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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9N40

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 **12/21/2017** (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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Stephanie Powers, HFE NE II 01/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Rep 01/03/2018 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245344

January 3, 2018

Ms. Jane Sheeran, Administrator
Fairview Care Center
702 10th Avenue Northwest, PO Box 10
Dodge Center, MN 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 December 19, 2017 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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2018

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

RE: Project Number S5344029

Dear Ms. Sheeran:

On December 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 16, 2017. 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 January 1, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 21, 2017 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 November 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 19, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 16, 2017, effective December 19, 2017 and therefore remedies outlined in our letter to you dated December 1, 2017, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9N40

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Facility ID: 00103

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4. TYPE OF ACTION: **2** (L8)
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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 **11/16/2017** (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

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To (b) :

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10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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17. SURVEYOR SIGNATURE Date :
Stephanie Powers, HFE NE II 12/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Rep 01/02/2018 (L20)

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

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____ 2. Facility is not Eligible
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3. Both of the Above :
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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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 1, 2017

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

RE: Project Number S5344029

Dear Ms. Sheeran:

On November 16, 2017, 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 electronically delivered CMS-2567, whereby corrections are required.

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:

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

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

Remedies - 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
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (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 December 26, 2017, 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 26, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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.

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 February 16, 2018 (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 May 16, 2018 (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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING _____ B. WING _____	11/16/2017

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 On November 13, 14, 15, & 16, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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.	F 000		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	F 164		12/19/17

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

Electronically Signed | 12/11/2017

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 _____	11/16/2017

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 164	Continued From page 1 provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure confidentiality of medication administration records when staff were not present. Findings include: During observations on 11/13/17, at 7:44 a.m., two medication administration books were	F 164	Deficiency with ID Prefix Tag 164 shall be corrected. The facility shall ensure confidentiality of medication administration records when staff are not present. All Professional nurses, TMA's and nursing unit secretaries will be reeducated on maintaining confidentiality of medication administration records and	

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 _____	11/16/2017

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 164	Continued From page 2 observed open on one of two medication carts positioned between the living room and small dining room. There were no licensed staff present. During observations on 11/13/17, at 10:10 a.m., one medication administration book was observed open on a medication cart outside of room 207. Trained medication aide (TMA)-A walked away from the medication cart toward the small dining room, then back past the cart again and on to the 200 wing nurses station. Observations at 10:12 a.m., revealed TMA-A returned to the cart where the medication book remained open. During observations on 11/14/17, at 11:56 a.m., one of two medication administration books was open on the medication cart positioned between the living room and small dining room. There were no licensed staff present. During observations on 11/14/17, at 12:03 p.m., medication cart was located on the 200 wing hallway by the nurses station. TMA-A spoke with a resident and visitor at the medication cart, and then walked into a resident room. One medication administration book was open to a medication page at that time. During interview on 11/14/17, at 12:05 p.m., TMA-A verified the medication administration book was left open and closed the book at that time. TMA-A stated the medication administration books were suppose to be closed when staff were not present. During observations on 11/15/17, at 8:19 a.m., one medication administration book was open on	F 164	ensure books are closed when they are not present at the medication cart. The Director of Nursing shall or designee shall monitor for continued compliance through random audits of the MAR's to ensure they maintain confidentiality. Audits will be completed 5 days a week for a month. Results will be reviewed at the February, 2018 QAPI Meeting.	

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F 164	Continued From page 3 a medication cart located in the living room near the large dining room. There were no licensed staff present. During observations on 11/15/17, at 8:54 a.m., one of two medication administration books was open on top of one of two medication carts positioned between the living room and small dining room. There were no licensed staff present. One resident sat in a wheelchair between the two medication carts. During observations on 11/15/17, at 8:57 a.m., registered nurse (RN)-B walked by the medication cart and closed the medication book. During interview on 11/15/17, at 11:44 a.m., director of nursing stated she expected medication administration books to be closed or the page flipped up to a blank page so as no medications or names could be seen. During interview on 11/15/17, at 11:50 a.m., RN-B verified had left the medication book open. RN-B stated the medication book should be closed when not present. Document review of facility Confidentiality and Health Information Portability and Accountability Act, policy, undated, directed staff that all employees and agents shall respect and protect the confidentiality of resident records and other personal information.	F 164		
F 176 SS=D	RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE CFR(s): 483.10(c)(7) (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by	F 176		12/19/17

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F 176	Continued From page 4 §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R61) was assessed for safe self-administration of medications. Findings include: R61 had diagnosis that included chronic obstructive pulmonary disease, diabetes mellitus, depression and anxiety according to facility Admission Record. The facility identified R61 on the significant change Minimum Data Set (MDS) dated 11/1/17, to have cognition intact, no moods, no behaviors and required limited to extensive assist of 1 staff for activities of daily living. R61's care plan revision dated 10/23/17, directed staff R61 was noted to pocket oxycontin (pain medication) while taking medications and staff had found medication on R61's night stand recently. Licensed nursing staff have been instructed to explain medications to R61, and make sure R61 wanted medications before administering them. Staff were to observe R61's room when providing cares, look for any medications that R61 possibly pocketed and then took out of mouth. Medications have been found on R61's nightstand as of today. Document review of physician orders dated 11/2017, revealed no orders to self-administer medications.	F 176	Deficiency with ID Prefix Tag F176 shall be corrected. The facility shall ensure that residents are assessed for safe self administration of medications. R61 had been assessed to not be safe to self administer medications and is directly observed to ensure proper medication administration and nebulizer use. All residents who are assessed to not be safe in self administering medications shall be directly observed for proper medication administration. All Professional Nurses and TMA's will be reeducated on the self administration policy and procedure and the self administration assessment. The Director of Nursing or designee shall monitor this Plan of Correction for continued compliance through random audits of personnel administering medications. Audits will be completed 5 days a week for a month. Results will be reviewed at the February, 2018 QAPI Meeting.	

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F 176	Continued From page 5	F 176		

During observations on 11/13/17, at 7:38 a.m., R61 sat at the dining room table with a medication cup of several medications beside R61's plate. At that time, R61 placed all medications onto the plate and began to swallow one at a time. There was no licensed staff present. During observations at 7:41 a.m., trained medication assistant (TMA)-A entered the dining room and stood by R61, who swallowed the last two medications.

During observations on 11/13/2017, at 1:30 p.m., R61 was in own room with nebulizer mask on and treatment running. There was no licensed staff present.

During observations on 11/14/17, at 11:54 a.m., R61 sat at the dining room table with one medication on the placemat. R61 was asleep. There were no licensed staff present. Observations at 11:56 a.m., revealed the same with R61 asleep, one medication on the place mat, and no licensed staff present.

During interview on 11/14/17, at 12:05 p.m., trained medication assistant (TMA)-A stated R61 could be left alone with medications if within watch distance. TMA-A verified R61 had medication at the table while TMA-A was down the hallway. TMA-A verified R61 was not to self administer medication. TMA-A verified medication administration record and facility daily assignment sheet do not identify self administration of medication.

During interview on 11/14/127, at 12:10 p.m., licensed practical nurse (LPN)-A verified R61 did not have physician orders to self-administer medication.

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F 176	Continued From page 6 During interview on 11/15/17, at 11:44 a.m., director of nursing verified R61 was not to self-administer medication. Director of nursing stated she expected staff would stay with R61 and observe medications had been taken. Document review of facility Self Administration of Medication policy dated 5/2/17, directed staff to obtain a written order for self-administration of medications, nursing to complete an assessment, and establish a self-administration care plan.	F 176		
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a clean, comfortable room environment for 1 of 1 resident (R78) reviewed. Findings include: R78 had been interviewed on 11/13/17, at 11:16 a.m. R78 stated he would be embarrassed if company came to visit him, pointing at a reddish brown stain on the carpet next to the bed. R78 stated, "They made a mistake with some guy here, I guess it happened long ago and he ended up dying here." R78 said if he were "in charge of this place" he would have fixed it a long time ago. During an observation on 11/16/17 at 9:20 a.m. of R78's room showed the bed was made and a	F 253	Deficiency with ID Prefix tag F253 shall be corrected. The facility shall provide a clean and comfortable room environment for all residents. R78 has moved to a new room and no resident is residing in the bed with the stained carpet. The carpet in this room shall be replaced. The Maintenance Director shall ensure this replacement is completed. This Plan of correction shall be reviewed at the February, 2018 QAPI meeting.	12/19/17

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F 253	Continued From page 7 sign was on the bed saying the room had been cleaned, indicating the room was ready for a new admission. However, the reddish brown stain continued to be present. On 11/16/17 at 10:09 a.m. in an interview with the director of housekeeping and laundry and housekeeper (H)-C, identified the spot as either blood or iodine, stating that it had happened on the afternoon or night shift and had a chance to set in before housekeeping could get to it. (H)-C indicated the stain had been there for around 4 months and she had tried everything she could to try to remove the stain, stating, "I've cleaned the carpet so much I'm afraid to see what's underneath, it's probably rotten under there." On 11/16/17 at 10:24 a.m. in an interview with the administrator, she verified the stain on the carpet and stated that flooring in the building was included in the 5 year capitol plan. She indicated that flooring in other rooms had been repaired and said that the stain would be discussed to see if the carpet should be changed. A facility policy, Cleaning a Resident's Room during the Week, dated 1/1/16, indicates that it is the policy to provide a safe, functional, sanitary and comfortable environment for all residents.	F 253		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate	F 278		12/19/17

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F 278	Continued From page 8 each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Minimum Data Set (MDS) was coded accurately for bed mobility for 1 of 3 residents (R37) reviewed for activities of daily living. Findings include: R37's quarterly MDS dated 8/2/17, identified for	F 278	Deficiency with ID Prefix Tag F278 shall be corrected. The facility shall ensure the MDS is coded accurately for bed mobility for activities of daily living. The MDS for resident R37 was modified to correctly address bed mobility. Any MDS changes shall have documentation to clarify the changes made.	

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F 278	Continued From page 9 bed mobility R37 required total dependence (full staff performance every time during entire seven day period) for bed mobility. R37's current care plan identified positioning devices/restraint alternatives, R37 will be independent with bed mobility with interventions of assistive bed rail times two and electric low bed. In addition, the care plan identified R37 required two staff assist to turn and reposition every one hour. During observation on 11/14/17, at 3:51 p.m., R37 laid in bed and the director of nursing (DON) and nursing assistant (NA)-A repositioned R37 onto her left side in bed. R37 had not participated with the repositioning. During interview on 11/15/17, at 10:43 a.m., registered nurse (RN)-A verified R37's MDS dated 8/2/17, was coded total assistance. RN-A stated the seven day look back period for the 8/2/17, MDS was dated from 7/27/17, through 8/2/17. RN-A stated during the seven days R37 required total assist for bed mobility, except for one episode R37 required extensive assist. RN-A stated R37 fluctuated with assistance from staff for bed mobility. RN-A stated she coded R37 as total assist for bed mobility (instead of extensive assist) due to she had looked at who (staff person) had documented the extensive assist for bed mobility and the staff person who had documented the information was not always accurate with their documentation. RN-A stated due to the staff person not always being accurate with documentation, she felt that would nullify the one episode documented as extensive assistance and coded total assistance for bed mobility instead. When queried if she had	F 278	The MDS Coordinator has been reeducated on the importance of clarification documentation when changes are made to the MDS. The Director of Nursing or designee shall monitor for continued compliance of this plan of correction through audits of any changes made to ensure there is documentation to clarify the changes made. Audits will be conducted over the next month with results reported on at the February, 2018 QAPI meeting.	

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F 278	Continued From page 10 interviewed the staff person regarding the documented episode of extensive assist (to clarify whether R37 had required total or extensive assist) RN-A replied no. When queried whether she had documented a clarification note in R37's record explaining why the MDS was coded as total assist for bed mobility, instead of extensive assist, RN-A replied no. During interview on 11/15/17, at 2:34 p.m., the DON stated she would expect documentation in the resident record explaining the reason why the MDS was coded total assistance instead of extensive assistance for bed mobility. The facility policy Billing and Coding, undated, indicated the facility is committed to properly and accurately billing for services we provide in accordance with all applicable regulations.	F 278		
F 282 SS=E	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement care plan interventions as directed for 1 of 3 residents (R6) reviewed for non-pressure related skin conditions; 2 of 5 residents (R61, R11) reviewed for	F 282	Deficiency with ID Prefix Tag 282 shall be corrected. The facility shall ensure care plan interventions are implemented for non-pressure skin related conditions, unnecessary medication use and	12/19/17

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F 282	Continued From page 11 unnecessary medication use; and 1 of 2 residents (R37) reviewed for pressure ulcers. Findings include: R6 was admitted to the facility on 6/23/16, according to face sheet, with the diagnoses of congestive heart failure, major depressive disorder, and presence of a cardiac pacemaker. R6's quarterly Minimum Data Set (MDS) dated, 8/23/17, indicated R6 to have intact cognition. Care Plan dated, 11/14/17, indicated that R6's skin is monitored with cares and the bathing process. The goal is to maintain intact skin integrity. Interventions if skin is reddened, bruised, or has open areas; report to licensed staff. Then follow facility protocol/ regime for treating breaks in skin integrity and document all new abnormal skin findings. Review of bath sheets from 10/26/17, to 11/13/17, identify no skin concerns to the top of R6's left hand. Progress note dated 11/13/17, at 11:29 a.m., indicated no new skin concerns noted during a.m. shower. On 11/13/17, at 10:46 a.m., R6 was observed to have a dressing placed on top of left hand. On 11/14/17, at 3:20 p.m., during interview, R6 was noted to have a white dressing on top of left hand. When surveyor asked R6 why she had the dressing on her hand, R6 stated she didn't know what happened to her hand and that, "when you get this old your skin gets thin." On 11/14/17, at 6:11 p.m., during interview with	F 282	supplements. The skin condition for R6 was identified and documented on upon notification by the surveyor. Facility identified that an incident report had not been completed the day prior. The skin condition is healed. R61's and R11's medical records shall have documentation for non pharmacologic interventions attempted and or offered prior to PRN medication use and the effectiveness of any PRN used. R37 receives a Magic Cup as ordered. All residents who have an identified skin condition shall have an incident report completed. All residents who use a PRN medication shall have the non-pharmacologic interventions attempted documented in their medical records prior to administering the PRN and the record shall also document the effectiveness of the PRN medication. All residents who have a supplement ordered shall receive it at the time ordered. Policy and Procedures were reviewed and found to be appropriate. All Professional nurses and TMA's will be reeducated on 1. Completion of Incident Report for skin conditions, 2. documentation of all non pharmacologic interventions offered and attempted prior to the administration of any PRN medication. 3. Documentation of the effectiveness of the PRN mediation will also be reviewed. Dietary personnel shall be reeducated on the importance of checking the	

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F 282	Continued From page 12 licensed practical nurse (LPN)-B stated, "I think R6 has a skin tear on her left hand." LPN-B verified that R6 had a dressing (tagaderm plus) on top of her left hand and there is nothing in R6's treatment sheet identifying the skin concern. Further LPN-B verified the staff usually date the dressings when they are changed and verified R6's is undated. LPN-B was unsure of when R6's dressing was last changed. On 11/14/17, at 6:22 p.m., LPN-B stated, "I would love to tell you I found the documentation about her skin tear on her left hand in the medical record, but then I would be lying. They have all of her other skin issues in here just nothing that addresses R6's left hand." LPN-B stated they use, "problem sheets" every shift, that go back to the date of 10/27/17, and verified there was nothing identifying a skin concern for R6's left hand. During interview on 11/14/17, at 6:50 p.m., director of nursing (DON) verified R6 has a dressing on top of her left hand and further verified there is nothing in the medical record that identified, monitored or treated a skin issue on the top of R6's hand. DON stated her expectation is for staff to do skin checks at least on bath days and when staff find a skin concern it should be reported to the nurse immediately. The nurse should then assess the area, measure the wound, cleanse the area and dress it. DON then said, "Everything should be documented in the medical record." On 11/15/2017, 12:00 p.m., DON stated, "My expectation is for all my staff to follow the residents care plan." R61's significant change Minimum Data Set	F 282	nourishment and supplement lists to ensure residents receive what is ordered for them. The Director of Nursing or designee shall monitor this plan of correction for continued compliance through random audits of resident progress notes. 5 residents per week will be audited for one month. Results will be reported on at the February, 2018 QAPI Meeting. The Dietary Manager shall monitor the part of this plan of correction relating to nourishments and supplements. Random audits will be done 5 time a week for a month. Results will be reported on at the February, 2018 QAPI Meeting.	

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(MDS) dated 11/1/17, indicated R61 had no cognitive impairment with a diagnosis of lung cancer, chronic pain, low back pain, osteoarthritis, and knee pain.

R61's care plan dated 11/14/17, indicated R61 had an identified problem of, "risk for pain related to diagnosis of osteoarthritis, spinal stenosis, bilateral low back pain and left hip pain." Offer non-pharmacological interventions for pain: warm blanket, reposition, ice pack, snack, and one to one time. Administer pain medication as per MD orders and note effectiveness. Give PRN (as needed) meds for breakthrough pain as per MD orders and note the effectiveness.

R61's orders for October, 2017, include Morphine 20 mg/ml give 0.75 ml every 2 hours as needed for pain.
Review of R61's medication administration record (MAR) for September, October and November, 2017 identified how many times non-pharmacological measures were documented prior to PRN morphine administration and how many times medication effectiveness were documented.

Review of the MAR showed the following:

September, 2017: documented 19 of 50 times morphine given
October, 2017: documented 6 of 30 times morphine given
November, 2017: documented 2 of 17 times morphine given

On 11/14/17 at 7:08 p.m., R61 was observed to be sitting in her wheelchair in her room watching television and eating a cup of ice cream. No

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pained facial expression noted.

During interview on 11/15/17, at 10:05 a.m., trained medication assistant (TMA)-B stated when she gives a PRN pain medication she would have to write down on her report sheet any non-pharmacological approaches and medication effectiveness for all PRN medications given. TMA-B stated she gives the report sheet to the licensed nurse on her wing and the licensed nurse will document this in the residents chart.

During interview on 11/15/17, at 11:16 a.m., registered nurse (RN)-C stated that the TMA's do not have access to the resident's progress notes so they are unable to document non-pharmacological interventions offered prior to PRN medication being given or medication effectiveness. RN-C further stated the documentation of PRN medications is the nurses' job. RN-C said, "It is supposed to be 100 percent of documentation each time a PRN is given." It has been drilled into our heads to always offer non-pharmacological interventions and document effectiveness for PRN pain medications. RN-C verifies there is missing documentation for September, October, and November, 2017 for R61, and then stated, "It makes sense though because we have more TMA's working the cart and they can't document in the progress notes."

During interview on 11/15/17, at 12:00 p.m., director of nursing (DON) verified the missing documentation from September, October, and November, 2017 for R61 having non-pharmacological interventions attempted before medication is used. DON stated, my expectation for documentation of PRN medications is to first have the resident rate their

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pain, offer a non-pharmacological approach, give the PRN medication if the approaches did not help, wait 30 minutes go back and ask the resident if medication was effective. Then everything needs to be documented in the residents nursing progress notes. DON said, "My expectation for all my staff is to follow the resident's care plan."

R11's quarterly Minimum Data Set (MDS) dated 9/13/17, indicated R11 had moderate cognitive impairment with a diagnosis of , chronic obstructive pulmonary disease (COPD), Schizophrenia, Depression, Diabetes, congestive heart failure (CHF), left foot ulcer with first metatarsal (toe) osteomyelitis (infection in bone). chronic pain, low back pain, osteoarthritis, and knee pain.

R11's care plan dated 9/26/17, indicated R11 had an identified problem of, "risk for pain related to diagnosis of left foot ulcer with first metatarsal osteomyelitis, COPD, and paranoid schizophrenia." Offer non-pharmacological interventions for pain: warm blanket, reposition, ice pack, hot pack, snack, ride in wheelchair (w/c) and one to one time. Administer pain medication as per MD orders and note effectiveness. Give as needed (PRN) meds for breakthrough pain as per MD orders and note the effectiveness. Document/report complaints and nonverbal signs of pain.

R61's orders for October, 2017, include Neurontin 100 mg by mouth twice daily for pain, Oxycodone 5 mg by mouth every four hours as needed (PRN) for pain, dyspnea (difficult breathing) and restlessness. Tylenol 1000 mg by mouth every six

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F 282	Continued From page 16 hours PRN for pain. Review of R11's medication administration record (MAR) for September, October and November, 2017 identified how many times non-pharmacological measures were documented prior to PRN oxycodone administration and how many times medication effectiveness were documented as follows: September, 2017: documented 4 of 21 times oxycodone given with effectiveness October, 2017: documented 1 of 8 times oxycodone given with effectiveness November, 2017: documented 1 of 5 times oxycodone given with effectiveness 11/15/17, at 9:11 a.m. trained medication aide (TMA)-A stated, "I will try warm blankets, toileting. Whatever I tried I will write on my sheet and let my charge nurse know." "I also write on my sheet if effective [non-pharmacological interventions] and let the charge nurse know." 11/15/17, at 11:39 a.m., during interview LPN-A verified that there is only documentation for non-pharmacological and effectiveness of PRN pain meds given four times in September, one time in October and once in November 2017. LPN-A said that the expectation is every time PRN medication is given that non-pharmacological and effectiveness of interventions is documented along with pain rate before and after med pain. R37's current care plan identified assistance in eating. Requires mechanically altered diet related to increased confusion. At risk for weight loss	F 282		

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related to spitting out all food. Will take fluids. Resident's weight is slightly above suggested weight range. Weight loss of 12 pounds in the last six months. Weight loss related to increased confusion and letting food run out of mouth. Interventions included regular diet with pureed texture as ordered, monitor meal intake and supplements as ordered.

R37's current physician orders dated 11/7/17, included magic cup (supplement) twice daily at 12 noon and 5:30 p.m., supper.

During observation on 11/14/17, at 5:58 p.m., R37 was seated in a Broda chair in the dining room at a table. Nursing assistant (NA)-B was seated next to R37 and assisting R37 with eating.

During interview on 11/14/17, at 6:07 p.m., NA-B confirmed she had assisted R37 with her meal. NA-B stated R37 was served orange juice, water, tomato juice, pizza and peaches. When queried if R37 was served a magic cup, NA-B stated no.

During observation on 11/15/17, at 11:44 a.m., R37 was seated in Broda chair in the dining room at a table. NA-D was seated next to R37. R37's food was observed to be served and NA-D stated R37 was served cake, ham, potatoes, broccoli and drinks included milk, ensure alive drink, and water. NA-D assisted R37 with eating. At 11:55 a.m., when queried if R37 was ever served a magic cup supplement for lunch, NA-D stated sometimes R37 received a magic cup if R37 did not receive the ensure alive drink.

During interview on 11/15/17, at 12:01 p.m., dietary cook (DC)-A stated supplements during mealtime were passed out by dietary staff. DC-A

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stated she was aware R37 was to receive a magic cup, but was changed to receive the ensure alive drink that was red in color.

During interview on 11/15/17, at 12:03 p.m., dietary aide (DA)-A stated R37 was to receive the ensure alive drink, I follow what is on the list.

During interview on 11/15/17, at 12:05 p.m., the dietary manager (DM) stated R37 had been receiving ensure clear, but that was discontinued because R37 was not taking it. DM reviewed R37's orders and confirmed the orders included an order for magic cup twice daily. DM stated I do not know how the order did not get communicated to everybody. DM stated I will double check the nourishment list. DM stated it might be an error on my part if the magic cup is not on the list, I will double check it.

During interview on 11/15/17, at 2:39 p.m., the director of nursing (DON) stated she would expect the dietary department to provide the magic cup as ordered during the lunch and supper meal. The DON stated dietary was informed anytime there were changes in orders.

The facility policy Care Plan, dated reviewed 12/4/13, indicated Policy: The facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will describe: 1). the services that will be furnished to attain or maintain the resident's highest practicable physical, mental, psychosocial well-being.

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F 312	Continued From page 19	F 312		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R24 & R11) who were dependent on staff for meeting activities of daily living (ADLs) including trimmed and clean fingernails. Findings Include: R24 was observed on 11/13/17, at 10:16 a.m., to have fingernails that were uneven, broken and long with black debris underneath the nail beds on both hands. During observation on 11/14/17, at 4:37 p.m., R24 was seated in a wheelchair in the lobby area. R24's fingernails remained uneven, broken and long with black debris underneath the nailbeds on both hands. During observation on 11/15/17, at 8:15 a.m., R24 was seated in a wheelchair in the lobby area. R24's fingernails remained uneven, broken and long with black debris underneath the nailbeds on both hands. R24's quarterly Minimum Data Set (MDS) dated 9/27/17, identified required extensive assist of two persons for personal hygiene and two person physical assist with bathing.	F 312	Deficiency with ID Prefix Tag F312 shall be corrected. The facility shall ensure residents fingernails are trimmed and clean. R24 nails were cleaned and trimmed immediately. R11 nails were cleaned but she declined trimming. All residents will be offered nail care including cleaning and trimming. All Professional Nurses and CNA's will be reeducated on proper fingernail care, including cleaning and trimming. Nail care shall be provided on bath days at a minimum. The Director of Nursing or designee shall monitor this plan of correction for continued compliance through random audits of resident nails. 10 residents a week for one month shall be audited. Results of the audits will be reviewed at the February, 2018 QAPI meeting.	12/19/17

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R24's current care plan identified R24 required extensive assist of one with grooming and dressing.

On 11/15/17, at 10:32 a.m., observation of the bath schedule wing one identified R24 received a shower on Tuesday a.m. and Friday a.m.

R24's bath sheets dated 11/10/17, 11/7/17 and 10/31/17, identified no documented care for fingernails.

During interview on 11/15/17, at 10:37 a.m. nursing assistant (NA)-C stated fingernails were cleaned and trimmed when a resident received a shower or every day when needed and there is time to provide the care, unless the resident was diabetic then the nurse would trim the residents nails.

During observation of R24's fingernails on 11/15/17, at 10:39 a.m., registered nurse (RN)-B stated, "Yeah, they need to be clipped, soaking would be better." RN-B confirmed R24's fingernails were uneven, long and had black debris underneath the nail beds. RN-B stated resident fingernails were to be cleaned and trimmed on bath days by the nursing assistant unless the resident was on Coumadin (anticoagulant) or diabetic then the nurse would provide the care.

During interview on 11/15/17, at 2:34 p.m., the director of nursing (DON) stated resident nails were trimmed on bath days and the facility had bath sheets to document nail care. DON stated nursing assistants were to provide nail care unless the resident is on Coumadin or is diabetic

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then the nurse would provide nail care.
R11 was observed on 11/14/17 at 12:31 p.m., to have long fingernails with brown substance under nails.

11/15/17, 1:18 p.m., R11 sitting in main lobby continues to have brown substance under fingernails, and long. Asked R11 if the staff help keep nails trimmed and clean. R11 said, "I don't know."

11/15/17, 11:55 a.m. trained medication aide (TMA)-B stated that nail care is done with bath and as needed. The nurses do nail care for residents with diabetes.

11/15/2017, 1:22 a.m., R11 observed picking nose with fingers of left hand at this time. Also picking and scratching ears.

11/15/17, 1:23 p.m., licensed practical nurse, (LPN)-B , looked at R11's nails and verified that nails were long and dirty. LPN-B said, "They need to be cleaned." Also said the expectation was nail care are check with a.m. and p.m. cares and after meals for cleaning needs and on shower days they should be cleaned and trimmed. LPN-B asked R11 if she wanted nails trimmed. R11 stated 'No", but agreed to have them cleaned and filed later.

R11's Progress note dated 10/28/17, indicated fingernails to be long and a couple broken, was offered to trim them and she refused. No reason given.

Progress note date 11/15/17, indicated that R11 declined to have fingernails trimmed, but allow staff to have them soaked and clean nails. Note

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F 312	Continued From page 22 further indicated that will continue to observe and assist to clean nails when needed. R11's Care plan dated 9/26/17 indicated that resident requires assist of licensed nursing staff to trim nails on bath day and PRN (as needed) due to risk of bleeding with use of anticoagulation medications, along with diagnosis of diabetes. A facility policy for fingernail care dated 11/27/2010, indicated Policy to provide cleanliness, prevent spread of infection, for comfort, prevent skin problems. procedure: give details in structures to soak hands for five minutes then scrub gently, trim and clean nails gently; file smoothly. NOTE: FINGERNAILS OF DIABETIC RESIDENTS ARE TO BE CUT BY THE NURSE. Also noted procedure maybe done directly after bath or shower rather than soaking hands.	F 312		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment	F 441		12/19/17

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F 441	Continued From page 23 implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified	F 441		

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F 441	Continued From page 24 under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure acceptable standards of practice to prevent the spread of infection by using a disinfectant following blood glucose procedure for 2 of 2 residents (R6 & R11); disinfecting/sanitizing nebulizer equipment after use for 1 of 1 resident (R18); and washing hands after when going from a soiled procedure to clean procedure during perineal cares and during wound dressing treatment for 1 of 1 resident (R37) who had a pressure ulcer treatment completed. Findings include: GLUCOMETER: R6 had been observed for blood sugar check on 11/13/17, at 7:45 a.m., licensed practical nurse (LPN)-A was observed to wash hands, don gloves, check R6's blood sugar using a glucometer, removed gloves, and wash hands. LPN-A placed the glucometer into a clear bag, which contained R6's insulin pens and placed the bag into a drawer of the medication cart. At the time LPN-A stated each resident had their own individual glucometer. LPN-A stated she had cleansed R6's glucometer with an alcohol pad.	F 441	Deficiency with ID Prefix Tag 441 shall be corrected. The facility shall ensure acceptable standards of practice to prevent the spread of infection by using disinfectant for glucometer cleaning, disinfecting/sanitizing nebulizer equipment after use and washing hands when going from a soiled procedure to a clean procedure. R6 and R11 glucometers are being clean with an appropriate bleach wipe. R18 nebulizer is cleaned after each use. Staff providing pericare and dressing changes to R37 use proper hand washing when going from soiled to clean procedures. All resident glucometers shall be cleaned with a bleach wipe. All residents who use a nebulizer shall have their nebulizers cleaned after each use. All residents receiving pericare or dressing changes shall have this completed using proper hand washing technique when changing gloves. All Professional nurses and CNA's shall be reeducated on the proper procedure for cleaning glucometers, Proper	

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F 441	Continued From page 25 When queried what the facility policy was for cleaning a glucometer, LPN-A stated I probably should have used the sanitizing bleach wipes to clean the glucometer. Observation of the container of Clorox bleach germicidal wipes identified the container read meets OSHA (Occupational Safety and Health Administration) bloodborne pathogen standards. R11 had been observed for blood sugar check on 11/14/17, at 4:24 p.m., LPN-B (a pool agency staff) (who was being trained directly by registered nurse (RN)-A) was observed to wash hands, don gloves, check R11's blood sugar using a glucometer, remove gloves, carried the glucometer on top of a clear bag out of R11's room, donned gloves, cleansed the glucometer with a Clorox disinfectant wipe, removed gloves, allowed the glucometer to dry, placed the glucometer into the clear bag and placed the bag into a drawer on the medication cart. LPN-B failed to wash hands after checking R11's blood sugar and after cleansing the glucometer. At the time when queried regarding the lack of washing hands after the glucometer check and after cleansing the glucometer, RN-A stated o.k. and LPN-B made no reply. NEBULIZER EQUIPMENT: R18 had been observed on 11/14/17, at 4:11 p.m., LPN-B was observed to wash hands, don gloves and administer albuterol sulfate medication to R18 via nebulizer using a mask. After administration of the mediation, LPN-B removed the mask from R18, placed the nebulizer mask and equipment onto the nebulizer machine, removed gloves, washed hands and walked out of R18's room. At the time when queried what the facility policy was regarding	F 441	procedure for cleaning nebulizers and proper handwashing technique when going from a soiled procedure to a clean procedure. The Director of Nursing shall monitor this plan of correction for continued compliance through random audits of 10 residents a week with all of the identified areas being audited. Results shall be reviewed at the February, 2018 QAPI Meeting.	

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cleaning of the nebulizer equipment after administration of medication RN-A stated, "I do not know if we have a policy." RN-A verified the R18's nebulizer equipment had not been cleaned after administration of medication by LPN-B. RN-A stated we typically do not clean the nebulizer equipment after administration of medication. RN-A stated the nebulizer equipment was changed weekly. LPN-B made no reply.

PERI-CARE:
R37 had been observed for bedtime cares on 11/14/17, at 6:32 p.m., nursing assistant (NA)-A washed hands, donned gloves and cleansed R37's peri area and buttocks area using a washcloth. NA-A with the same dirty gloves on applied a clean incontinent brief onto R37, touched R37's pajamas on R37's shoulder and removed gloves. NA-A applied gloves and proceeded to finished providing cares to R37, walked out of R37's room and washed hands. NA-A failed to remove gloves and wash hands after providing peri-care. At the time NA-A verified she had not washed hands after providing peri-care. NA-A stated she had removed gloves and put gloves back on after providing peri-cares.

WOUND DRESSING CHANGE:
R37 had been observed during a pressure ulcer wound dressing change on 11/15/17, at 10:02 a.m., RN-B was observed to wash hands, don gloves, remove old dressing from R37's right buttock, removed gloves, donned gloves, cleansed the wound area using normal saline and gauze, removed gloves, donned gloves, applied metronidazole (antibiotic) cream with a q-tip onto the wound area, applied a gauze pad over the wound area, put R37's incontinent brief in place to hold the dressing in place, removed gloves and

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washed hands. RN-B failed to wash hands after removal of soiled wound dressing and after cleansing the wound. At the time, RN-B confirmed she had not washed hands during the dressing change procedure.

During interview on 11/15/17, at 10:51 a.m., when queried when staff should wash hands during the provision of care for a glucometer check, RN-A stated, "I do not know." RN-A reviewed the facility policy for glucometer check and stated the policy did not address handwashing. RN-A stated the facility policy for handwashing does not address when hands should be washed for a glucometer check. RN-A stated after providing peri-cares gloves should be removed before touching anything else and hands washed. RN-A stated for a wound dressing change she would expect handwashing to be done between glove changes and gloves to be changed between tasks.

During interview on 11/15/17, at 2:29 p.m., the director of nursing (DON) stated the cleansing a glucometer with an alcohol pad was not sufficient. The DON stated she would expect handwashing after glove removal for checking a blood sugar and cleansing a glucometer. DON stated she would expect nebulizer equipment to be rinsed under warm water and laid on a paper towel to air dry after administration of medication. DON stated after peri-cares I would want staff to remove gloves and wash hands. DON stated she would expect for wound care dressing change staff to wash hands or use sanitizer after soiling gloves and moving on to a clean procedure.

The facility policy Handwashing, dated reviewed 12/4/13, indicated Policy: Medical asepsis to control infection and to reduce transmission of

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organisms, with procedure of how to wash hands. The policy did not address when to wash hands during or after which procedures.

The facility policy Personal Protective Equipment Gloves, dated revised 7/09, indicated Policy Interpretation and Implementation 8. Wash your hands after removing gloves.

The facility policy Disinfecting Glucometer, dated 3/1/10, indicated Policy to prevent cross-contamination of pathogens among residents needing blood glucose monitoring. Procedure: 1. Wipe meter with clean lint free cloth dampened with 10 percent household bleach and water, or EPA approved solution. Allow to dry following manufacturer guidelines. 3. Do not use alcohol to clean meter as it will cause damage to the meter. The policy did not address washing hands.

The facility policy Perineal Care, dated 11/18/10, indicated Policy 1. To cleanse the perineum and prevent infection and odor. Procedure: 3. Don gloves before contact with linens, incontinent pads or resident. The policy did not address when to remove gloves and wash hands.

The facility policy Dressing Change (clean), dated 11/22/10, indicated Policy: 1. To protect wound. 2. To prevent irritation. 3. To prevent infection and spread of infection. 4. To promote healing. Procedure: 5. Put on first pair of disposable gloves. 6. Remove soiled dressing and discard in plastic bag. 7. Dispose of gloves in plastic bag. 8. Put on second pair of disposable gloves. 10. Cleanse wound with prescribed solution. 11. Apply prescribed medication if ordered. 12. Apply dressings and secure with tape. 13. Remove

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F 441	Continued From page 29 gloves and discard with all unused supplies in plastic bag. 14. Assist resident to comfortable position with call light in reach. The policy did not address washing hands.	F 441		

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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 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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

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

Electronically Signed | 12/11/2017

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 Angela.Kappenman@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 protected by a full fire sprinkler system. 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. The facility has a capacity of 55 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351	Sprinkler System - Installation	K 351		12/19/17

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K 351 SS=D	Continued From page 2 CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of	K 351	Deficiency with ID Prefix Tag K351 shall be corrected. A new up-right sprinkler head was installed on 12/1/2018. Tony Bauer, Director of Maintenance is responsible for this plan of correction and shall monitor for continued compliance of the plan of correction.	

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K 351	Continued From page 3 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Findings Include: On facility tour between 09:00 AM and 0100 PM on 11/16/2017, based on observation and interview revealed that the following include: Found Room 317 need fire sprinkler head relocated to up-right style as ceiling tiles were removed. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351		
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	K 354		12/19/17

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K 354	Continued From page 4 This REQUIREMENT is not met as evidenced by: Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/16/2017, based on documentation review and interview that the following include: Facility does not have a current out of service policy for fire sprinkler system. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 354	Deficiency with ID Prefix Tag 354 shall be corrected. Sprinkler System - Out of Service Policy and Procedure has been updated to the current requirement of initiating a Fire Watch when the sprinkler System is out of service for more than 10 hours. This was completed on 12/7/2017. Tony Bauer, Maintenance Director, shall monitor this Plan of correction for continued compliance.	
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls	K 362		12/19/17

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K 362	Continued From page 5 constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating B if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.	K 362	Deficiency with ID Prefix Tag K362 shall be corrected. The identified penetration in the east wing smoke barrier above access panel around conduit pipe and large hole to old roof has been sealed off. This was completed on 12/11/17. Tony Bauer, Maintenance Director is responsible for continued compliance of this plan of correction.	

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K 362	Continued From page 6 19.3.6.2, 19.3.6.2.7 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/16/2017, based on observation and interview revealed that the following include: Penetration's in east wing smoke barrier above access panel around conduit pipe and large hole to old roof unit. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 362		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920		12/19/17

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K 920	Continued From page 7 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 11/16/2017, based on observation and interview revealed that the following include:	K 920	Deficiency with ID Prefix Tag K920 shall be corrected. All multi power strips that are not UL 1363 listed have been removed from resident rooms. Only UL 1363 multi power strips shall be used in resident rooms. Tony Bauer, Maintenance Director shall monitor this Plan of correction for continued compliance.	

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K 920	Continued From page 8 Found multi plug adapters being used that are not UL1363 listed in resident rooms through out facility. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920		