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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C0TP

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 **12/15/2016** (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 :
Kyla Einertson, HFE NE II 12/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/28/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245344

December 20, 2016

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 November 22, 2016 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
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 20, 2016

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

RE: Project Number S5344028

Dear Ms. Sheeran:

On October 31, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 19, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 23, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 22, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 19, 2016, effective November 22, 2016 and therefore remedies outlined in our letter to you dated October 31, 2016, 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.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245344 Y1	A. Building B. Wing Y2	12/15/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0278	Correction	ID Prefix F0312	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.20(g) - (j)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	11/22/2016	LSC	11/22/2016	LSC	11/22/2016
ID Prefix F0329	Correction	ID Prefix F0334	Correction	ID Prefix F0465	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.25(n)	Completed	Reg. # 483.70(h)	Completed
LSC	11/22/2016	LSC	11/22/2016	LSC	11/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kf	12/20/2016	28651	12/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
10/19/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245344	A. Building 01 - MAIN BUILDING 01 B. Wing	11/23/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 11/22/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 11/22/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 12/20/2016	SIGNATURE OF SURVEYOR 37008	DATE 11/23/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/18/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

December 20, 2016

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

Re: Reinspection Results - Project Number S5344028

Dear Ms. Sheeran:

On December 15, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 15, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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
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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00103 Y1	A. Building B. Wing Y2	12/15/2016 Y3

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20920	Correction	ID Prefix 21426	Correction	ID Prefix 21540	Correction
Reg. # MN Rule 4658.0525 Subp. 6 B	Completed	Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.1315 Subp. 2	Completed
LSC	11/22/2016	LSC	11/22/2016	LSC	11/22/2016
ID Prefix 21695	Correction	ID Prefix 21800	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.1415 Subp. 4	Completed	Reg. # MN St. Statute144.651 Subd. 4	Completed	Reg. #	Completed
LSC	11/22/2016	LSC	11/22/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/19/2016	☐ 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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C0TP

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 **10/19/2016** (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
X 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: **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 Finertson, HFE NE II 11/17/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/07/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 31, 2016

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

RE: Project Number S5344028

Dear Ms. Sheeran:

On October 19, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: 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 November 28, 2016, 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 November 28, 2016 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 January 19, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 19, 2017 (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

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 _____	10/19/2016

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.	F 000		
F 156 SS=D	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 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	F 156		11/22/16

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

Electronically Signed | 11/10/2016

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	F 156		

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 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

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F 156	Continued From page 2 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 required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of all Medicare Part A skilled services for 3 of 3 residents (R8, R49, R69) reviewed for liability notice and beneficiary appeal rights. Findings Include: R8 was discharged from Medicare Part A on 6/17/16, and remained in the facility. R8 used 68 days of Medicare A coverage out of 100 days. The facility did not provide R8 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to	F 156	Deficiency with ID Prefix Tag F156 shall be corrected. The facility shall ensure they provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of Medicare Part A Skilled Services. An SNF ABN CMS 10055 will be given to the legal representative of R8. This notice will not change Medicare Billing because R8 was not receiving any Medicare qualified services after June 17, 2016. This notice is given to be in compliance with Medicare ABN Guidelines. An SNF ABN CMS-10055 will be given to the legal representative of R49. This notice will not change Medicare Billing because R49 was not receiving any Medicare qualified services after May 18,	

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F 156	Continued From page 3 Medicare. R49 was discharged from Medicare Part A on 5/18/16, and remained in the facility. R49 used 37 days of Medicare A coverage. The facility did not provide R49 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare R69 was discharged from Medicare Part A on 7/1/16, and remained in the facility. R69 used 59 days of Medicare A coverage. The facility did not provide R69 and/or his legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform him of potential liability for non-covered services and of her right to appeal the denial to Medicare On 10/19/2016, 10:13 a.m. the business office manager (BOM) stated she believed the only denial notice being issued by the facility was the generic notice. On 10/19/16 at 12:15 p.m. the BOM stated she spoke with the staff member responsible for completing the Medicare denial notices for the facility and stated the facility does not issue SNFABNS at this time based on information provided at a training she had attended. The Fairview Care Center Medicare Denial and Demand Bill Notices policy implemented 12/07 instructed staff to provide proper notice when a resident's Medicare Part A or Part B is ending. It instructed staff to utilize an attached "Forms and New Expedited Appeals Process" which directed staff as to which forms must be given based on	F 156	2016. This notice is given to be in compliance with Medicare ABN Guidelines. An SNF ABN CMS-10055 will be given to the legal representative of R69. This notice will not change Medicare Billing because R69 was not receiving Medicare qualified services after July 1, 2016. This notice is given to be in compliance with Medicare ABN Guidelines. All residents resident covered under Medicare A have a potential to be effected. The Reference Binder for all Medicare Notification forms has been reviewed and updated to ensure the guidelines for use of the SNF ABN is correct and accurate. A consultant will be meeting with staff responsible for ensuring the SNF ABN is given to re educate them on the guidelines for use of this notice. This training is scheduled for November 18, 2016. The Administrator shall monitor this Plan of Correction for continued compliance through review of all residents whose Medicare A coverage ends and they remain in the facility. This shall continue for three months and findings reported at the February, 2016 QAPI Meeting.	

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F 156	Continued From page 4 the specific situation of the resident. The Skilled Nursing notice quick reference indicated, "Part A stay will end because: beneficiary no longer requires daily skilled services but will remain in the SNF [skilled nursing facility]." The facility was to issue the SNFABN (CMS-100550 and the expedited Determination/Generic Notice.	F 156		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		11/22/16

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F 278	Continued From page 5 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 accurately coded for 1 of 1 resident (R30) reviewed for accidents. Findings Include: R30's Annual Minimum Data Set (MDS) dated 9/6/16, identified R30 displayed behavior of wandering on a daily basis and the wandering placed R30 at significant risk for getting to a potentially dangerous place. R30 was observed on 10/17/2016, at 3:22 p.m. in common area of the facility sitting in her wheelchair. Resident has not been observed to be wander. R30 was observed on 10/18/2016, at 10:22 a.m. sitting in her wheelchair in the common area of the facility. Resident has not been observed to wander. R30 was observed on 10/19/2016, at 9:10 a.m. in the common area of the facility sitting in her wheelchair. Resident has not been observed to wander. R30's elopement evaluation dated 9/1/16 included, "Resident is not at risk for elopement at this time. She does not ask to leave and does not attempt to leave the facility. She knows this is her home. Will continue to monitor and eval [evaluate] quarterly and with any changes." R30's care plan did not identify behavior of wandering. R30's progress note dated 9-6-16 included, "... is	F 278	Deficiency with ID Prefix Tag F278 shall be corrected. The facility shall ensure the Minimum Data Set (MDS) is coded accurately for accidents. A modification for R30's MDS will be completed to accurately code for accidents. All MDS's for residents who have wandering coded will be reviewed to ensure accuracy in coding. The Social Worker and MDS Coordinator shall both be reeducated on the coding of wandering on the MDS through review of the RAI Manual and reeducation by a Consultant on November 18, 2016. The Director of Nursing or designee shall monitor continued compliance with this Plan of Correction through random review of two MDS's a week over the next two months. Findings will be reported at the February, 2016 QAPI	

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F 278	Continued From page 6 alert and oriented to person and place. She is very forgetful of information so she requires much cueing and assistance from staff. She often gets turned around so staff will direct her in the right direction as she gets disoriented very easily and will wander down the wrong wing or hallway..." On 10/19/2016, at 11:02 a.m. nursing assistant (NA)-A stated there were no concerns with R30 and wandering. NA-A stated R30 did not go into other resident rooms that she had seen, she did not try to leave the building and did not use a wander guard. On 10/19/2016, at 8:28 a.m. the director of nursing (DON) stated R30 had no elopements in the last year. The DON stated she has not known R30 to wander and stated she did not think R30 even wandered into other resident rooms. The DON stated R30 did not wear a wander guard and did not have a history of wandering. The DON stated she spoke to the social worker that completed the behavior section of the MDS and stated she believed the MDS was coded in error.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 provide nail care for 1	F 312	Deficiency with ID Prefix Tag F312 shall be corrected. Fairview Care Center shall	11/22/16

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F 312	Continued From page 7 of 3 resident (R4) reviewed for activities of daily living. Findings include: R4 on 10/18/16 at 12:15 p.m., and on 10/19/16, at 8:59 a.m. was observed to have had dark debris under all the fingernails on the right hand. The left hand had three sharp and jagged fingernails and the forefinger nail had curled over and an indentation of skin was noted caused by nail growth. R4's quarterly Minimum Data Set (MDS) (a standardized, primary screening and assessment tool) dated 7/26/16, indicated R4 required extensive assistance with personal hygiene. R4's MDS indicated R4 had significant cognitive impairment. R4's diagnosis, listed on the Resident Face Sheet, included dementia, Type 2 diabetes mellitus and occlusion and stenosis of basilar artery. R4's activity of daily living (ADL) Care Area Assessment (CAA) worksheet dated 10/17/16, revealed that R4 had an activities of daily living (ADL) deficit related to dementia and required extensive assistance with personal hygiene. R4's care plan indicated licensed nursing staff to trim toenails and fingernails for safety. R4's care plan specified registered nurse, licensed practical nurse/licensed vocational nurse was responsible to trim toenails and fingernails. On 10/19/16, at 8:47 a.m. nursing assistant (NA)-A was assisting R4 with morning cares. NA-A stated R4 had a shower at 5:00 a.m. by the night shift. NA-A confirmed R4 had long, jagged	F 312	ensure that residents who are not able to carry on activities of daily living receive the necessary services to maintain good nutrition, grooming and personal oral hygiene. R4 received proper nail care immediately upon being made aware of need. R4 shall be offered nail care with bathing and as needed by licensed staff per facility policy. All residents who need assistance with nail care shall be offered this in accordance with their care plan and facility policy. All nursing personnel will be educated on the importance of following the procedure for nail care. The Director of Nursing or designee shall monitor for continued compliance with this plan of correction through direct observation of residents to ensure that they are receiving proper nail care. Five residents a week will be observed for the next two months. Findings will be reported at the February QAPI.	

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F 312	Continued From page 8 and debris under his fingernails. NA- stated the nurses do nail care for R4 because of his diabetes. On 10/19/16, at 1: 13 p.m. the director of nursing and the nurse manager confirmed that R4's nail care should have been done by the night nurse on bath days due to R4's diagnosis of diabetes mellitus and warfarin (blood thinner) therapy. On 10/19/16, at 1: 25 p.m., registered nurse (RN)-B stated the night nurse had not asked her to provide nail care to R4. RN-B stated R4's nails had been trimmed after she was made aware of the need to have fingernails trimmed by surveyor. Policy titled Nails, Care of (Finger and Toe) dated 11/27/10, was provided. Under the procedure section of the policy, it indicated "NOTE: FINGERNAILS OF DIABETIC RESIDENTS ARE TO BE CUT BY THE NURSE."	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		11/22/16

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F 329	Continued From page 9 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure clear parameters were in place for use of pain medication and facility had not attempt non-pharmacological interventions prior to the use of narcotic pain and anti-anxiety medications for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include: R4's quarterly Minimum Data Set (MDS) (a standardized, primary screening and assessment tool) dated 7/26/16, indicated R4 required extensive assist with bed mobility and transfers to and from one surface to another; had a pain management regimen and did not have a condition or prognosis that may have resulted in a life expectancy of less than six months. The MDS indicated significant cognitive impairment. R4's diagnosis, listed on the physician order sheet, included dementia, Type 2 diabetes mellitus, dementia, hemiplegia and hemiparesis following cerebral infarction affecting left side, depression and anxiety.	F 329	Deficiency with ID Prefix Tag F329 shall be corrected. Fairview Care Center shall ensure that a residents' drug regimen is free from unnecessary drugs. R4 medications were reviewed and Dilaudid and Lorazepam were discontinued by the MD. A pain assessment was completed to assure pain was being managed with prescribed medications. All residents who receive PRN medications will have parameters for their use in accordance with their care plan and facility policy. The pain management policy will be reviewed and Clinical Nurse Managers will be educated on the importance of indicating parameters with PRN medications. The Director of Nursing and/or designee shall monitor this plan of correction for continued compliance through random monitoring of orders received for PRN medications and parameters indicated. Findings will be reviewed the February,	

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F 329	Continued From page 10 Review of R4's current physician orders dated October 2016, included the following medication orders: Tramadol 25 my by mouth (po) three times daily (for moderate pain) Tramadol 25 mg po every four hours as needed (PRN) for breakthrough pain Dilaudid 1 milligram (mg)/milliliter (ml) by mouth (PO) every one hour PRN pain. shortness of breathe (SOB)/restlessness/anxiety (for moderate to severe pain) Lorazepam (anti-anxiety medication) 2 mg/ml PO every 4 hours PRN anxiety/restlessness/agitation/ not relieved by Dilaudid. On 9/1/16, at 6:33 a.m. registered nurse (RN)-C documented in the electronic medical record that R4 "was having some anxiety at 2300 [11:00 p.m.] He stated he needed to get up out of bed and get a pair of pliers to finish up a job before going to bed. He was holding on to a CNA's [certified nursing assistant's] arm tightly and stated he would not let go until someone got him up out of bed. administered dilaudid at 2315 [11:15 p.m.] Writer talked to with him for a bit and during that time he grabbed writer's hair say he would not let go until someone go him up out of bed. Continued to yell out "get me out of bed please." Administered Ativan at 12 am [12:00 a.m.] Resident was sleeping at 1230 [12:30 a.m.] am. He woke up about 0500 [5:00 a.m.] to take morning medications..." Pharmacist Medication Regimen Review dated 9/27/16 at 5:55 p.m. indicated the Consultant Pharmacist reviewed "labs and medical history reviewed, no significant irregularities identified."	F 329	2017 QAPI.	

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 _____	10/19/2016

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 329	Continued From page 11 Interview with licensed practical nurse (LPN)-A on 10/19/16 at 1: 15 p.m. revealed that the Dilaudid and lorazepam were ordered for end-of-life care. LPN-A stated R4 had declined in health after his wife passed away. The medications were ordered in anticipation of providing comfort. LPN-A stated the staff should have assisted R4 out of bed when her requested it rather then giving a pain pill. LPN-A confirmed there were no parameters for when to give pain medication vs. antianxiety medication. The director of nursing (DON) was interviewed on 10/19/16, at 1:13 p.m. The DON stated the staff should have gotten R4 up out of bed when her requested to get up. The DON confirmed there were no clear parameters for giving the pain medication vs. the antianxiety medication. A policy was requested for medication parameters however, none was provided.	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334		11/22/16

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F 334	Continued From page 12 immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 334	Continued From page 13 (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to ensure pneumococcal vaccinations were completed for 1 of 6 residents (R60) who qualified for the most current pneumococcal immunizations regimen. Findings include: R60 was admitted to the facility on 7/1/16 according to the admission form. On asking the facility for R60's pneumococcal vaccination history. None was provided. Interview on 10/19/16, at 4:04 p.m. with registered nurse (RN)-A stated the facility usually admits residents from Mayo Clinic facilities and the facility is able to get all vaccination records on admission. However, RN-A stated if the resident is admitted from a non-Mayo Clinic affiliate they don't often get the information from these providers. RN-A stated R60 was asked on admission about pneumococcal vaccinations and stated he had the vaccinations prior to admission. RN-A stated that she did not document this information anywhere and had not request vaccination status from previous health clinic/facility. Policy titled, Influenza and Pneumococcal Disease Prevention dated 10/4/16, indicates a	F 334	Deficiency with ID Prefix Tag F334 shall be corrected. Facility shall ensure pneumococcal immunizations are complete for residents who qualify for the most current pneumococcal immunization regimen. R60 has received the correct pneumococcal immunization according to the most current regimen. All current resident immunization records will be reviewed to ensure they are compliant with current pneumococcal regimen. New admissions will have their immunization records reviewed to ensure proper immunizations are offered. The Influenza and Pneumococcal Disease Prevention Policy and Procedure was reviewed at the November 8, 2016 QAPI meeting and found to be accurate and compliant with the current regimen. The Director of Nursing and/or designee shall monitor this Plan of Correction for continued compliance through review of all new admissions over the next two months. Findings will be reported at the	

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F 334	Continued From page 14 permanent vaccination record is placed in each resident's chart indicating the residents immunization status from the time of admission until discharge.	F 334	February 2017 QAPI Meeting.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the bathroom exhaust vents located in resident bathrooms were cleaned to maintain a sanitary environment both physically and odor wise and promote optimal air removal in the bathroom environment for 31 of 36 bathrooms (101, 102, 103, 104, 105, 107, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220) which were used by residents residing in attached bedrooms. Findings include: Upon entrance to the facility on 10/17/16 at 2:31 p.m. resident bathrooms in rooms 109, 115, 202, 205, 206, and 208 were observed to have visible heavy debris/dust present on the vent grille covers. Upon further investigation on 10/18/16 at 4:05 p.m. the following bathroom exhaust vents had heavy debris/dust present on vent grille covers: 101, 102, 103, 104, 105, 107, 109, 110,	F 465	Deficiency with ID Prefix Tag F465 shall be corrected. Fairview Care Center shall ensure appropriate cleaning of resident bathroom exhaust vents. All bathroom exhaust vents were cleaned on 10/18/2016. Cleaning of the resident bathroom ceiling exhaust vents is included on the daily housekeeping tasks ensuring each resident bathroom exhaust vent is cleaned on a weekly basis. Policy on "Full Room Cleaning" has been reviewed and revised to include cleaning of the bathroom exhaust vents on a weekly basis. Housekeeping staff has been reeducated on the Full Room Cleaning Policy and Procedure and the responsibility of ensuring the bathroom exhaust vents are cleaned weekly. The Housekeeping Supervisor or dsignee will monitor this Plan of Correction for continued compliance through direct	11/22/16

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F 465	Continued From page 15 111, 112, 113, 114, 115, 116, 117, 118, 119, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220 which had been visible from the doorway of the bathroom. On 10/18/16 at 4:40 p.m. the maintenance director observed the exhaust vent in bathroom 208 and 101. The maintenance director confirmed the vent grille cover was covered in dust adding the facility had recently switched from cooling to heating. On 10/19/16 at 10:30 a.m. the housekeeping supervisor observed the exhaust vent in bathroom 105. The housekeeping supervisor stated the exhaust vents looked "poor" and quite dusty. Adding; the housekeeping staff were suppose to be cleaning the vents every week. The housekeeping supervisor provided a document titled, Cleaning A Residents Rooms During the Week, undated which read, "Dusting means the TV [television] and the TV stand. Dusting of ceiling vents in bathrooms and rooms... Dusting on shelves, heat vents, ceiling vents, under beds, etc. on these designated room days."	F 465	observation of the resident bathroom exhaust vents. 10 bathrooms per week shall be observed over the next two months with finding reported at the February, 2017 QAPI meeting.	

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	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2016**

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FAIRVIEW CARE CENTER	**702 10TH AVENUE NORTHWEST, PO BOX 10** **DODGE CENTER, MN 55927**

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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 dated 10-18-2016, 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		11/08/2016

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	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto: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 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

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	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2016**

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K 000	Continued From page 2 notification. Fairview Care Center has elected to use the following categorical waivers - Extinguishing Requirements, Capacity of Means of Egress and Combustible decorations on walls, doors and ceilings. The facility has a capacity of 55 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 On facility tour between 09:00 AM and 01:00 PM on 10/18/2016, based on observation and interview revealed, Findings include: That the fire sprinkler coverage in the small chapel area does not meet requirements of NFPA 13 Installation of Fire Sprinkler Systems. One of the fire sprinkler heads is to far off one of the walls.	K 062	Deficiency with ID Prefix Tag K62 shall be corrected. The identified sprinkler head will be moved to the center of the Chapel to meet the requirements of NFPA 13. This work is scheduled to be completed by Olympic Sprinkler on November 16, 2016. The Director of Maintenance is responsible to ensure completion of this Plan of Correction and continued compliance.	11/22/16

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	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/18/2016**

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K 062	Continued From page 3 This deficient practice could affect the safety of the (18) residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 062		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 On facility tour between 09:00 AM and 01:00 PM on 10/18/2016, based on observation and interview revealed that the following: Findings include: Residents rooms has multi-plug adapters installed for Cable TV systems and do not meet NFPA 70 electrical standard. This deficient practice could affect the safety of the residents, Staff and Visitors within the building This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 147	Deficiency with ID Prefix Tag K147 shall be corrected. All multi plug adapters have been removed. Surge protected multi-plug adaptors have been purchased and are available for residents who request one. This Plan of Correction shall be monitored for continued compliance by the Director of Maintenance through monthly observation of outlets to ensure multi-plug adaptors are compliant with NFPA 70 electrical standard.	11/22/16

Electronically submitted
October 31, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5344028

Dear Ms. Sheeran:

The above facility was surveyed on October 17, 2016 through October 19, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation 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 contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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
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

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 _____	10/19/2016

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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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	00103	A. BUILDING: _____ B. WING _____	10/19/2016

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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 October 17, 18 & 19, 2016, 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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	00103	A. BUILDING: _____ B. WING _____	10/19/2016

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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.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care for 1 of 3 resident (R4) reviewed for activities of daily living. Findings include: R4 on 10/18/16 at 12:15 p.m., and on 10/19/16, at 8:59 a.m. was observed to have had dark debris under all the fingernails on the right hand. The left hand had three sharp and jagged fingernails and the forefinger nail had curled over and an indentation of skin was noted caused by nail growth. R4's quarterly Minimum Data Set (MDS) (a standardized, primary screening and assessment tool) dated 7/26/16, indicated R4 required extensive assistance with personal hygiene. R4's MDS indicated R4 had significant cognitive impairment. R4's diagnosis, listed on the	2 920	Corrected.	11/22/16

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2 920	Continued From page 3 Resident Face Sheet, included dementia, Type 2 diabetes mellitus and occlusion and stenosis of basilar artery. R4's activity of daily living (ADL) Care Area Assessment (CAA) worksheet dated 10/17/16, revealed that R4 had an activities of daily living (ADL) deficit related to dementia and required extensive assistance with personal hygiene. R4's care plan indicated licensed nursing staff to trim toenails and fingernails for safety. R4's care plan specified registered nurse, licensed practical nurse/licensed vocational nurse was responsible to trim toenails and fingernails. On 10/19/16, at 8:47 a.m. nursing assistant (NA)-A was assisting R4 with morning cares. NA-A stated R4 had a shower at 5:00 a.m. by the night shift. NA-A confirmed R4 had long, jagged and debris under his fingernails. NA- stated the nurses do nail care for R4 because of his diabetes. On 10/19/16, at 1: 13 p.m. the director of nursing and the nurse manager confirmed that R4's nail care should have been done by the night nurse on bath days due to R4's diagnosis of diabetes mellitus and warfarin (blood thinner) therapy. On 10/19/16, at 1: 25 p.m., registered nurse (RN)-B stated the night nurse had not asked her to provide nail care to R4. RN-B stated R4's nails had been trimmed after she was made aware of the need to have fingernails trimmed by surveyor. Policy titled Nails, Care of (Finger and Toe) dated 11/27/10, was provided. Under the procedure section of the policy, it indicated "NOTE: FINGERNAILS OF DIABETIC RESIDENTS ARE	2 920		

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2 920	Continued From page 4 TO BE CUT BY THE NURSE." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review ADL policies for providing assist with nail care with nursing staff members and provide education as needed. The DON or designee could then develop and implement an auditing system as part of their quality assurance to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		11/22/16

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21426	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, facility failed to ensure a baseline tuberculosis (TB) screening was completed for 1 of 6 residents (R14) reviewed for licensing. Findings include: R14 was admitted to the facility on 9/16/16. R14 received a chest X-ray on 9/13/16. Clinical Document Copy from Mayo Clinic dated 9/19/16 identifies R14 to not have active TB. Interview on 10/19/16, at 4:04 p.m. with registered nurse (RN)-A stated a TB screening had not been completed for R14 since R14 had a history of positive reaction to TB and received a chest X-ray to rule out active TB prior to admission to the facility. RN-A stated usually the TB screening is completed on admission but since the facility knew R14 had a history of reacting positive to the TB test that a screening wasn't completed. Facility policy titled, Tuberculosis Screening-Residents, dated 9/2014 does not identify completing a TB screening prior to administration of skin test. SUGGESTED METHOD OF CORRECTION: The facility could designate an employee that would be responsible to ensure that all new residents receive a baseline tuberculosis screening according to the most current centers for disease control (CDC). A designee could complete audits to ensure ongoing compliance.	21426	Corrected.	

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21426	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure clear parameters were in place for use of pain medication and facility had not attempt non-pharmacological interventions prior to the use of narcotic pain and anti-anxiety medications for 1 of 5 residents (R4) reviewed for unnecessary medications.	21540	Corrected.	11/22/16

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21540	Continued From page 7 Findings include: R4's quarterly Minimum Data Set (MDS) (a standardized, primary screening and assessment tool) dated 7/26/16, indicated R4 required extensive assist with bed mobility and transfers to and from one surface to another; had a pain management regimen and did not have a condition or prognosis that may have resulted in a life expectancy of less than six months. The MDS indicated significant cognitive impairment. R4's diagnosis, listed on the physician order sheet, included dementia, Type 2 diabetes mellitus, dementia, hemiplegia and hemiparesis following cerebral infarction affecting left side, depression and anxiety. Review of R4's current physician orders dated October 2016, included the following medication orders: Tramadol 25 my by mouth (po) three times daily (for moderate pain) Tramadol 25 mg po every four hours as needed (PRN) for breakthrough pain Dilaudid 1 milligram (mg)/milliliter (ml) by mouth (PO) every one hour PRN pain. shortness of breathe (SOB)/restlessness/anxiety (for moderate to severe pain) Lorazepam (anti-anxiety medication) 2 mg/ml PO every 4 hours PRN anxiety/restlessness/agitation/ not relieved by Dilaudid. On 9/1/16, at 6:33 a.m. registered nurse (RN)-C documented in the electronic medical record that R4 "was having some anxiety at 2300 [11:00 p.m.] He stated he needed to get up out of bed and get a pair of pliers to finish up a job before going to bed. He was holding on to a CNA's	21540		

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21540	Continued From page 8 [certified nursing assistant's] arm tightly and stated he would not let go until someone got him up out of bed. administered dilaudid at 2315 [11:15 p.m.] Writer talked to with him for a bit and during that time he grabbed writer's hair say he would not let go until someone go him up out of bed. Continued to yell out "get me out of bed please." Administered Ativan at 12 am [12:00 a.m.] Resident was sleeping at 1230 [12:30 a.m.] am. He woke up about 0500 [5:00 a.m.] to take morning medications..." Pharmacist Medication Regimen Review dated 9/27/16 at 5:55 p.m. indicated the Consultant Pharmacist reviewed "labs and medical history reviewed, no significant irregularities identified." Interview with licensed practical nurse (LPN)-A on 10/19/16 at 1: 15 p.m. revealed that the Dilaudid and lorazepam were ordered for end-of-life care. LPN-A stated R4 had declined in health after his wife passed away. The medications were ordered in anticipation of providing comfort. LPN-A stated the staff should have assisted R4 out of bed when her requested it rather then giving a pain pill. LPN-A confirmed there were no parameters for when to give pain medication vs. antianxiety medication. The director of nursing (DON) was interviewed on 10/19/16, at 1:13 p.m. The DON stated the staff should have gotten R4 up out of bed when her requested to get up. The DON confirmed there were no clear parameters for giving the pain medication vs. the antianxiety medication. A policy was requested for medication parameters however, none was provided. SUGGESTED METHOD OF CORRECTION:	21540		

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21540	Continued From page 9 The Director of Nursing or her designee could develop policies and procedures to ensure residents drug regimen if free of unnecessary drugs. The Director of Nursing or her designee could develop policies and procedures regarding obtaining a diagnoses, monitoring for effectiveness, and ensuring indications for use of the medications. The Director of Nursing or her designee could educate all appropriate staff. The Director of Nursing or her designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the bathroom exhaust vents located in resident bathrooms were cleaned to maintain a sanitary environment both physically and odor wise and promote optimal air removal in the bathroom environment for 31 of 36 bathrooms (101, 102, 103, 104, 105, 107, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220)	21695	Corrected.	11/22/16

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21695	Continued From page 10 which were used by residents residing in attached bedrooms. Findings include: Upon entrance to the facility on 10/17/16 at 2:31 p.m. resident bathrooms in rooms 109, 115, 202, 205, 206, and 208 were observed to have visible heavy debris/dust present on the vent grille covers. Upon further investigation on 10/18/16 at 4:05 p.m. the following bathroom exhaust vents had heavy debris/dust present on vent grille covers: 101, 102, 103, 104, 105, 107, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220 which had been visible from the doorway of the bathroom. On 10/18/16 at 4:40 p.m. the maintenance director observed the exhaust vent in bathroom 208 and 101. The maintenance director confirmed the vent grille cover was covered in dust adding the facility had recently switched from cooling to heating. On 10/19/16 at 10:30 a.m. the housekeeping supervisor observed the exhaust vent in bathroom 105. The housekeeping supervisor stated the exhaust vents looked "poor" and quite dusty. Adding; the housekeeping staff were suppose to be cleaning the vents every week. The housekeeping supervisor provided a document titled, Cleaning A Residents Rooms During the Week, undated which read, "Dusting means the TV [television] and the TV stand. Dusting of ceiling vents in bathrooms and rooms... Dusting on shelves, heat vents, ceiling vents, under beds, etc. on these designated room days."	21695		

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21695	Continued From page 11 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
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	21800		11/22/16

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21800	Continued From page 12 to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff 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 required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of all Medicare Part A skilled services for 3 of 3 residents (R8, R49, R69) reviewed for liability notice and beneficiary appeal rights. Findings Include: R8 was discharged from Medicare Part A on 6/17/16, and remained in the facility. R8 used 68 days of Medicare A coverage out of 100 days. The facility did not provide R8 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R49 was discharged from Medicare Part A on 5/18/16, and remained in the facility. R49 used 37 days of Medicare A coverage. The facility did not provide R49 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare	21800	Corrected.	

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21800	Continued From page 13 R69 was discharged from Medicare Part A on 7/1/16, and remained in the facility. R69 used 59 days of Medicare A coverage. The facility did not provide R69 and/or his legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform him of potential liability for non-covered services and of her right to appeal the denial to Medicare On 10/19/2016, 10:13 a.m. the business office manager (BOM) stated she believed the only denial notice being issued by the facility was the generic notice. On 10/19/16 at 12:15 p.m. the BOM stated she spoke with the staff member responsible for completing the Medicare denial notices for the facility and stated the facility does not issue SNFABNS at this time based on information provided at a training she had attended. The Fairview Care Center Medicare Denial and Demand Bill Notices policy implemented 12/07 instructed staff to provide proper notice when a resident's Medicare Part A or Part B is ending. It instructed staff to utilize an attached "Forms and New Expedited Appeals Process" which directed staff as to which forms must be given based on the specific situation of the resident. The Skilled Nursing notice quick reference indicated, "Part A stay will end because: beneficiary no longer requires daily skilled services but will remain in the SNF [skilled nursing facility]." The facility was to issue the SNFABN (CMS-100550 and the expedited Determination/Generic Notice. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate	21800		

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21800	Continued From page 14 liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21800		