table, cleared the table and scraped foods, where R8 was still eating. At 6:37 p.m., DA-A moved the cart next to the table where R16 and R34 were still eating. After this table DA-A pushed the metal cart with buckets into the kitchen. During observations of breakfast on 2/11/15, at 7:44 a.m., cook (C)-A wiped a table with a cloth while R52 was finishing her meal. Immediately after wiping this table C-A moved to the next table and wiped the table are located around R81 who was still eating her meal. During interview on 2/11/15, at 11:10 a.m., certified dietary manager (CDM) stated she expected staff to clean tables after residents were done and gone from the table. CDM stated in the mornings, staff clear tables as residents finish eating to make room for other residents. CDM stated she expected staff to use the metal cart and buckets for clearing food scraps when residents were all gone from the table. Also CDM stated the facility did not have a policy for dining room clean-up.	F 241		

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F 241	Continued From page 9 During interview on 2/10/15, at 1:30 p.m., administrator stated the facility did not have a policy for dignity. Administrator stated the facility followed the resident rights and staff were educated about treating residents with dignity when they are first hired and then yearly, according to the resident bill of rights. A copy of the Resident's Rights dated 2014, page 4, read, "The Right to be Treated with Dignity and Respect. Another right residents have when living in a long-term care facility is the right to be treated with dignity and respect. Under this right, residents are entitled to care that promotes their physical, psychological, and social well-being. To uphold this right, a long-term care facility must demonstrate that it accommodates residents' needs. For example, if a resident prefers to take a shower rather then a bath, the facility must make the necessary adjustments to meet this need. It is important for the facility to remember that a resident is much more than just his or her diagnosis. Residents are people with productive and meaningful pasts. Therefore, a facility's physical environment and staff behaviors should support resident's right to dignity and respect." A copy of the course description of residents rights inservice dated 2/19/14, read, "Resident rights emphasize the importance of resident-focused care, independence, privacy, dignity, and respect."	F 241		

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	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Fairview Care Center was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 02/26/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER	**702 10TH AVENUE NORTHWEST, PO BOX 10 DODGE CENTER, MN 55927**

(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	Continued From page 1 By email to: 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. Fairview Care Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1975 and was determined to be of Type II(000) construction. In 1997, addition was constructed to the North Wing that was determined to be of Type II(000) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. Fairview Care Center has elected to use the following categorical waivers - Extinguishing Requirements, Capacity of Means of Egress and	K 000		

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K 000	Continued From page 2 Combustible decorations on walls, doors and ceilings. The facility has a capacity of 55 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 5 out 52 residents. Findings include: On facility tour between 8:50 AM and 11:20 AM	K 029	Deficiency with Tag 29 has been corrected. A new door knob and latching mechanism has been installed on the laundry soiled linen room corridor door. The door now latches properly. The Maintenance Director is responsible for correction and shall monitor this plan of correction to prevent a reoccurrence of the deficiency.	3/12/15

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K 029	Continued From page 3 on 02/11/2015, observation revealed, that the laundry soiled linen room corridor door will not latch. This deficient practice was confirmed by the Administrator (JS) at the time of discovery.	K 029		
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure oxygen transfill room is separated as required by 1999 NFPA 99 Section 8-6.2.5.2 (a) and (c), and 1999 NFPA 80. The deficient practice could affect 5 out of 52 residents.	K 143	Deficiency with Tag 143 has been corrected. The open penetrations around the sprinkler pipe and up to deck have been sealed. The missing hinge has been replaced. Signs have been placed on the door indicating Oxidizing gases stored in the room, No Smoking and that	3/12/15

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K 143	Continued From page 4 Findings include: On facility tour between 8:50 AM and 11:20 AM on 02/11/2015, observation revealed that the liquid oxygen transfill room # 314 that the following was found: 1. Open penetration above the ceiling around sprinkler piping/not sealed to deck 2. The corridor door is missing the middle hinge 3. No sign on the door indicating transferring is occurring These deficient practices were confirmed by the Administrator (JS) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 143	transferring of Oxygen occurs in the room. The Maintenance Director is responsible for correction and shall monitor area to prevent a reoccurrence of the deficiency.	

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
February 18, 2015

Ms. Jane Sheeran, Administrator
Fairview Care Center
702 10th Avenue Northwest, PO Box 10
Dodge Center, Minnesota 55927

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5344025 & H5344018

Dear Ms. Sheeran:

The above facility was surveyed on February 9, 2015 through February 11, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5344018 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00103	A. BUILDING: _____ B. WING _____	02/11/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 9, 10 & 11, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, complaint investigation(s) were also completed at the time of the licensing survey & recertification survey and complaint H5344018 was not substantiated.	2 000		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff	21800		3/12/15

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21800	Continued From page 3 person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the notice of provider noncoverage, or generic notice, upon discontinuation of Medicare part-A services for 4 of 4 residents (R67, R73, R71, 46) who meet the eligibility requirements to receive Medicare part-A. Findings Include: R67's Resident Admission Record indicated she had been admitted to the facility on 9/13/2014, on Medicare part-A services and discharged from the facility on 10/1/14. The Occupational Therapist Progress and Discharge summary dated 9/30/14 indicated R67 was discharged from occupational therapy on 9/30/14. The Stay By Reason Discharge Report showed R67 used 18 Medicare part-A days during her stay in the facility. R67 was not issued a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization by the facility. R73's Resident Admission Record indicated he had been admitted to the facility on 12/15/2014, on Medicare part-A services and discharged from the facility on 1/13/15. The Physical Therapist Progress and Discharge summary dated 1/12/15 indicated R73 was discharged from physical therapy on 1/12/15. The Stay By Reason Discharge Report showed R73 used 17 Medicare	21800	Corrected	

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21800	Continued From page 4 part-A days during his stay in the facility. R73 was not issued a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization by the facility. R71's Resident Admission Record indicated she had been admitted to the facility on 10/23/2014, on Medicare part-A services and discharged from the facility on 12/13/14. The Physical Therapist Progress and Discharge summary dated 12/12/14 indicated R71 was discharged from physical therapy on 12/12/14. The Stay By Reason Discharge Report showed R71 used 51 Medicare part-A days during her stay in the facility. R71 was not issued a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization by the facility. R46's Resident Admission Record indicated she had been admitted to the facility on 12/09/2014, on Medicare part-A services and discharged from the facility on 1/16/15. The Physical Therapist Progress and Discharge summary dated 1/15/15 indicated R46 was discharged from physical therapy on 1/15/15. The Stay By Reason Discharge Report showed R46 used 23 Medicare part-A days during her stay in the facility. R46 was not issued a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization by the facility. On 2/10/14 at 2:47 p.m. the accountant technician stated when residents discharge off of their Medicare part-A service when they chose to go home the facility does not provide Medicare denial notices.	21800		

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21800	Continued From page 5 A policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The administrator or designee could educate staff on the process of providing liability notices and resident appeals rights. The administrator or designee could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity during the dining experience for 9 of 13 residents (R16, R65, R34, R44, R57, R8, R81, R52, and R28) who were observed during meals. Findings include: LACK OF DIGNIFIED DINING ASSISTANCE AND ENVIRONMENT: R16 was identified by the facility to need assistance with eating but received no assistance for 18 minutes, after food was served.	21805	Corrected	3/12/15

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21805	Continued From page 6 The facility identified R16 on the quarterly Minimum Data Set (MDS), an assessment dated 1/6/15, to have severe cognitive impairment, dementia, and required extensive assistance of one staff for eating. R16 ' s care plan, not dated, revealed a focus of mechanically altered diet related to cerebral vascular accident with right hemiplegia. Interventions included total assistance in eating, Sippy cups to aide in drinking fluids; honey thickened fluids, and pureed diet. R16 received the first plate of food served from the kitchen for supper on 2/9/15, at 5:55 p.m. R16 received pureed food was on a divided plate, bowl of purred fruit and thickened liquids. Nursing assistant (NA)-B sat with R16 and began to assist her to eat her pureed fruit. On 2/9/15, at 6:04 p.m., R16 was observed in the wheelchair holding an adaptive cup with thickened apple juice with eyes closed and head bowed. R16 had eaten all of the pureed fruit but the dinner plate of pureed food was uncovered and untouched by R16. At 6:10 p.m., R16 independently took a sip of thickened juice from the adaptive cup he had been holding in his hand. From 6:16 p.m. to 6:22 p.m. (six minutes) R16 was not assisted by staff to eat nor encouraged to eat his food. At 6:22 p.m. (six minutes) NA-B sat with R16 and assisted him to eat ice cream but did not offer him any food items on the dinner plate. At 6:40 p.m., NA-B left R16 to assist another resident in the dining room. The policy Feeding The Resident (Dependent Eating) dated 11/27/10 read, "Policy: 1. To assist the resident with feeding as necessary. 2. To provide adequate nutrition. Procedure: 8. Never	21805		

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21805	Continued From page 7	21805		

make the resident feel that the meal must be hurried, make the meal pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident when possible."
During interview on 2/11/15, at 11:10 a.m., certified dietary manager stated she expected staff to assist R16 with eating as he would accept food.

USE OF TERMS OF ENDEARMENT WITHOUT PERMISSION FROM THE RESIDENT:

During dining observations in the dining room during supper on 2/9/15, at 5:25 .p.m., 12 residents were seated at the tables and at various places in the meal eating process
During observations at that time, registered nurse (RN)-A was heard to called R65, "Honey" and "Sweetie." At 5:55 p.m., dietary aide (DA)-A served a plate of food to R34 and called her "Honey." At 5:57 p.m., cook (C)-A called R44 "Boops" when conversing with her. At 6:04 p.m., C-A said to R57, "Here you go wild hair woman" as C-A gave R57 her plate of food. Also at 6:04 p.m. DA-A served R65 a plate of food and said, "Here you go hun."

During dining observations in the dining room, for the noon meal on 2/10/15, at 11:57 a.m., DA-B served a plate of food to R34, and stated, "There you go honey." At 11:58 a.m., DA-B stated to R8, "I'm going to scoot you up a little honey" before DA-B moved R8 closer to the table.

During dining observations for breakfast on 2/11/15, at 7:42 a.m., nursing assistant (NA)-A stated, " (R8) (R8), take a bite of your toast sweetie." At 7:44 a.m., NA-A stated to R81, "How you doing sweetie?" At 7:46 a.m., NA-A stated to R44, "Are you all done honey?"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00103	A. BUILDING: _____ B. WING _____	02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER	702 10TH AVENUE NORTHWEST, PO BOX 10 DODGE CENTER, MN 55927

(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) COMPLETE DATE
21805	Continued From page 8 R65, R34, R44, R57, R8, and R81 care plans were reviewed and no identification of use of nicknames was found. During interview on 2/11/15, at 11:10 a.m., certified dietary manager (CDM) stated she expected staff to not call residents by nicknames unless the residents have asked to be called a nick name. CDM stated she was not aware of any resident who wanted to be called by these nicknames used during the three meals observed. During interview on 2/11/15, at 11:43 a.m., director of nursing stated nicknames were alright to use if residents thought it was alright, as this was their home. Director of nursing stated she was not aware of any resident who had requested to be called the nicknames used during the three meals observed. Director of nursing verified she had not asked any resident if it was alright to call them by a nickname. During interview at that time, a facility policy for use of nicknames was requested, although none was provided. RESIDENTS WERE EATING AND STAFF STARTED TO CLEAN TABLES AROUND THEM: During observations of the supper dining experience on 2/9/15, at 6:19 p.m., dietary aide (DA)-A placed one large gray bucket, two small pails, and one small clear plastic container onto the top shelf of a three shelf metal cart. At 6:26 p.m., DA-A moved the metal cart used to hold garbage from tables to a table R57 was still eating her meal of ice cream while DA-A began to remove soiled dishes, scrape foods into a bucket, pour liquids into a bucket, and stack soiled dishes on the cart. At 6:30 p.m., DA-A moved the metal cart to the next table, cleared the table and scraped foods where R28 was still eating. At 6:35	21805		

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	00103	A. BUILDING: _____ B. WING _____	02/11/2015

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21805	Continued From page 9	21805		

p.m., revealed DA-A moved the cart to the next table, cleared the table and scraped foods, where R8 was still eating. At 6:37 p.m., DA-A moved the cart next to the table where R16 and R34 were still eating. After this table DA-A pushed the metal cart with buckets into the kitchen.

During observations of breakfast on 2/11/15, at 7:44 a.m., cook (C)-A wiped a table with a cloth while R52 was finishing her meal. Immediately after wiping this table C-A moved to the next table and wiped the table are located around R81 who was still eating her meal.

During interview on 2/11/15, at 11:10 a.m., certified dietary manager (CDM) stated she expected staff to clean tables after residents were done and gone from the table. CDM stated in the mornings, staff clear tables as residents finish eating to make room for other residents. CDM stated she expected staff to use the metal cart and buckets for clearing food scraps when residents were all gone from the table. Also CDM stated the facility did not have a policy for dining room clean-up.

During interview on 2/10/15, at 1:30 p.m., administrator stated the facility did not have a policy for dignity. Administrator stated the facility followed the resident rights and staff were educated about treating residents with dignity when they are first hired and then yearly, according to the resident bill of rights.

A copy of the Resident's Rights dated 2014, page 4, read, "The Right to be Treated with Dignity and Respect. Another right residents have when living in a long-term care facility is the right to be treated with dignity and respect. Under this right, residents are entitled to care that promotes their

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21805	Continued From page 10 physical, psychological, and social well-being. To uphold this right, a long-term care facility must demonstrate that it accommodates residents' needs. For example, if a resident prefers to take a shower rather then a bath, the facility must make the necessary adjustments to meet this need. It is important for the facility to remember that a resident is much more than just his or her diagnosis. Residents are people with productive and meaningful pasts. Therefore, a facility's physical environment and staff behaviors should support resident's right to dignity and respect." A copy of the course description of residents rights inservice dated 2/19/14, read, "Resident rights emphasize the importance of resident-focused care, independence, privacy, dignity, and respect." SUGGESTED METHOD OF CORRECTION: The administrator, director or nursing or designee could provide staff education related to dignified dining services and monitor for compliance TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		