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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FHW5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00103

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245344**

2.STATE VENDOR OR MEDICAID NO.
(L2) **134240100**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/12/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 03/13/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/13/2012 (L20)

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

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/4/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/12/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN: 24-5344

Fairview Care Center was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on January 27, 2012. On March 12, 2012, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction. Based on the PCR, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on January 27, 2012, effective February 29, 2012. Refer to the CMS-2567b for health.

Effective February 29, 2012, the facility is certified for 55 skilled nursing facility beds.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCM): 24-5344

March 13, 2012

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

Dear Ms. Sheeran:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 29, 2012 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,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4118 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 13, 2012

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

RE: Project Number S5344022

Dear Ms. Sheeran:

On February 14, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 27, 2012. 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 March 12, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 27, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 29, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 27, 2012, effective February 29, 2012 and therefore remedies outlined in our letter to you dated February 14, 2012, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Gary Nederhoff

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File 5344r12.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245344	A. Building B. Wing	3/12/2012

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **02/29/2012**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **02/29/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **02/29/2012**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/29/2012**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **02/29/2012**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **02/29/2012**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/29/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/29/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/29/2012**
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** MM/GPN	**Date:** 03/13/2012	**Signature of Surveyor:** 10160	**Date:** 03/12/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/27/2012

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: FHW5

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 **01/27/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	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):
At the time of the January 27, 2012 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Jennifer Lageson, HFE NEII — 02/27/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 03/07/2012 (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
Posted 03/12/2012 CO. FHW5

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 5929

February 14, 2012

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

RE: Project Number S5344022

Dear Ms. Sheeran:

On January 27, 2012, 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;

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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731

Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 7, 2012, 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 March 7, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 27, 2012 (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 July 27, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

Feel free to contact me if you have questions.

Sincerely,

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 206-2731 Fax: (507) 206-2711

Enclosure

cc: Licensing and Certification File 5344s12.rtf

RECEIVED

FEB 2 8 2012 Feb 27, 2012 SPN

Minn Dept of Health
Enclosure Center

PRINTED: 02/14/2012
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	01/27/2012

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	See Attachment 1 02-27-12 SPN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jane Sheeran — TITLE: Administrator — (X6) DATE: 2/24/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING _____ B. WING _____	01/27/2012

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 272	Continued From page 1 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess pain for 1 of 4 residents (R54) in the sample with ongoing uncontrolled pain. Findings Include: R54 had a new onset of low back pain that was not controlled. R54 was admitted to the facility 11/2010, and had a diagnosis to include but not limited to osteoporosis, a severe thoracic aortic aneurysm and degenerative joint disease. An annual Minimum Data Set (MDS) (a resident assessment and screening tool) was completed 11/8/2011. A Brief Interview for Mental Status (BIMS) (cognitive assessment) was done and R54 scored 11 out of 15 that indicated moderate impairment in mental status. The care plan dated 2/18/2010 indicated R54 was independent in toileting, transferring with a walker, and was assisted as needed for hygiene and grooming.	F 272		

ATTACHMENT 1

F Tag 272
Comprehensive Assessments

Fairview Care Center conducts initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity The facility makes a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment includes at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in the assessment.

Resident #54 has had a comprehensive pain assessment completed which has been reviewed and analyzed by a Registered Nurse.

The most recent pain assessments for all residents have been reviewed and analyzed by a registered nurse for appropriateness and to assure a beneficial pain regimen.

A Registered Nurse shall review, analyze and sign all comprehensive pain assessments.

The Director of Nursing or Designee shall monitor continued compliance through random audits of comprehensive pain assessments. Compliance will be reviewed at the February QA Meeting.

Completion Date: February 29, 2012.

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 _____	01/27/2012

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F 272	Continued From page 2 During review of the two pain evaluation forms completed by the licensed practical nurse (LPN) dated 7/26/11 and 10/31/11 had information about the resident ' s pain however, a registered nurse had not analyzed the information to determine if the pain regimen was beneficial for R54 or if it needed to be changed. On asking for the registered nurse pain assessment the surveyor was directed to the pain evaluation form. The facility did not provide a comprehensive pain assessment completed by the registered nurse. The director of nursing (DON) was interviewed on 1/27/2012, at 9:29 a.m. The DON confirmed that she had not had a registered nurse complete a comprehensive pain assessment and reassessment when there was a change of pain control for R54.	F 272		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to comprehensively reassess pain for one of one resident (R41) in the sample. Findings include: R41 lacked a pain management reassessment. R41 had diagnoses which included Alzheimer's	F 276	See Attachment 2	

ATTACHMENT 2

F Tag 276
Quarterly Assessment at Least Every 3 Months

Fairview Care Center assesses residents using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.

Resident #~~54~~ 41 has had a pain assessment completed which has been reviewed and analyzed by a Registered Nurse.

The most recent pain assessments for all residents have been reviewed and analyzed by a registered nurse for appropriateness and to assure a beneficial pain regimen.

A Registered Nurse shall review, analyze and sign all quarterly pain assessments.

The Director of Nursing or Designee shall monitor continued compliance through random audits of quarterly pain assessments. Compliance will be reviewed at the February QA Meeting.

Completion Date: February 29, 2012.

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F 276	Continued From page 3 disease, history of back pain, osteoporosis, and arthritis. A quarterly Minimum Data Set Assessment dated 11/16/2011 was reviewed. It identified the resident with short and long term memory loss and moderate cognitive impairment. The resident was identified on a scheduled pain medication regime, received prn (as needed) pain medication and received non-medication interventions for pain. Indicators of pain identified crying, whining, gasping, moaning, groaning and facial expressions included grimacing and wincing. The pain was observed on 3-4 days during the seven day assessment. A pain evaluation form completed by a licensed practical nurse dated 12/15/2011 was reviewed. It identified R41 was unable to verbalize at time of interview the pain frequency or relief measures that work. It had data in regards to history, pain medications used, signs and symptoms of verbal and non-verbal indications of pain. This evaluation was completed by the licensed practical nurse. However, there was no registered nurse pain reassessment completed specific to this resident ' s pain management regime and on asking for the registered pain reassessment none was provided by the facility. On 1/26/2012 at 1:55 p.m., the director of nursing (DON) was interviewed. The DON said that pain evaluation form was completed by a licensed practical nurse. The DON then said that she reviews and co-signs other assessments related to pain. Other pain assessments were requested and none were provided to the surveyor.	F 276		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279	See Attachment 3	

ATTACHMENT 3

F Tag 279
Develop Comprehensive Care Plans

Fairview Care Center uses the results of the comprehensive assessment to develop, review and revise the resident's comprehensive plan of care. The facility develops a comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan describes services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and respect the resident's right to refuse cares/services.

Resident #54's care plan was immediately updated to include the risk of dehydration.

All care plans of residents identified as being at risk for dehydration have been reviewed to assure this is identified on the care plan.

The Clinical Nurse Managers have responsibility for identifying risk of dehydration on the Care Plans. The Director of Nursing has reviewed Indications for residents being at risk for dehydration with the Clinical Nurse Managers.

The Director of Nursing or her designee will monitor care plans of residents at risk of dehydration to ensure the risk is identified on the care plan. This will be at the weekly Care Plan Meeting. Compliance will be reviewed at the February, 2012 QA Meeting.

Completion Date: February 29, 2012.

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F 279 SS=D	Continued From page 4 COMPREHENSIVE CARE PLANS	F 279		

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to develop a comprehensive care plan that addressed risk for dehydration for 1 of 2 residents (R54) reviewed in the sample who was at risk of dehydration.

Findings include:

R54 did not have a comprehensive care plan developed to address the identified risk of dehydration/fluid maintenance.

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F 279	Continued From page 5 R54 was admitted to the facility 11/2010, and had a diagnosis to include but not limited to osteoporosis, a severe thoracic aortic aneurysm, constipation and degenerative joint disease. An annual Minimum Data Set (MDS) (a preliminary resident assessment and screening tool) was completed on 11/8/2011. A Brief Interview for Mental Status (BIMS) (cognitive assessment) was done and R54 scored 11 out of 15 that indicated moderate impairment in mental status. The care area assessment (CAA) (care areas are triggered by MDS that indicate the need for additional assessment based on problem identification that are areas known to be problematic for nursing home residents) triggered due to constipation indicating a potential risk for dehydration. Under care plan consideration indicated that dehydration/fluid maintenance would be addressed in the care plan. Review of the R54's most current comprehensive care plan lacked the development related to the risk of dehydration/fluid maintenance. Licensed practical nurse/clinical manger (LPN/CM)-B was interviewed on 1/26/2012, at 3:15 p.m. and was asked if R54 had or was on intake and output (I&O) monitoring due to having a urinary tract infection and two recent bowel impactions. LPN/CM-B stated; " Why would we have her on I&O monitoring?" LPN/CM-B then said that I&O monitoring had not been done for R54. The director of nursing (DON) was interviewed on 1/27/2012, at 9:29 a.m. and indicated, based on the CAA; dehydration should have been on the care plan.	F 279		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	See Attachment 4	

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F 309 SS=D	Continued From page 6 HIGHEST WELL BEING	F 309		

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to complete a comprehensive pain reassessment and provide appropriate care and services for break through pain for two of three residents (R54 and R41) reviewed for pain. Findings include:

R54 had a recent increase in break through pain which was not reassessed and pain medications were not monitored for effectiveness.

R54 was admitted to the facility 11/2010, and had a diagnosis to include but not limited to osteoporosis, a severe thoracic aortic aneurysm, constipation and degenerative joint disease.

During an interview and observations on 1/25/2012, at 8:45 a.m. R54 was sitting in a recliner, slow guarded movement was observed and R54 stated, "I have such back pain." R54 rated the pain 8 on a pain scale of 0 to 10 with 10 being the most severe. A hot pack was also placed at R54's lower back by nursing assistant (NA)-K during interview. On reading the medication administration record it was found that

Attachment 4

F Tag 309
Provide Care/Services For Highest Well Being

Each resident receives and Fairview Care Center provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Fairview Care Center takes pain management very seriously and strives to plan an appropriate pain management regimen for each individual resident.

Resident #5 had a comprehensive pain assessment completed on 1/25/2012. Resident has recently started receiving TNS Unit treatments and long-acting narcotics and is improving. The staff will continue to monitor pain symptoms/comfort/results of pain management interventions and keep nurse practitioner and family informed.

Resident #41 has a history of pain issues along with a diagnosis of Alzheimer 's disease with behavioral dyscontrol and displays many of the same non-verbal symptoms for both. Non-pharmacological interventions including warm blankets, ice packs, repositioning, 1:1 time, ride in wheelchair and snacks are attempted before pain meds are given. Most current pain assessment was completed on 12/15/2011.

The Policy and Procedure for assessing pain and the effectiveness of pain management interventions have been reviewed and updated. Nursing were in serviced on the policy and procedure on February 23, 2012. The staff will continue to assess resident's pain upon admission, readmission, with a significant change in condition, a new complaint of pain that persists for more than 48 hours, a change in pain medication and/or non-pharmacological interventions and no less than every three months to assure development and timely revisions to the plan of care. Facility will be using a Pain Management Flow Sheet to aide in monitoring pain and effectiveness of both non-pharmacological and medication interventions.

The RN MDS Coordinator or RN designee will be assigned to review and analyze pain assessments to assure an appropriate pain management regimen is in place.

The Director of Nursing or designee will monitor compliance through random chart audits to assure completion of pain assessments with an appropriate pain management regimen.

Completion Date: February 29, 2012.

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F 309	Continued From page 7 a nurse gave oxycodone 5 mg was given at 7:45 a.m. R54 was interviewed on 1/25/2012, at 12:50 p.m. R54 was asked again about the back pain and she indicated the pain was now a 7-8 on the pain scale and pointed to her lower back for location. R54 stated that sitting in the recliner did help relieve the pain somewhat. R54 stated that she now needed help with walking, personal bathing and dressing because of the increase in back pain. An annual Minimum Data Set (MDS) (a resident assessment and screening tool) was completed 11/8/2011. The MDS indicated that R54 required "Limited Assistance" with ambulation in the room, personal hygiene and transfers. A Brief Interview for Mental Status (BIMS) (cognitive assessment) was done and R54 scored 11 out of 15 that indicated moderate impairment in mental status. R54 had occasional pain rated as a 7 on a scale of 0 to 10 and 10 being the worst. The care plan dated 2/18/2010 The care plan was revised to address pain on 10/31/2011, and indicated that R54 was at risk for pain, had a history of back pain and that it did not interfere with any of her daily activities. On 1/5/2012, at 1:14 p.m. licensed practical nurse (LPN)-I documented that R54 complained of having increased back pain. R54 stated she had been scooting herself into the bed due to the bed not low enough. Oxycodone 2.5 mg had been given at 12:45 p.m. with no documentation to indicate if the pain medication was effective to relieve pain.	F 309		

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F 309	Continued From page 8 An entry in the electronic medical record dated 1/11/2012, at 11:35 p.m. revealed that R54's family member (F1) a medical doctor asked that the oxycodone be increased to 5 mg because the 2.5 mg was not controlling the pain. On 1/12/2012, the Family Certified Nurse Practitioner (FCNP) changed the dosage of oxycodone from 2.5 mg to 5 mg. On reading the "Pain Management" policy dated 03/01/10 it indicated a pain assessment should have been done due to the increase in pain medication. However, none had been completed. A progress note on 1/14/2012, at 10:34 p.m. by LPN-F indicated that oxycodone 5 mg had been given two times and hot packs applied to low back two times on the evening shift. R54 stated that she didn ' t feel anything (even the pain medication) was helping when having the spasms. Required staff assistance with bedtime cares. A progress note on 1/15/2012, at 11:40 a.m. LPN-I documented that R54 "stated nothing seems to be helping and I keep having these spasms in my back." R54 had meal in room and more assistance during activities of daily living at bedtime. A progress note on 1/15/2012, at 2:29 p.m. LPN-I documented that R54 stayed in room all day. R54 needed staff assist with dressing upper and lower body, was unable to put on her shirt which she can usually do herself. Needed assist with dressing upper and lower body and was unable to put on her shirt which she can usually do herself. During review of the "Nursing Home Limited	F 309		

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F 309	Continued From page 9 Exam" document dated 1/18/2012 indicated R54 was seen by the primary physician for a routine visit. The physician documented "nursing concerns include an increase in back pain since 1/6 with an increased usage of oxycodone" The physician's "Impression/Report/Plan indicated that R54 was independent in ADL ' s, ambulation with gait aid/walker, transfers, Change in status: No." The physician note also indicated "pain was controlled with Tylenol, oxycodone as needed, calcium and vitamin D. Continue current medication regimen as pain is well controlled ... Anticipate being able to deescalate dosing once UTI (urinary tract infection) has been treated. Will reevaluate pain at that time." A progress note on 1/21/2012, at 6:21 a.m. LPN-I documented that R54 "complained of severe low back pain and can hear creaking when she moves. Oxycodone [5 mg] given at 0115 [1:15 a.m.] and 0515 [5:15 a.m.] and hot pack to back at 130am. Assisted her to and from BR [bathroom] during the night." An oxycodone 5 mg had been given at 5:15 a.m. with no documentation to indicate its effectiveness. During the interview with LPN/CM-B on 1/25/2012, at 12:01 p.m. she had noted the decline in R54's activities of daily living (ADLs) recently and an increase in pain. On 1/25/2012, at 2:45 p.m. during an interview with LPN/CM-B it was learned that the FCNP was contacted about the residents break out pain and an x-ray of the low back had been ordered and on 1/26/2012. R54 had an x-ray of the lumbar spine. On review of the Clinical Document Copy of the x-ray dated 1/26/2012,	F 309		

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F 309	Continued From page 10 revealed that R54 had "new age indeterminate compression fracture of L4 [lumbar] vertebral body. Increased compression to T12 [thoracic] vertebral body. Stable compression of fracture of L2." Despite the findings on the x-ray of the increased compression to the spine a pain reassessment had not been completed to determine the current pain regimen was effective. The director of nursing (DON) was interviewed on 1/27/2012, at 9:29 a.m. The DON confirmed that a comprehensive pain reassessment had not been completed after the increase in break out pain or following the increase in pain medication according to the Pain Management policy. During review of the Pain Management policy dated March 1, 2010. The policy indicated that "Fairview Care Center was committed to keeping its resident as comfortable as possible. To that end pain management is an ongoing process initiated prior to the time a resident is admitted to the facility and continuing throughout their stay." The policy also indicated that "a full pain assessment will be initiated on admission, quarterly, annually and when: pain medication is changed (i.e. a new medication is added, an increase or decrease in dose or discontinuation of a pain medication); there is a decline in functioning that could be related to pain (i.e. decrease in mobility status, range of motion, ability to complete activities of daily living, etc.); A new complaint of pain begins and persists for more than 48 hours or a significant change in pain intensity is reported." R41 had chronic pain and lacked a pain reassessment, timely pain control measures, use	F 309		

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F 309	Continued From page 11 of non-pharmacological interventions to manage pain before use of pain medication, giving pain medication before activities that cause pain such as a.m. and p.m. cares and repositioning and identifying if pain medications were effective in managing break through pain for this resident. R41 had diagnoses which included Alzheimer's disease, history of back pain, osteoporosis, and arthritis. On 1/24/2012 at 4:46 p.m., during observation, R41 was observed to be groaning and making moaning noises. During observation on 1/24/2012 at 6:27 p.m., R41 was observed to be up in the wheelchair and again moaning. At 7:00 p.m., R41 was observed to be moaning and making crying noises while in the bedroom. Staff walked past the resident's room and made no attempt to find out what was wrong with the resident. The following morning on 1/25/2012, R41's medication sheet and nursing notes were reviewed. No prn (as needed) pain medication had been given for the possible pain R41 was exhibiting yesterday nor was the resident's behaviors of moaning and crying from the previous night been documented. On 1/26/2012 at 6:45 a.m., R41 was to receive personal cares from nurse aide (NA)-A and (NA) -D. As they were washing the resident, move the resident from side to side in bed, and dressed the resident, R41 would moan. As the nurse aides transferred the resident from the bed to wheelchair, R41 would again start to moan. On review of the quarterly Minimum Data Set dated 11/16/11, it was learned that there was not	F 309		

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F 309	Continued From page 12 a reassessment of R41's pain completed. On asking for this pain assessment, there was none provided. A pain evaluation form completed by a licensed practical nurse (LPN) dated 12/15/2011 was reviewed. It identified R41 was unable to verbalize at time of interview the pain frequency or relief measures that work. R41 had a history of back pain. Signs and symptoms of discomfort in non-verbal cognitively impaired residents was listed as moaning, calling out for help, resistive with cares, threatening gestures, increased agitation, and frequent position changes. Pain medications R41 was receiving was identified as Tylenol 1000 mg bid with one prn dose and oxycodone 5 mg every 6 hours prn for pain. The summary of the evaluation noted the resident had a history of back pain and had a diagnosis of arthritis and osteoporosis which placed R41 at risk for pain. R41 was unable to verbalize if in pain. If staff asked the resident if was having pain when heard moaning or making repetitive statements, R41 would sometimes say yes and sometimes say no. The staff was to monitor for nonverbal signs and symptoms of pain such as moaning, calling out for help, being resistive with cares, increased agitation, frequent position changes, and threatening gestures. R41 had used 5 doses of prn pain medication this month [December] and used it the majority of the time in the evening. Physician orders dated 8/24 and 8/30/2011 identified R41 was on scheduled Tylenol 1000 mg bid and one prn dose and oxycodone every 6 hours prn for pain. Tylenol was given at 8:00 am and 5:30 p.m. daily. The prn pain medication	F 309		

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 _____	01/27/2012

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

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F 309	Continued From page 13 (oxycodone) for 1/2012 was given twice a day for several days. For 12/11, R41 was given prn oxycodone 1-2 x day for 17 days of the month and for 11/11, R41 was given prn oxycodone 1-2 x per day for 11 days of the month. Nursing notes dated 11/11 through 1/25/2012 were reviewed and the following was noted: The resident on 1/8/12 was noted to be yelling out from 9-10:30 a.m. and stated had pain all over and everywhere. The resident was given prn oxycodone with good effect. The pain medication Oxycodone was documented as given at 10:45 a.m. this was after the yelling and stated was in pain for 1.5 hours. No documentation of non-pharmacological interventions attempted was evident. On 12/2211, it was noted the resident had 5 incidents of yelling out. The documentation did not include why the resident was yelling and/or whether prn pain medication was given or other pharmacological interventions were used. On 12/15/11, it was noted R41 had 6 episodes of yelling out. The note did not identify if pharmacological interventions had been used or if prn pain medication was used to address the yelling and possible pain. On 12/9/11, it was noted the resident was awake at 2 a.m., continued to "holler out" quietly and had not been give the oxycodone (prn medication) until 4 a.m. which was two hours after the pain symptoms were first noted. After receiving the pain medication R41 was asleep by 4:45 a.m. and the pain medication was effective. During review of the medication administration record for the months of November, December 2011 and January 2012, the prn pain medication documented as being given to the resident lacked	F 309		

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F 309	Continued From page 14 if the pain medication was effective. Also there was no indication if nonpharmacological interventions were attempted before giving the prn pain medication. On 1/26/2012 at 1:31 p.m., the director of nursing (DON) was interviewed regarding documentation of effectiveness of pain medication. She indicated it would typically be documented in the nursing progress notes. However, the notes did not always document the effectiveness of the pain medication. R41's care plan with print date of 11/29/2011 was reviewed. It identified R41 at risk for pain related to history of back pain, osteoporosis, and arthritis. R41 had Alzheimer's disease and was rarely able to verbalize pain. Interventions included: administer pain medication as per medical doctor's orders and note the effectiveness. Give PRN meds for breakthrough pain, and offer non-pharmacological interventions such as hot packs, repositioning, and warm blankets. Document and report complaints and nonverbal signs of pain (increased behaviors ex. calling out for help, screaming, cursing and insomnia.) On 1/26/2012 at 7:45 a.m., a licensed practical nurse (LPN)-C indicated she had given R41 scheduled Tylenol this a.m. LPN-C continued to say that the resident takes the prn Oxycodone twice a day frequently and If R41 had been moaning or calling out that usually meant R41 was in pain. LPN-C then said that the resident can also tell you when in pain. During an interview on 1/26/2012 at 6:55 a.m., NA-A and NA-D stated R41 would tell you when has pain but starts yelling out usually when that happens. Then when you ask R41, the resident	F 309		

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F 309	Continued From page 15 would tell you and you can tell by body language too. On 1/26/2012 at 1:55 p.m., the director of nursing (DON) was interviewed. She said that R41 will tell you if she had pain. R41 could say yes or no. DON indicated she had tried a blanket, cookies, etc. When questioned should staff trying other non-pharmacological interventions prior to giving prn, the DON responded, "It is on the care plan." They are to do this! "We just know R41 and we don't document what we should." The staff should always go in and decide whether R41 is having pain or if it is just a behavior. The non-pharmacological interventions should be tried first before the prn dose of oxycodone. Also the staff should give the pain medication at the time of the pain symptoms occur and not wait an hour and 1/2 or longer before medicating R41 for pain.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide care and	F 315	See Attachment 5	

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F 315	Continued From page 16 services to minimize the reoccurrence of urinary tract infections (UTIs) for 1 of 2 residents (R27) in the sample, reviewed with indwelling catheter. Findings include: R27 currently had an indwelling catheter and was not provided proper catheter care to prevent UTIs. R27 admitted to facility on 12/7/11 with diagnoses that included chronic indwelling catheter and UTIs with pseudomonas (a common bacterium that can cause disease in humans). The admission Minimum Data Set (MDS), dated 12/18/11, identified R27 had severe cognitive impairment, needed extensive assistance with transfers and toileting and had an indwelling catheter. Upon review of the medical record, the physician ordered Foley (indwelling) catheter upon admission for retention and history of UTIs. Bowel and bladder evaluation dated 12/28/11 indicated that R27 had an indwelling catheter in place and had a history of UTIs. On 1/26/12 at 8:43 a.m., nursing assistant (NA)-A and NA-D put gloves on and unclamped the drainage port and emptied the urine in graduate. NA-D grabbed alcohol wipe out of pocket and wiped off drainage port and placed drainage port back in pouch on catheter bag. NA-A removed R27.' s pants and disconnected rubber catheter from drainage bag tubing, wiped end of rubber catheter and tubing of catheter drainage bag with alcohol wipe. Gloves were changed. NA-D placed 100 cc of vinegar in bag with water and rinsed out catheter tubing attached to catheter bag into the toilet. NA-D proceeded to place	F 315		

ATTACHMENT 5

F Tag 315
No Catheter, Prevent UTI, Restore Bladder

Fairview Care Center ensures that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is continent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Resident #27 was admitted with an indwelling catheter and never acquired a Urinary Tract infection while residing at facility. This resident has successfully returned home.

Policy and Procedure for Urinary Catheter Emptying has been reviewed and found to be accurate and appropriate. This Policy and Procedure was reviewed with all nursing personnel on February 23, 2012.

The Director of Nursing or Designee will monitor compliance with this plan of correction through direct observation of staff over the next month. Compliance will be reviewed at the QA meeting.

Completion Date: February 29, 2012.

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F 315	Continued From page 17 catheter bag with tubing on same hook in bathroom with 2 transfer belts. The end of the catheter tubing had not been covered to protect from being soiled before inserting it back into the rubber Foley catheter. NA-D indicated at this time she had completed cleaning the catheter bag. Upon interview at 8:51 a.m. NA-D confirmed that the end of the tubing should be covered and would go get a cap. NA-D verified that the end of the catheter tubing would be considered contaminated if not covered. Reviewed policy titled, Urinary Catheter Emptying dated November 16, 2010 which indicated it is the policy of Fairview Care Center to ensure safe practice during the emptying of a urinary catheter bag. Under procedure section of the policy #7 indicated " DO NOT ALLOW THE DRAINAGE PORT TO TOUCH THE GRADUATE " and #9 " Wipe port area with alcohol wipe. On 1/26/12 at 7:45 a.m., the Director of nursing verified the policy was current and was to be followed as written.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	See Attachment 6	

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F 325	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a significant weight loss for one of three residents (R65) reviewed in the sample for weight loss. Findings include: R65 had a 10.6 pound weight loss over a six month which was a significant weight loss for this resident and there was not a system in place to identify this. R65 was admitted to the facility on 6/2011, with a diagnosis to include but not limited to dementia, depressive disorder and adult failure to thrive. A significant change Minimum Data Set (MDS) (a resident assessment and screening tool) was done on 11/16/2011. A Brief Interview for Mental Status (BIMS) (cognitive assessment) was done and R65 scored 3 out of 15 that indicated severe impairment in mental status. The MDS indicated that R65 did not have any difficulty with eating. The care plan dated 12/12/2011 did identify R65 had diagnosis of adult failure to thrive with interventions that included; encourage resident to eat meals and provide snacks between meals and nutritional supplements three times daily. The care plan also identified a potential for less than body requirement characterized by weight loss, inadequate intake and decreased appetite related to cognitive impairment and depression. The goal was to maintain or increase weight. R65 weighed 99 pounds (lbs.) on 7/17/2011, 97	F 325		

ATTACHMENT 6

F Tag 325
Maintain Nutritional Status Unless Unavoidable

Fairview Care Center ensures that a resident – (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.

Resident #65's weight loss has been reviewed, identified on her care plan and added to IDT report for weekly review.

All weights have been reviewed to assure that any unplanned weight loss has been identified and is being addressed appropriately.

Facility's Weight Loss Policy and Procedure has been revised to assure a system is in place with accountability for identifying any residents with unplanned weight loss. All appropriate staff were educated on the Policy and Procedure by February 23, 2012.

The Administrator will monitor for compliance with random audits of resident weights and comparing any identified weight loss to IDT reports. (The IDT reports identify residents with weight loss.) Results will be reviewed at the February QA Meeting.

Completion Date: February 29, 2012.

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F 325	Continued From page 19 lbs. on 10/16/2011, 94 lbs. on 12/11/2011, and 89.4 lbs. on 1/1/12. R65 experienced a weight loss of greater than 10 percent for the six month period of July to January 1, 2012. On 1/26/2012, at 7:10 a.m. R65 was observed eating in the small dining room and was eating scrambled eggs, hot cereal, toast, coffee, milk and orange juice. R65 did receive Med plus 2.0 (a dietary food supplement) four ounces at 7:18 a.m. R65 at approximately 75 percent of the meal and did drink all of the Med plus 2.0. The registered dietician (RD) had a note in the electronic medical record (EMR) on 6/24/2011, at 6:35 a.m. The note indicated that R65 was at risk for weight loss due to diagnosis with history of weight loss. The RD indicated that the staff was to monitor intake, weights and notify the certified dietary manager (CDM.) The RD indicated that R65 ' s ideal body weight was 115 lbs. R65 health status was discussed at the interdisciplinary team (IDT) meetings on 1/2/2012, 1/6/2012, 1/9/2012, 1/12/2012, 1/16/2012, and 1/19/2012, as evident by the progress note made by licensed practical nurse/clinical manager (LPN/CM)-B. However, the significant weight loss from July to January 2012 had not been discussed. On 1/26/2012, at 8:40 a.m. the CDM was interviewed and was not aware of R65's significant weight loss. The CDM stated that all resident weights are checked weekly and that R65 ' s weight loss had been missed. On questioning the system they had in place to address the weight loss the CDM said that if the	F 325		

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F 325	Continued From page 20 weight loss had been identified it would be discussed at the facility weekly IDT meeting. The CDM stated, " I am in the dining room every day and if someone is new or has a poor appetite, I put them on the IDT list. [R65] is not on my list." LPN/CM-B was interviewed on 1/26/2012, at 1:00 p.m. and indicated that she was not aware of R65's weight loss. The Weight Policy dated 3/1/2010, indicated "the multidisciplinary team will strive to prevent, monitor and intervene for undesirable weight loss for our residents." The procedure indicated a significant weight change will be reported to the CDM and/or primary care provider in a timely manner and the CDM would review the weight and discuss significant weight changes at the IDT meeting. The director of nursing (DON) was interviewed on 1/27/2012, at 8:55 a.m. regarding R65's significant weight loss. The DON stated it is everyone responsibility to monitor weight loss and there may be a " broken system. " The DON also stated that weight loss was discussed at the IDT meetings and there was no indication that R65's weights had been discussed. The DON was asked by the surveyor if other residents ' weight loss could be missed with a "broken system " and the DON stated, "There are residents who could fall through the cracks."	F 325		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356	See Attachment 7	

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F 356	Continued From page 21 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the daily nurse staff posting included the total number of actual hours worked. Findings include: On 1/26/12 at 2:00 p.m. the posted nursing hours included the position and total hours worked, but did not include the actual hours worked by the	F 356		

ATTACHMENT 7

F Tag 356
Posted Nurse Staffing Information

Fairview Care Center posts the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
-Registered Nurses
- Licensed Practical Nurses or licensed vocational nurses (as defined under State law).
- Certified Nurse Aides.
o Resident Census.

The facility posts the nurse staffing data specified above on a daily basis at the beginning of each shift. Data is posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility, upon oral or written request, makes nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility maintains the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

Fairview Care has posted the required information prior to the start of shifts every day. Being that the hours must be posted prior to the start of the shift, the hours must be projected based on scheduled hours. When there is a change to the schedule, (someone becomes ill, gets injured or needs to leave early for any variety of reasons) the posted hours will be updated by the Nursing unit Secretary.

The Director of Nursing or Designee will monitor this plan of correction though random audits of posted hours compared to actual hours worked.

Date of Completion: February 29, 2012.

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F 356	Continued From page 22 staff. During an interview at 2:00 p.m. on 1/26/12, the administrator indicated the hours were projected and that the shifts listed did not include the actual hours worked by staff.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a sanitary kitchen that would minimize the possibility of food borne illness. This had the potential to affect 54 out of 55 residents residing in the facility. Findings include: During the kitchen tour on 1/27/2012, at 12:39 p.m., the following was observed and confirmed by the certified dietary manager (CDM). The caulking around the hand washing sink and the laminate counter tops, around the perimeter of the kitchen, were discolored, had cut marks into the finish and dime size pieces of the laminate were missing in several places. The laminate counter tops were used for food	F 371	See Attachment 8	

ATTACHMENT 8

F Tag 371
Food Procure, Store/Prepare/Serve - Sanitary

Fairview Care Center –

(1) Procures food from sources approved or considered satisfactory by Federal, State or local authorities; and

(2) Stores, prepares, distributes and serves food under sanitary conditions.

The caulking around the hand washing sink in the kitchen has been replaced. The facility has ordered new stainless steel countertops to replace existing countertops with cut marks in the finish, and missing pieces of laminate. The countertops have been ordered through Rochester Restaurant Supply and anticipated installation date is March 27, 2012. See attached Letter of Intent to Proceed and Sales Order.

All coffee carafes with cracks have been disposed and replaced with new ones.

The identified chest freezer has been defrosted. Defrosting of this freezer is scheduled to be done every month.

The Certified Dietary Manager will monitor compliance of this plan of correction through;

1.) Observation of carafes and disposal of any with cracks on a weekly basis.
2.) Ongoing observation of entire kitchen area for any needed repairs and/or replacement. Repair requests will be submitted to Maintenance as needed.
3.) Chest freezer will be observed monthly to assure there is no excessive ice buildup

Completion Date: February 29, 2012.

Rochester
RESTAURANT
SUPPLY

Rochester Restaurant Supply
3025 40th Ave. NW
Rochester, MN 55901
507-289-1601
507-289-0066 Fax

Letter of Intent to Proceed

Date: 2/24/2012	**From: Noah Vig @ Rochester Restaurant Supply**
To: Fairview Care Center ATTN: GALEN	**Special Instructions:**
Fax number: 507-374-2918	**Phone number:** 507-261-6560

Comments:

Fairview Care Center has placed an order with us to proceed with the removal and replacement of existing laminate countertops with NSF fabricated stainless steel countertops.
Shop drawings are currently being produced and will be available 02/27/12.
After shop drawings are signed, we have a four week production timeline, followed by installation on approximately 03/27/12.

Please call with any questions regarding this order. A copy of the sales order is attached.

Thanks
Noah Vig
Project Manager
Rochester Restaurant Supply
507-289-1601

ROCHESTER
RESTAURANT SUPPLY
3025 40th Ave. N.W.
Rochester, MN 55901

Phone 507-289-1601
Fax 507-289-0066

ORIGINAL INVOICE

SOLD TO:
FAIRVIEW NURSING HOME
ROUTE #1 BOX 10
DODGE CENTER, MN 55927

SHIP TO:

SALES ORDER NUMBER	INVOICE DATE	INVOICE NUMBER
105028	02-24-12	105028

CUSTOMER ORDER NO.	CUST. NUMBER	DATE SHIPPED	SLSM	I.D.	SHIPPED VIA	F.O.B.	TERMS
	60050	02-24-12	7	NCV		ROCHESTER	/NET 30

SHIPPED	B/O	ITEM NUMBER	DESCRIPTION	UNIT PRICE	UNIT	AMOUNT
1		5	CUSTOM COUNTERTOP #1	. 1793.880	EACH	1,793.88
			144"WX25.5"D			
1		5	CUSTOM COUNTER #2	. 813.780	EACH	813.78
			96"WX25"D			
1		5	CUSTOM COUNTER #3	. 1487.700	EACH	1,487.70
			96"X25.5"			
1		5	CUSTOM COUNTER #4	. 1890.540	EACH	1,890.54
			156"X25.5"			
1		LABOR	REMOVE EXISTING COUNTERTOPS	100.000		100.00

(CONTINUED ON PAGE 2.)

NET AMOUNT	TAX	FRT.	INVOICE TOTAL
$	$	$	$

THANK YOU

All Accounts Are 30 Days Net. A 1½% Finance Charge will be added on all past due accounts.

All claims and returned goods MUST be accompanied by this bill.

NO RETURNS AFTER 30 DAYS. ANY APPLICABLE SALES OR USE TAX WILL BE BORNE BY THE PURCHASER

ROCHESTER
RESTAURANT SUPPLY

3025 40th Ave. N.W.
Rochester, MN 55901

Phone 507-289-1601
Fax 507-289-0066

ORIGINAL INVOICE

SOLD TO
FAIRVIEW NURSING HOME
ROUTE #1 BOX 10
DODGE CENTER, MN 55927

SHIP TO

SALES ORDER NUMBER	INVOICE DATE	INVOICE NUMBER
105028	02-24-12	105028

CUSTOMER ORDER NO.	CUST NUMBER	DATE SHIPPED	SLSM	T.D.	SHIPPED VIA	F.O.B.	TERMS
	60050	02-24-12	7	NCV		ROCHESTER	/NET 30

SHIPPED	B/O	ITEM NUMBER	DESCRIPTION	UNIT PRICE	UNIT	AMOUNT
1		LABOR	DELIVER AND INSTALL NEW COUNTERS	250.000		250.00

NET AMOUNT	TAX	FRT.	INVOICE TOTAL
$ 5,985.90	$	$	$ 6,335.90

THANK YOU

All Accounts Are 30 Days Net. A 1½% Finance Charge will be added on all past due accounts.

All claims and returned goods MUST be accompanied by this bill.

NO RETURNS AFTER 30 DAYS. ANY APPLICABLE SALES OR USE TAX WILL BE BORNE BY THE PURCHASER.

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 _____	01/27/2012

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 371	Continued From page 23 preparation. There were five coffee carafes sitting on the counter in the kitchen. Three of the five carafes had numerous cracks starting at the base and extended up approximately two to three inches. The CDM confirmed that they were used to serve coffee to the residents. The CDM stated the carafes were thrown out when they needed replacement. However, these were in use and they would be difficult to sanitize due to the cracks. The large chest freezer, located adjacent to the CDM ' s work/office area, was observed to have a half inch to an inch and a half of ice buildup on all four interior walls. The ice was observed to cover at least 50 percent of the surfaces on all four walls. The freezer contained numerous cases of individual ice cream cups. The CDM stated that the freezer is " defrosted a couple of times a year" and there was no schedule of when it was last done.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	See Attachment 9	

ATTACHMENT 9

F Tag 441
Infection Control, Prevent Spread, Linens

Fairview Care Center established and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

Nursing Personnel were all reminded immediately to rinse nebulizer chambers after each use.

Policy and Procedure for Nebulizer Chamber Cleaning has been reviewed and found to be accurate and appropriate. This Policy and Procedure was reviewed in detail with all nursing personnel on February 23, 2012.

The Director of Nursing or Designee will monitor compliance with this plan of correction through direct observation of staff over the next month. Compliance will be reviewed at the QA meeting.

Completion Date: February 29, 2012.

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 _____	01/27/2012

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F 441	Continued From page 24 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the nebulizer equipment was cleaned to reduce the risk of spreading infection for 2 of 2 residents (R16, R8) reviewed utilizing a nebulizer in the sample. Findings include: Nebulizer chambers (the jar that holds the medication for instillation) was not rinsed and dried between medication administrations. This	F 441		

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 _____	01/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 25 had the potential for increased risk of infection. R8 was observed on 1/24/12 at 3:15 p.m. R8 had a history of respiratory problems. Nebulizer ' s chamber was observed connected to the machine and the chamber was observed to have fluid in it. The licensed practical nurse (LPN)-A stated the nebulizers were to be rinsed and air dried after each use. On 1/24/12, at 4:45 p.m. R16 was observed during medication administration by LPN-A. R16 had a current history of pneumonia. LPN-A was to administer a nebulizer treatment and noted the chamber was attached to the machine and contained liquid. LPN-A stated the chamber should have been rinsed and air dried after each use. The facility policy entitled Nebulizer Use dated 3/1/2010 was reviewed. The policy indicated nebulizer jar (chamber) was to be rinsed after each use. On 1/26/11, at 7:30 a.m. the director of nursing was interviewed. She indicated she would expect the nebulizer chamber to be rinsed out after each use.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/24/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 25822 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Fairview Care Center was found 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. 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(111) construction. In 1997, addition was constructed to the North Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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