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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GPJ3

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245333**

2.STATE VENDOR OR MEDICAID NO.
(L2) **138740500**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/14/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (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
	40			
(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 :
Gayle Lantto, Unit Supervisor — 12/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Heath — 12/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/08/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245333

December 29, 2015

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

Dear Ms. Sandmann:

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

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

Effective November 30, 2015 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

December 29, 2015

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

RE: Project Number S5333025

Dear Ms. Sandmann:

On November 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 22, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On December 14, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 13, 2015, 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 22, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 30, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 22, 2015, effective November 30, 2015 and therefore remedies outlined in our letter to you dated November 13, 2015, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245333	A. Building B. Wing	12/14/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/30/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/30/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/30/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	12/29/2015	15507	12/14/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/22/2015

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

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245333	A. Building B. Wing **01 - MAIN BUILDING**	12/13/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0054	**11/03/2015**	ID Prefix Reg. # **NFPA 101** LSC K0147	**11/18/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	12/29/2015	34764	12/13/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/21/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GPJ3

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245333**

2.STATE VENDOR OR MEDICAID NO.
(L2) **138740500**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/22/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
CCN: 24-5333

Reduction in the number of certified SNF/NF beds from 50 beds to 40 beds, effective November 1, 2015, in accordance with a change in licensure. Due to ten beds being placed in lay away status (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective November 1, 2015, all 40 facility beds are certified SNF/NF.

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NEII 11/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 3020 0001 8869 0343

November 13, 2015

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

RE: Project Number S5333025

Dear Ms. Sandmann:

On October 22, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<u>Informal Dispute Resolution</u> - 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:

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Gayle.Lantto@state.mn.us
Telephone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 1, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 22, 2016 (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 22, 2016 (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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Enclosure
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245333	A. BUILDING _____ B. WING _____	10/22/2015

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

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED NOV 25 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	See Attached POC accepted as Plan to 11/25/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy Landmann | TITLE: ADMINISTRATOR | (X6) DATE: 11-19-15

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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	245333	A. BUILDING _____ B. WING _____	10/22/2015

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the administrator and designated State agency (SA) and to thoroughly investigate an allegation for 1 of 1 resident (R2) who alleged verbal abuse by staff. Findings include: R2 reported she was not treated with dignity and respect by two nursing assistants (NAs), when interviewed on 10/19/15, at 4:02 p.m. R2 explained that last week on Friday or Saturday, she asked NA-H during cares to move her tray table to a different location and NA-H asked, "Why are you throwing all these orders around at me?" R2 then asked NA-H not to forgot to clean her teeth. NA-H replied, "Don't worry about it. I will get to it." R2 stated that she reported incident to trained medication aide (TMA)-A, who assured the resident staff should not talk to her that way. TMA-A instructed her that if it continued, she should report it to the director of nursing. R2	F 225		

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F 225	Continued From page 2 further stated NA-H also did not wash her "like she should." R2 stated she had told multiple people including another NA, TMA-A and a registered nurse (RN)-A. R2 also stated the other day she had asked NA-C to make her bed, and the NA heavily sighed and walked away without making her bed. R2 put her call light on and NA-C eventually returned to the room and made the bed. R2 stated she reported the situation to TMA-A. In addition, R2 reported that about six to eight months ago, she was requiring more help with activities of daily living (ADLs), a NA was rough when assisting the resident with turning in bed. She reported the incident to the DON, who told R2 she "took care of it." A NA reportedly then told R2, "Don't be telling [the DON]." R2 could not recall name of the NA. R2 was admitted in 2013, with diagnoses including schizophrenia, anxiety and depression. The quarterly Minimum Data Set (MDS) dated 9/14/15, identified the resident had no cognitive impairment and required extensive assistance with bed mobility and toileting, limited assistance with dressing, supervision with hygiene and transfers and was independent in walking. The care plan dated 9/3/15, identified R2 had an ADL self-care performance deficit related to various diagnoses and medical history. R2 was able to perform about 85% of her ADL's independently with assistance and supervision, but was unable to perform peri-care independently. Interventions indicated the resident was capable of ambulating independently to the bathroom and seating herself on the toilet. She sometimes needed assistance off of the toilet, and used the call light to summon help. She needed assistance with	F 225		

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F 225	Continued From page 3	F 225		

peri-care for cleanliness, as well as with personal hygiene and oral care.

The DON was interviewed on 10/22/15, at 11:26 a.m. She explained she visited with R2 several times a week and the resident had not made any complaints regarding staff treatment or about NA-C or NA-H. The incident log was reviewed with the DON, which revealed no documented incidents for R2.

TMA-A had worked at the facility for several years, and was interviewed on 10/22/15, at 11:54 a.m. TMA-A explained R2 had made complaints in the last couple weeks, a couple different times about NA-H and NA-C. The complaints were about how they performed cares and did not thoroughly wash the resident and/or with peri-care. In addition, they did not answer her call light timely. TMA-A reported she informed a nurse of R2's complaints, but did not recall which nurse she told. She said several people had been telling the nurses about residents' complained about the two NAs, and said , "I know they have been talked to couple times by nurses."

An interview was conducted with the DON, administrator and the licensed practical nurse /social services designee on 10/22/15, at 1:07 p.m. They all stated they had not been informed of R2's complaints regarding NA-H and NA-C. Although the nurses may have thought they addressed R2's complaints with the NAs, they were unsure why the complaints were not then brought to the administrative level. It was stated the nurses may have tried to retrain the NAs, but they acknowledged they should have been notified, and further investigation should have been conducted nd potentially a report made to

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F 225	Continued From page 4 the SA. The facility's Abuse Prohibition Policy, dated 7/9/13, directed staff: "Suspected or substantiated cases of resident mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property will be thoroughly investigated and documented by Administrator or designee. Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician, families, and/or resident responsible party. The subject of abuse shall be routinely and openly discussed. Staff members, volunteers, family members, and others must report incidents of abuse of suspected abuse, and will be assured that retaliation is not tolerated for reporting." The Abuse Investigative policy updated 7/1/13, directed staff, "If incident or suspected incident of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property must be immediately reported to the Administrator. The Administrator will be notified in person, by phone, or by Personal Digital Assistant (PDA). The administrator or designee with the same authority will make an initial report of the incident or suspected incident, to the State Agency (Office of Health Facility Complaints) immediately in accordance with law, and to the County Common Entry Point (CEP)--if required by county."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	See Attached	

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This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to implement their abuse prohibition policy for immediate reporting allegations of abuse to the the administrator and designated State agency (SA) and thoroughly investigate allegation of abuse for 1 of 4 residents (R2) reviewed for abuse prohibition and ensure background checks were completed before 1 of 5 newly hired employees provided direct care services to residents (E5). In addition, the facility failed to maintain evidence of reference checks for 1 of 5 newly employed staff (E3) and failed to ensure current licensure for 1 of 1 (E5) newly employed licensed staff .

Based on interview and document review, the facility failed to immediately report allegations of abuse to the administrator and designated State agency (SA) and to thoroughly investigate an allegation for 1 of 1 resident (R2) who alleged verbal abuse by staff.

Findings include:

The facility's Abuse Prohibition Policy, dated 7/9/13, directed staff: "Suspected or substantiated cases of resident mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property will be thoroughly investigated and documented by Administrator or designee. Suspected or substantiated cases must also be reported to respective agencies such as state agencies, law enforcement, physician, families, and/or resident

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responsible party. The subject of abuse shall be routinely and openly discussed. Staff members, volunteers, family members, and others must report incidents of abuse of suspected abuse, and will be assured that retaliation is not tolerated for reporting." The Abuse Investigative policy updated 7/1/13, directed staff, "If incident or suspected incident of mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of property must be immediately reported to the Administrator. The Administrator will be notified in person, by phone, or by Personal Digital Assistant (PDA). The administrator or designee with the same authority will make an initial report of the incident or suspected incident, to the State Agency (Office of Health Facility Complaints) immediately in accordance with law, and to the County Common Entry Point (CEP)--if required by county."

R2 reported she was not treated with dignity and respect by nursing assistants (NA), when interviewed on 10/19/15, at 4:02 p.m. R2 explained that last week on Friday or Saturday, she asked NA-H during cares to move her tray table to a different location and NA-H asked, "Why are you throwing all these orders around at me?" R2 then asked NA-H not to forgot to clean her teeth. NA-H replied, "Don't worry about it. I will get to it." R2 stated that she reported incident to trained medication aide (TMA)-A, who assured the resident staff should not talk to her that way. TMA-A instructed her that if it continued, she should report it to the director of nursing. R2 further stated NA-H also did not wash her "like she should." R2 stated she had told multiple people including another NA, TMA-A and a registered nurse (RN)-A. R2 also stated the other day she had asked NA-C to make her bed, and

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the NA heavily sighed and walked away without making her bed. R2 put her call light on and NA-C eventually returned to the room and made the bed. R2 stated she reported the situation to TMA-A. In addition, R2 reported that about six to eight months ago, she was requiring more help with activities of daily living (ADLs), a NA was rough when assisting the resident with turning in bed. She reported the incident to the DON, who told R2 she "took care of it." A NA reportedly then told R2, "Don't be telling [the DON]." R2 could not recall name of the NA.

R2 was admitted in 2013, with diagnoses including schizophrenia, anxiety and depression. The quarterly minimum data set (MDS) dated 9/14/15, identified that resident had no cognitive impairment and required extensive assistance with bed mobility and toileting, supervision with hygiene, transfers and independent in walking, and limited assistance with dressing. The care plan dated 9/3/15, identified R2 has an ADL self-care performance deficit related to various diagnoses and medical history. R2 is able to perform about 85% of her ADL's (activities of daily living) independently with assist and supervision. She continues to be unable to perform peri-cares independently. The interventions indicated the resident is able to: ambulate independently to the bathroom, she is capable of seating herself on the toilet. She sometimes needs assistance to transition off of the toilet, she will use the call light to summon help. She does need assistance with peri-cares for cleanliness, requires assistance by one staff with personal hygiene and oral care.

Interview with the director of nursing (DON) on 10/22/15, at 11:26 a.m. explained she visits with

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R2 several times a week and resident has not made any complaints regarding staff treatment or about NA-C or NA-H. Reviewed incident log with DON which revealed no incidents documented for R2.

R2 was admitted in 2013, with diagnoses including schizophrenia, anxiety and depression. The quarterly Minimum Data Set (MDS) dated 9/14/15, identified the resident had no cognitive impairment and required extensive assistance with bed mobility and toileting, limited assistance with dressing, supervision with hygiene and transfers and was independent in walking.

The care plan dated 9/3/15, identified R2 had an ADL self-care performance deficit related to various diagnoses and medical history. R2 was able to perform about 85% of her ADL's independently with assistance and supervision, but was unable to perform peri-care independently. Interventions indicated the resident was capable of ambulating independently to the bathroom and seating herself on the toilet. She sometimes needed assistance off of the toilet, and used the call light to summon help. She needed assistance with peri-care for cleanliness, as well as with personal hygiene and oral care.

The DON was interviewed on 10/22/15, at 11:26 a.m. She explained she visited with R2 several times a week and the resident had not made any complaints regarding staff treatment or about NA-C or NA-H. The incident log was reviewed with the DON, which revealed no documented incidents for R2.

TMA-A had worked at the facility for several

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years, and was interviewed on 10/22/15, at 11:54 a.m. TMA-A explained R2 had made complaints in the last couple weeks, a couple different times about NA-H and NA-C. The complaints were about how they performed cares and did not thoroughly wash the resident and/or with peri-care. In addition, they did not answer her call light timely. TMA-A reported she informed a nurse of R2's complaints, but did not recall which nurse she told. She said several people had been telling the nurses about residents' complained about the two NAs, and said , "I know they have been talked to couple times by nurses."

An interview was conducted with the DON, administrator and the licensed practical nurse /social services designee on 10/22/15, at 1:07 p.m. They all stated they had not been informed of R2's complaints regarding NA-H and NA-C. Although the nurses may have thought they addressed R2's complaints with the NAs, they were unsure why the complaints were not then brought to the administrative level. It was stated the nurses may have tried to retrain the NAs, but they acknowledged they should have been notified, and further investigation should have been conducted nd potentially a report made to the SA.

Background studies were not completed for E5. E5's employee file revealed a hire date of 9/2/15. Time sheet reports indicated E5 worked the following days: 9/3, 9/8, 9/10, 9/14, 9/15, 10/1, 10/2, 10/6, 10/7, 10/8 and 10/13/15, however, evidence was lacking to show a required background study had been completed prior to working without direct supervision.

The administrator stated on 10/21/15, at 3:07

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F 226	Continued From page 10 p.m. she was unable to find documentation showing a background study had been completed. The administrator said the DON was also unable to find that a background study had been completed. The administrated stated "I think she got lost in the shuffle." E3's employee file lacked evidence reference check(s) was completed prior to hire. E3 was hired on 10/16/15, but the file lacked evidence reference check(s) had been performed prior to hire. E3's Application For Employment dated 9/1/15, revealed three names and telephone numbers under the personal reference section, however, there was no documentation to show any of the references had been contacted. The administrator confirmed on 10/21/15, at 3:07 p.m. that a reference check was not documented as having been completed on E3's employment application. Staff had no evidence the Minnesota Board of Nursing licensing had been checked to ensure E5 held a current registered nurse (RN) license and was in good standing. E5 was hired and began work at the facility on 9/2/15. E5's employee file included a copy of a payment to the Minnesota Board of Nursing dated 6/9/14, which indicated E5's RN licence would expire on 9/30/16, however, the facility failed to check the online system to ensure E5 was in good standing as a RN. The administrator stated on 10/21/15, at 3:07 p.m. she had accepted a receipt of payment for E5's RN license as evidence, but should have checked the system to ensure the license was still current and had not otherwise been revoked.	F 226		

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F 226	Continued From page 11 A 9/12, Background Screening Investigations policy read, "Our facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on individuals making application for employment with our facility...the personnel/human resources director, or other designee, will conduct employment background checks (including fingerprinting as may be required by state law) on persons making application for employment with this facility, such investigation will be initiated within two days of employment or offer of employment...For any licensed professional applying for a position that may involve direct contact with residents, his/her respective licensing board will be contacted to determine if any sanctions have been assessed against the applicant's license."	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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	F 279	See Attached	

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F 279	Continued From page 12 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 care plan to minimize the risk for falls for 1 of 2 residents (R17) who were reviewed for accidents. Findings include: R17 was observed on 10/20/15, at 3:37 p.m. lying on his bed. The resident had large fading bruises on the left forehead, left cheek and under his left eye, as well as small bruises on his right forearm, right hand and left thumb. R17's left arm was in a sling. Pillows were fitted snuggly on either side of the resident. The resident looked at surveyor and stated, "I want my wheelchair." A Resident Incident Report for R17, dated 3/25/15, indicated R17 had been found on the floor on his right side at 9:35 a.m. The report indicated the resident had explained he had been going to open his window curtains and fell. It was noted the resident had not used the call light to request help from staff. R17 complained of right hip pain and was sent to the hospital. An emergency report revealed a new diagnosis of strains of multiple ligaments and muscles. Follow up information directed the facility staff to "Schedule an appointment as soon as possible for a visit" with R17's primary physician. A follow up appointment on 3/31/15, was made with no changes in the resident's care.	F 279		

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F 279	Continued From page 13 The 3/25/15, Resident Incident Report lacked evidence the following factors had been considered, as all were left blank on the form: Measures In Place If Fall, Behaviors, and Possible Contributing Factors. Interdisciplinary Team Comments read, "Resident frequently ambulates 'I' [independently] in his room. Sent to ER [emergency room]." A care plan change was limited to Focus "The resident had an actual fall with strains of multiple ligaments and muscles related to unsteady gait, Poor communication/ comprehension." Interventions were limited to "72-hour monitoring of signs and symptoms for example, pain, bruising, changes in mental status, etc." On 9/26/15, a Resident Incident Report for R17 indicated; "Resident was found lying on the floor outside his bathroom. Resident stated he was in pain. Resident's body position and inability to assist in moving himself required the ambulance to be called." The Resident Incident Report lacked evidence the following were not considered, as all were left blank on the form: Measures In Place If Fall, Medications, Behaviors, and Possible Contributing Factors. Interdisciplinary Team Comments read, "[R17] underwent surgical repair of his left hip Sat [Saturday] 9/26/15. He also broke his left shoulder but the hospital decided only to sling that." R17's annual Minimum Data Set (MDS) dated 4/26/15, indicated R17's cognition was impaired and he required extensive assistance with one staff person for bed mobility, transferring, toileting, and limited assistance for walking, but was "not steady." R17 was identified as frequently	F 279		

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incontinent and was on a toileting program. R17 had experienced a fall with injury since the previous assessment. A quarterly MDS dated 7/27/15, revealed R17 continued to require extensive assistance with activities of daily living." Discrepancies were noted between the MDS and care plan regarding toileting, transferring, bed mobility and walking in room for R17 for MDS dates 4/26/15, 7/27/15, and 9/26/15.

A Care Area Assessment dated 5/3/15, noted falls would be addressed in the resident's care plan. Under "Describe impact of this problem/need on the resident and your rationale for care plan decision. (Include complications and risk factors and the need for referral to other health professionals)" the following was documented: R17 had "unsteady balance during transitions and ambulation, but was able to stabilize without human assistance...No change in status since last assessment...impaired cognitive status. He is incontinent of bladder...Lasix for fluid retention [medication to remove fluid from tissues which causes an increase in urination]...His gait is unsteady and he requires FWW and w/c [four wheeled walker and wheelchair] for mobility needs. Refer to Morse Fall Scale of 4/26/15, scoring 80, indicating is at high risk for falls. Will proceed to the care plan as before to ensure safety from falls. No need to refer at this time. Is a referral to another discipline warranted? No."

R17's progress note dated 5/23/15, indicated "He is limited assist of 1 staff for transfers and ambulation in room w/ [with] walker. W/C main mode of transport."

The director of nursing (DON) reported on 10/19/15, at 7:15 p.m. R17 had experienced a fall

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F 279	Continued From page 15 within last 30 days resulting in a hip and shoulder fracture. The DON explained R17 was supposed to have assistance from staff , but self-transferred "all the time" and lacked safety awareness. On 10/20/15, at 3:40 p.m. a nursing assistant (NA)-A said R17 was currently transferred with a Hoyer (mechanical) lift and two staff. NA-A said that prior to R17's last fall, he had been able to stand with one staff's help, although he was not supposed to as he was known to transfer himself in and out of bed and on and off the toilet. The DON explained on 10/20/15, at 3:54 p.m. that the interdisciplinary team reviewed each fall and met weekly and more often including dietary, social services, activities and the nurse who completed the MDS assessments. Staff were aware R17 had been self-transferring since his admission to the facility. Prior to the hip fracture if staff saw him walking alone they would run and get his walker and provide necessary supervision, which was needed in order for him to walk safely. The DON stated R17's room was at the far end of the hallway, but he had been moved for closer supervision after fracturing his hip and shoulder. The DON explained they moved R17 because of his injury (hip and shoulder fracture) and that R17 had always presented at risk for falling because of his cognitive impairment. The DON also stated that in 3/15, R17 had fallen while walking around his room unassisted, and that she and the nurse practitioner (NP) were in the adjacent room at the time and had heard the resident fall. The DON said she "did not like the way" R17's foot looked following the fall, and that he had been sent to the emergency room, and returned newly diagnosed with strains of multiple ligaments and muscles. While looking at the incident reports the DON	F 279		

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verified parts of the incident reports for R17 to be left blank by the nurse filling them out and the DON stated that she would need to re-educate the nurses on the proper completion of an incident form after a resident fall.

On 10/21/15, at 7:37 a.m. NA-B stated that prior to his hip and shoulder fracture, R17 always needed one staff assist for transferring and walking, but the resident did not always use his call light to request assistance. She thought it was due to his cognition impairment. NA-B also observed R17 had gradually become more weak and unsteady in the last year. NA-B stated that R17 had just been moved to a new room "last Friday" because of the fall resulting in fractures.

At 8:18 a.m. on 10/21/15, NA-C stated R17 now required a Hoyer lift. Prior to the last fall, R17 walked with a walker and staff supervision.

On 10/21/15 at 10:10 a.m., the registered physical therapist (PT) stated R17 had not been seen for a therapy evaluation, nor had a request been made for an evaluation. She was unfamiliar with the resident, although had seen him at a distance walking throughout the facility independently with a walker and without staff present.

On 10/21/15 at 10:33 a.m., the DON stated that although she had considered moving R17 to a room closer to the nursing station in the past, they instead moved him after he sustained the fractured hip and shoulder. She also verified that falls had been initiated on the care plan after his initial fall in 3/15, with ligament and muscle strain, but interventions to minimize the risk of further falls had not been included in the plan. The DON

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speculated, "I think all of R17's falls have had something to do with having to go to the toilet. I think a third of the time [R17] would wake up, have to go to the bathroom and forget to put his shoes on." R17 also did not use his call light to request help, and said it was typical of the resident.

At 11:05 a.m. a licensed practical nurse (LPN)-A stated R17 presented a fall risk because of his tendency to self-transfer and lose his footing. LPN-A explained R17 fell in the bathroom this last fall, presumably needing to use the toilet. An unnamed NA went into R17's room and told him to "wait," and then left the room leaving R17 unassisted. LPN-A was unaware of any increased monitoring that had been implemented for R17, "just the every two hours repositioning and check for toileting."

At 11:13 a.m. NA-D stated R17 was a falls risk due to self-transferring. R17 did not use his call light, "does not wait for help" and tried to use the toilet by himself. NA-D also reported nothing had changed related the R17's care plan since his fall in 3/15, and he continued to be at risk for falls, needed staff's assistance, and did not wait for help.

That afternoon at 2:55 p.m. NA-E described R17 would walk from his bed to the toilet and back to bed by himself. NA-E also stated R17 had been falling because he did not remember to put on his shoes. R17 typically used the toilet right after leaving the dining room and sometimes toileted himself, and was occasionally incontinent of urine.

On 10/22/15, at 8:22 a.m. R17's family member

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F 279	Continued From page 18 (FM)-A stated the resident had fallen more than once at the facility, most recently breaking his hip and shoulder. FM-A also said R17 became "impatient" and had balance issues and was more unsteady when walking in the past year. FM-A reportedly asked at the last care conference about staffing at the facility, as there had been fewer residents, more open rooms, and fewer staff present. FM-A reiterated he had inquired about the staffing levels. A progress note dated 10/15/15, revealed a Quality Care Conference was held and "One of the first questions brought up by the family was if we were considering moving [R17] closer up the hallway. DON explained that was already in the works as soon as there was a room empty. DON explained that this could happen with in 2-3 weeks. Family member were in agreement that this should happen. They also asked about staffing ratio to resident census and again the DON explained the state minimum guidelines and what we staff at." On 10/22/15, at 10:17 a.m. NA-F stated that R17 toileted himself and wanted privacy. She thought R17 last fell trying to shut the bathroom door as he always wanted it that way. Although staff toiled R17 every two hours, he also toileted himself in between those times. NA-F further stated R17 left the dining room right away and used the toilet himself. Sometimes he also left in the middle of a meal to use the toilet. When asked why the staff did not follow the resident to assist him NA-F answered, "We are busy." NA-F stated everyone knew R17 was toileting himself regardless if staff told him he should wait for help. NA-F also reported staff would just ask R17 if he needed the toilet and he would say he just went by himself,	F 279		

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F 279	Continued From page 19 "and then we would just mark it down." On 10/22/15, a registered nurse (RN)-A at 11:30 a.m. reported the need for a therapy evaluation had not been brought up for R17 until after his last fall that resulted in hip and shoulder fractures. At 1:37 p.m. NA-G stated R17 would not use his call light, most likely due to cognitive impairment, and sometimes was found in the bathroom by himself. NA-G also stated, as a restorative aide she assisted the residents who required assistance to walk, including R17, and he could walk a long distance with help. NA-G said the provision of restorative walking was not documented. NA-G denied doing any stretching or strengthening exercises for R17. NA-G stated she thought R17 fell because he was unable to manage his pants and pull up. "Often times I would catch him walking out of the bathroom with his pants not yet pulled up, with him holding onto his pants and pad." The administrator at 2:34 p.m. stated that falls were discussed daily at the facility Monday through Friday. The team analyzed falls and reviewed interventions put into place to prevent another fall. The administrator explained "proper documentation of the IT [Interdisciplinary team] notes are probably not always being done." A 3/25/15, Interdisciplinary Weekly & Daily Team Review Tracking Log indicated "Resident Name [R17] Issues (S) fall Follow-Up Sent to ER refer to incident report CP Updated PCC Note entered [left blank]." The tracking log did not indicate any follow up intervention put in place for R17 to prevent another fall.	F 279		

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F 279	Continued From page 20 Policy provided by the facility Assessing Falls And Their Causes dated Revised October 2010 indicated "The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. 1. Review the resident's care plan to assess for any special needs of the resident. 2. Identify the resident's current medications and active medical conditions. ... 3. Identifying Causes of A Fall or Fall Risk: Within 24 hours of a fall, the nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairments, etc. ... Documentation When a resident falls, the following information should be recorded in the resident's medical record: ... 2. Assessment data, ... 3. Interventions, ... 5. Completion of a falls risk assessment 6. Appropriate interventions taken to prevent future falls." Policy provided by the facility Care Plans--Comprehensive dated Revised October 2010 "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Developing the comprehensive Care Plan 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Basis of Comprehensive Care Plan 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. ... Interdisciplinary Process 6. Identifying problem	F 279		

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F 279	Continued From page 21 areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician (or primary healthcare provider) is integral to this process."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for activities of daily living (ADLs) related to incontinence care and minimizing risk for pressure ulcers for 1 of 1 resident (R24) reviewed for urinary incontinence and pressure ulcers. Findings include: R24's care plan reviewed on 10/9/15, identified R24 as at risk for skin/pressure ulcers related to immobility and need for extensive assist of two staff for turning and repositioning while in her bed and/or while sitting in her wheelchair. Interventions directed staff to assist resident with turning and reposition at least every two hours and to assist to shift weight in wheelchair every 45-60 minutes. The goal was "Resident will have	F 282	See Attached	

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intact skin, free of redness, blisters or discoloration." R24 was also incontinent of bladder. Interventions directed staff to check at least every two hours and as required for incontinence, wash, rinse and dry perineum, change clothing as needed after incontinence episodes, uses small disposable briefs. The goal was "Resident will decrease frequency of urinary incontinence from 21% to 35% times per week."

R24's quarterly Minimum Data Set (MDS) dated 9/4/15, revealed diagnoses including dementia with severely impaired cognition. She was frequently incontinent of urine and required extensive assistance of two staff for transfers, bed mobility and ambulation.

R24 was not assisted with repositioning or toileting during observation on 10/21/15, from 7:10 a.m. until 9:50 a.m. (2 hours, 40 minutes). At 7:10 a.m. R 24 was in a wheelchair, asleep, seated in the dining room. At 8:16 a.m. R24 remained in the dining room at a table with a banana and three glasses of juice on the table in front of her. At 9:40 a.m. R24 was wheeled into the day room and remained in the day room until 9:50 a.m.

Nursing assistant (NA)-D, who consistently worked on R24's unit explained in an interview on 10/21/15, at 10:05 a.m. she had just assisted R24 to the commode then back to her wheelchair, approximately 15 minutes ago ((9:50 a.m.) NA-D stated she had been helping out on another wing after breakfast and had been unable to provide care for R24. NA-D said she had assisted R24 out of bed around 7:00 a.m. and had not provided any further cares until assisting resident with toileting at 9:50 a.m. NA-D indicated R24 should

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F 282	Continued From page 23 have been assisted with toileting/incontinence care and repositioning every two hours and acknowledged this had not been provided for resident. During an interview on 10/22/15, at 11:42 a.m. with director of nursing (DON) stated R24 is not able to communicate her needs and was dependent on staff for toileting and repositioning and should have been checked for incontinence every two hours. A 2010 Care Plans--Comprehensive indicated "Each residents' comprehensive care plan is designed to; incorporate identified problem areas; identify the professional service that are responsible for each element of care, aide in preventing or reducing declines in the resident's functional status and/or functional levels."	F 282		
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 did ensure activities of daily living (ADLs) related to toileting assistance was provided for for 1 of 1 resident (R24) reviewed for incontinence care. Findings include:	F 312	See Attached	

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F 312	Continued From page 24 R24 was assessed as incontinent of bladder, however, was not toileted every two hours during observation on 10/21/15, from 7:10 a.m. until 9:50 a.m. (2 hours, 40 minutes). At 7:10 a.m. R24 was in a wheelchair, asleep, seated in the dining room. At 8:16 a.m. R24 remained in the dining room at a table with a banana and three glasses of juice on the table in front of her. At 9:40 a.m. R24 was wheeled into the day room and remained in the day room until 9:50 a.m. A nursing assistant (NA)-D, who consistently worked on R24's unit explained in an interview on 10/21/15, at 10:05 a.m. she had just assisted R24 to the commode then back to her wheelchair, approximately 15 minutes prior (9:50 a.m.) NA-D stated had been busy helping out on another wing after breakfast and had been unable to provide care for R24. NA-D said she had assisted R24 out of bed around 7:00 a.m. and had not provided any further cares until assisting resident with toileting at 9:50 a.m. NA-D indicated R24 should have been assisted with toileting/incontinence care every two hours and acknowledged this had not been provided for the resident. R24's Care Area Assessment (CAA) summary/analysis for urinary incontinence dated 3/12/15, indicated "CAA triggered due to resident extensive assist with toileting needs. Her BIMS [cognitive function test] score indicates cognitive impairment and she exhibits signs of confusion which contribute to incontinence. Will proceed to care plan to ensure good skin integrity, dignity, and prevention of complications. No need to refer at this time." R24's quarterly Minimum Data Set (MDS) dated	F 312		

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F 312	Continued From page 25 9/4/15, revealed diagnoses including dementia with severely impaired cognition. She was frequently incontinent of urine and required extensive assistance of two staff for transferring and toilet use. R24's Bowel and Bladder Quarterly Review reviewed 8/29/15, indicated no changes from the assessment dated 3/3/14. The assessments indicated the resident's bladder urge sensation was diminished. A kiosk report from 2/25/14 to 3/3/14, noted the R24 was frequently incontinent of bowel and bladder. R24's care plan reviewed on 10/9/15, identified the resident was incontinent of bladder and directed staff to check at least every two hours and as required for incontinence. "Wash, rinse and dry perineum, change clothing as needed after incontinence episodes, uses small disposable briefs." During an interview on 10/22/15, at 11:42 a.m. with director of nursing (DON) it was stated R24 was unable to communicate her needs and was dependent on staff for toileting and should have been checked for incontinence every two hours. An undated Toileting Policy and Procedure indicated, "It is the policy of the Fairfax Community Home, Inc. to assist our residents with their elimination needs per an individualized care plan. Every resident who is dependent on staff for the toileting will be assisted to the toilet at least every two hours or per individualized care plan."	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	See Attached	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 1 of 2 residents (R24) reviewed for pressure ulcers. Findings include: R24 was assessed at risk for skin breakdown and was not repositioned every two hours during observation on 10/21/15, from 7:10 a.m. until 9:50 a.m. (2 hours, 40 minutes). At 7:10 a.m. R24 was in a wheelchair, asleep, seated in the dining room. At 8:16 a.m. R24 remained in the dining room at a table with a banana and three glasses of juice on the table in front of her. At 9:40 a.m. R24 was wheeled into the day room and remained in the day room until 9:50 a.m. A nursing assistant (NA)-D, who consistently worked on R24's unit explained in an interview on 10/21/15, at 10:05 a.m. she had just assisted R24 to the commode then back to her wheelchair, approximately 15 minutes prior (9:50 a.m.) NA-D stated she had been busy helping out on another wing after breakfast and had been unable to	F 314		

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F 314	Continued From page 27	F 314		

provide care for R24. NA-D acknowledge she had assisted R24 out of bed around 7:00 a.m. and had not provided any further cares until assisting the resident with repositioning with toileting at 9:50 a.m. NA-D indicated R24 should have been repositioned every two hours.

R24's Care Area Assessment (CAA) summary/analysis for pressure ulcers dated 3/12/15, indicated "CAA triggered due to mobility and incontinence level of resident. She is cognitively impaired and exhibits sign of confusion related to DX [diagnosis] of dementia. She requires 1-2 staff to turn and reposition her frequently. She also uses a Lintex pressure relief mattress; in addition there is a mat mounted on the wall side of her bed as she has a history of bumping her extremities on the wall and has very fragile skin and a history of bruising easily. Will proceed to care plan to ensure good skin integrity and prevention of skin breakdown."

R24's quarterly Minimum Data Set (MDS) dated 9/4/15, revealed diagnoses including dementia with severely impaired cognition. The resident required extensive assistance of two staff for transfers, bed mobility and ambulation.

R24's Comprehensive Skin Risk Data Collection reviewed on 8/29/15, indicated the resident was at risk for skin breakdown due to limited mobility related to Parkinson's disease. She stood poorly and required extensive assistance assistance of two to transfer with EZ stand lift (mechanical device), and received assistance to turn and reposition every two hours. She was identified as incontinent of bowel and bladder. Her appetite was fair to poor and supplements were provided.

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F 314	Continued From page 28 R24's Tissue Tolerance (prolonged pressure to skin) Data Worksheet dated 2/29/12, identified no redness after prolonged sitting for 2 hours. R24's 10/9/15, care plan identified R24 as at risk for skin/pressure ulcers related to immobility and need for extensive assist of two staff for turning and repositioning while in her bed and/or while sitting in her wheelchair. The goal was "Resident will have intact skin, free of redness, blisters or discoloration." Interventions directed staff to assist resident with turning and reposition at least every two hours and to assist to shift weight in wheelchair every 45-60 minutes. During an interview on 10/22/15, at 11:42 a.m. with director of nursing (DON) it was stated R24 was not able to communicate her needs, was dependent on staff for repositioning, and should have been assisted to reposition every two hours. A 2010 Policy and Procedure For the Prevention And Treatment of Skin Breakdown indicated pressure was the primary cause of pressure ulcers. "An effective turning and repositioning schedule can help reduce the risk of developing a pressure ulcer. Everyone's tissue tolerance [the ability of the skin and its supporting structures to endure the effects of pressure without breakdown] is different. Therefore it is important to individualize each residents turning and repositioning schedule."	F 314		

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F 314	Continued From page 29	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess causative factors of falls to minimize the risk of further falls for 1 of 2 residents (R17) reviewed for accidents. Findings include: R17 was observed on 10/20/15, at 3:37 p.m. lying on his bed. The resident had large fading bruises on the left forehead, left cheek and under his left eye, as well as small bruises on his right forearm, right hand and left thumb. R17's left arm was in a sling. Pillows were fitted snuggly on either side of the resident. Review of a Resident Incident Report dated 9/26/15, indicated R17 had sustained a fall with injury: "Resident was found lying on the floor outside his bathroom. Resident stated he was in pain. Resident's body position and inability to	F 323	See Attached	

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F 323	Continued From page 30 assist in moving himself required the ambulance to be called." Although the 9/26/15 Resident Incident Report inidcated the reisdent's prior mental status-confused, prioror mboility- independent with toileting/transfers, there was no further assessment documented to determine causative factors of the fall. The interdisciplinary comment section of the Incident Report, included, "...underwent surgical repair of his left hip Sat [Saturday] 9/26/15. He also broke his left shoulder..." The resident's care plan prior to the fall 9/26/15 indicated a problem with potential for fall identified 2/4/15. Care plan interventions prior to the fall included: "...The resident is able to toilet independently. The resident is able to self transfer but during times of weakness needs assist of 1 staff, and a gait belt..." However, the annual 4/26/15, and quarterly 4/26/15, 7/27/15 and 9/26/15, Minimum Data Set (MDS) assessments indicated the resident required extensive assistance with one staff person for bed mobility, transferring, toileting, and limited assistance for walking, but was "not steady." In addition, the MDS assessments indicated R17 was frequently incontinent and was on a toileting program. A Care Area Assessment dated 5/3/15, indicated falls would be addressed in the resident's care plan. Under "Describe impact of this problem/need on the resident and your rationale for care plan decision. [Include complications and risk factors and the need for referral to other health professionals]." The following was documented: R17 has "unsteady balance during	F 323		

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transitions and ambulation, but was able to stabilize without human assistance...No change in status since last assessment...impaired cognitive status. He is incontinent of bladder...Lasix for fluid retention [medication to remove fluid from tissues which causes an increase in urination]...His gait is unsteady and he requires FWW and w/c [four wheeled walker and wheelchair] for mobility needs. Refer to Morse Fall Scale of 4/26/15, scoring 80, indicating is at high risk for falls. Will proceed to the care plan as before to ensure safety from falls. No need to refer at this time. Is a referral to another discipline warranted? No."

During interview with the director of nursing (DON) 10/19/15, at 7:15 p.m. she stated R17 had experienced a fall within the last 30 days resulting in a hip and shoulder fracture. The DON explained R17 was supposed to have assistance from staff with transfers, but self-transferred "all the time" and lacked safety awareness.

On 10/20/15, at 3:40 p.m. a nursing assistant (NA)-A said R17 was currently transferred with a Hoyer (mechanical) lift and two staff. NA-A said that prior to R17's last fall, he had been able to stand with one staff assistance, although he was not supposed to as he was known to transfer himself in and out of bed and on and off the toilet.

The DON further stated on 10/20/15, at 3:54 p.m. that the interdisciplinary team reviewed each resident fall and met weekly and more often including dietary, social services, activities and the nurse who completed the MDS assessments. The DON verified staff were aware R17 had been self-transferring since his admission to the facility. She said that prior to the hip fracture, if staff saw

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F 323	Continued From page 32 R17 walking alone, they would run and get his walker and provide necessary supervision needed in order for him to walk safely. The DON stated R17's room was at the far end of the hallway, but that he'd been moved closer to the nursing station for increased supervision after fracturing his hip and shoulder. The DON verified R17 had a history of falling. She stated in March of 2015, R17 had fallen while walking around his room unassisted, and that she and the nurse practitioner (NP) were in the adjacent room at the time and had heard the resident fall. The DON said R17 had been sent to the emergency room, and returned with a diagnosis of strains of multiple ligaments and muscles. The DON speculated, "I think all of R17's falls have had something to do with having to go to the toilet. I think a third of the time [R17] would wake up, have to go to the bathroom and forget to put his shoes on." R17 also did not use his call light to request help, and said it was typical of the resident. On 10/21/15, at 7:37 a.m. NA-B stated that prior to his hip and shoulder fracture, R17 always needed one staff assist for transferring and walking, but the resident did not always use his call light to request assistance. She thought it was due to his cognitive impairment. NA-B also observed R17 had gradually become more weak and unsteady in the last year. NA-B stated that R17 had been moved to a room closer to the desk "last Friday" because of the fall resulting in fractures. At 8:18 a.m. on 10/21/15, NA-C stated R17 now required a Hoyer lift, but prior to the last fall, R17 had walked with a walker and staff supervision.	F 323		

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F 323	Continued From page 33 On 10/21/15 at 11:05 a.m., a licensed practical nurse (LPN)-A stated R17 presented a fall risk because of his tendency to self-transfer and lose his footing. LPN-A explained R17 had fallen in the bathroom this last fall, presumably needing to use the toilet. On 10/21/15 at 11:13 a.m., NA-D stated R17 was a fall risk due to self-transferring. R17 did not use his call light, "does not wait for help" and tried to use the toilet by himself. NA-D also reported nothing had changed related the R17's care plan since his fall in 3/15, and he continued to be at risk for falls, needed staff's assistance, and did not wait for help. On 10/21/15 at 2:55 p.m., NA-E stated that prior to his recent fall with fractures, R17 would walk from his bed to the toilet and back to bed by himself. NA-E also stated R17 had been falling because he did not remember to put on his shoes. NA-E said R17 typically used the toilet right after leaving the dining room and sometimes toileted himself, and was occasionally incontinent of urine. On 10/22/15, at 8:22 a.m. R17's family member (FM)-A stated the resident had fallen more than once at the facility, most recently breaking his hip and shoulder. FM-A also said R17 became "impatient" and had balance issues and was more unsteady when walking in the past year. On 10/22/15, at 10:17 a.m. NA-F stated that R17 had previously toileted himself and wanted privacy. NA-F said she thought R17's last fall was from him trying to shut the bathroom door as he always wanted it that way. NA-F said that although staff toileted R17 every two hours, he	F 323		

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F 323	Continued From page 34 also toileted himself in between those times. NA-F further stated R17 left the dining room right away and used the toilet himself. Sometimes he also left in the middle of a meal to use the toilet. When asked why the staff did not follow the resident to assist him, NA-F responded, "We are busy." NA-F stated everyone knew R17 was toileting himself regardless if staff told him he should wait for help. NA-F also reported staff would just ask R17 if he needed the toilet and he would say he just went by himself, "and then we would just mark it down." On 10/21/15 at 1:37 p.m., NA-G stated R17 would not use his call light, most likely due to cognitive impairment, and that sometimes he'd been found in the bathroom by himself. NA-G also stated, she thought R17's recent fall had occurred because he was unable to manage his pants to pull them up. "Often times I would catch him walking out of the bathroom with his pants not yet pulled up, with him holding onto his pants and pad." On 10/21/15 at 2:34 p.m., the administrator stated that any falls were discussed daily with the interdisciplinary team at the facility Monday through Friday. The administrator stated the team analyzed falls and reviewed interventions put into place to prevent another fall. However, she acknowledged, "proper documentation of the IT [Interdisciplinary team] notes are probably not always being done." A progress note dated 10/15/15, revealed a Quality Care Conference was held and "One of the first questions brought up by the family was if we were considering moving [R17] closer up the hallway. DON explained that was already in the	F 323		

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F 323	Continued From page 35 works as soon as there was a room empty. DON explained that this could happen with in 2-3 weeks. Family members were in agreement that this should happen." The facility's Falls And Fall Risk Managing policy dated 12/07 indicated, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Identify Interventions 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls...Additional/Different Interventions 4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant...Minimizing Serious Consequences of Falls 6. In conjunction with the Attending Physician, staff will identify and implement relevant interventions...to try to minimize serious consequences of falling." A 10/10 Falls Assessment And Recognition policy, directed staff as follows: "2. In addition, the nurse shall assess and document/report the following...h. Precipitating factors, details on how fall occurred i. All current medications, especially those associated with dizziness or lethargy j. All active diagnose 3. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk...5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc...Cause Identification 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the	F 323		

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F 323	Continued From page 36 fall...Treatment/Management 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of fallings." A facility policy dated 10/10, entitled Assessing Falls And Their Causes, included: "The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. 1. Review the resident's care plan to assess for any special needs of the resident. 2. Identify the resident's current medications and active medical conditions...3. Identifying Causes of A Fall or Fall Risk: Within 24 hours of a fall, the nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairments, etc...Documentation When a resident falls, the following information should be recorded in the resident's medical record...2. Assessment data...3. Interventions...5. Completion of a falls risk assessment 6. Appropriate interventions taken to prevent future falls."	F 323		

F Tag 225 Staff Treatment of Residents

It is the policy of Fairfax Community Home to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R2, the Director of Nursing has completed a thorough investigation in relation to allegation of not being treated with dignity and respect by two nursing assistants. An initial incident report identifying these complaints was filed with OHFC on 10/22/2015. The required investigation report has also been completed and submitted on 10/23/2015. On 11/05/2015 the oracle @state.mn.us sent a reply email stating, "The information has been reviewed and is has been determined that no further action by this office is necessary at this time."
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For other residents of Fairfax Community Home, the facility immediately reports allegations of abuse to the State Agencies following immediate communication directly to the Administrator, or designee with the same authority in the absence of the Administrator. Reports have been made immediately to OHFC and state agency according to the Abuse Prohibition Policy along with appropriate suspension of alleged perpetrator when identified. The results of these thorough investigations, including witness statements with interviews of residents and staff, have been completed and also filed as required. Systems are in place and reviewed and revised as needed for providing a safe and secure environment for the residents.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy and procedure for Resident Abuse was reviewed on 11/18/2015, by the QA/QI. No changes were made at that time as it is a current policy. Licensed staff were trained starting 11/10/2015 and ongoing regarding their responsibilities to communicate all concerns related to residents with a potential for harm or abuse immediately and verbally and/or on-line to specific identified individuals or agency. Specific training included thorough

	completion of incident reports, thorough investigation of suspicious injuries or resident concerns. Interdisciplinary team received scheduled training on 11/10/2015, and ongoing focusing on their responsibility to extensively review incident report for the determination of causal factors related to bruising and other resident incidents such as falls focusing on interventions for the prevention of reoccurrence of identified resident concerns.
How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Random audits will be conducted by the Director of Nursing or her designee to ensure staff's knowledge and compliance of identifying and reporting incidents of potential mistreatment, neglect, abuse or injuries of unknown source. IDT reviews will be completed on random audits to ensure facility protocols are followed to ensure the environment is safe, free of fear and potential for harm. The results will be reported to the QI/QA committee for further review and recommendations. Upon this review, system revisions and/or staff education will continue to be implemented if indicated by a prescribed action plan.
Who is responsible for this plan of correction?	The Director of Nursing, with the assistance of the Administrator, will be responsible for compliance. Date of Correction: 11/30/2015

F Tag 226 Staff Treatment of Residents

It is the policy of Fairfax Community Home to develop and implement policies and procedures regarding screening and training employees to prevent, identify, and report abuse, neglect, and mistreatment misappropriation of property. The interpretive guidelines for this F-tag refer to seven key components to be reviewed by surveyors to determine if facility is meeting the intent of F-226.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R2, the Director of Nursing has completed a thorough investigation in relation to allegation of not being treated with dignity and respect by two nursing assistants. An initial incident report identifying these complaints was filed with OHFC on 10/22/2015. The required investigation report has also been completed and submitted on 10/23/2015. On 11/05/2015 the oracle @state.mn.us sent a reply email stating, "The information has been reviewed and is has been determined that no further action by this office is necessary at this time." In regards to the background check; said background check was completed on E5 on 10/21/2015 and returned to our facility "Passed." Facility also obtained a copy of current licensure. Reference checks were performed for employee E5.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For other residents who may be affected by this practice a review of the Abuse Prohibition Policy and procedures with licensed staff was held (meeting) on 11/10/15. Training for other staff was held on 11/03/15 and 10/28/2015. Specific items include incident reporting and completion of a thorough investigation, assessing and care planning for resident vulnerabilities, care plan development, and follow through reporting to supervisors. All new hires shall have a background check submitted prior to orientation, in addition to obtaining a current copy of licensure. Also at least 2 references will be contacted for employment history verification along with documented verification of the attempted contact.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy and procedure from our resident protection manual which includes Criminal Background checks, reference checks, and confirmation on licensure has been reviewed. The QA/QI Committee reviewed the policy to ensure all components are present: screening, training, prevention, identification, investigation, protection, reporting, and response. Staff members were trained as it relates to their respective roles and responsibilities involving incident identification, completion, reporting and investigation.
How does the facility plan to monitor its performance to make sure that	Random audits will be performed on a new hires with in the first 7 days of hire to ensure that the

solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	proper background, current licensure (if applicable), and reference check has been performed. The results of those audits will be reported to the QA/QI Committee for further review and recommendations.
Who is responsible for this plan of correction?	The Human Resources designee will be responsible for compliance. Date of Correction: 11/30/2015

F Tag 279 Comprehensive Care Plans

It is the policy of Fairfax Community Home to utilize 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 following:

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).

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R 17, the care plan was reviewed and revised. The Interdisciplinary Team has developed a list if post fall interventions. This is a list which will be a continuing work in progress. Interventions will vary depending on the unique situation. Comprehensive care plans will be updated with appropriate interventions. Assessments are performed quarterly, annually, or if Significant change in status by the MDS nurse/coordinator.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For any other resident this could affect, a thorough review and potential new assessment would be completed with the addition on updating the care plan. Care plans are reviewed quarterly or in the event of a significant change.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy for Comprehensive Care Plans has been reviewed by the Facility QA/QI Committee and the Interdisciplinary Team. Care plans are reviewed quarterly or if a significant change is noted.
How the facility plans to monitor its performance to make sure that	Care plan audits will be completed randomly for two months to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations.

solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 11/30/2015

F Tag 282 Comprehensive Care Plans (Qualified Persons)

It is the policy of Fairfax Community Home to provide care and services by qualified persons in accordance with each resident's written plan of care.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R24, care plan was reviewed with staff for the appropriate follow through. In Service Training was held for nursing staff to review several aspects of resident cares.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For the facility residents who have deficit needs identified as a part of their MDS assessment, the current care plan interventions identified to assist the resident will be monitored for proper implementation. This will be done by observational audits.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy and procedure for Positioning the resident, Toileting, Bedpan/Urinal Offering/Removal were each reviewed on 11/18/2015, by the QA/QI Committee. Monitoring of staff in regards to the Provision of Care with in plan of care will be performed by supervising nurses, the director of nursing, and/or administration. Licensed staff were trained starting 11/10/2015 and ongoing regarding their responsibilities. Training for other staff was held on 11/03/15 and 10/28/2015. Specific items include incident reporting and completion of a thorough investigation, assessing and care planning for resident vulnerabilities, care plan development, and follow through reporting to supervisors. Also included focuses were toileting, repositioning, grooming, ambulation, and many generalized resident cares.
How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Random observation audits will be conducted monthly for two months. Audit findings will be shared with QA Committee at its next scheduled meeting for review and make further recommendations.

Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 11/30/2015

F Tag 312 Activities of Daily Living

It is the policy of Fairfax Community Home to provide care and services by qualified persons in accordance with each resident's written plan of care.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R24, care plan was reviewed with staff for the appropriate follow through. In Service Training was held for nursing staff to review several aspects of resident cares.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For the facility residents who have deficit needs identified as a part of their MDS assessment, the current care plan interventions identified to assist the resident will be monitored for proper implementation. This will be done by observational audits.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy and procedure for Positioning the resident, Toileting, Bedpan/Urinal Offering/Removal were each reviewed on 11/18/2015, by the QA/QI Committee. Monitoring of staff in regards to the Provision of Care within plan of care will be performed by supervising nurses, the director of nursing, and/or administration. Licensed staff were trained starting 11/10/2015 and ongoing regarding their responsibilities. Training for other staff was held on 11/03/15 and 10/28/2015. Specific items include incident reporting and completion of a thorough investigation, assessing and care planning for resident vulnerabilities, care plan development, and follow through reporting to supervisors. Also included focuses were toileting, repositioning, grooming, ambulation, and many generalized resident cares.
How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Random observation audits will be conducted randomly monthly for two months. Audit findings will be shared with QA Committee at its next scheduled meeting for review and make further recommendations.

Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 11/30/2015

F Tag 314 Treatment to Prevent/Heal Pressure Sores

It is the policy of Fairfax Community Home to provide care and services by qualified persons in accordance with each resident's written plan of care.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R24, care plan was reviewed with staff for the appropriate follow through. In Service Training was held for nursing staff to review several aspects of resident cares. Case Manager/DON have reviewed the care plan and have developed an individualized repositioning schedule to maintain skin integrity based on the residents individualized needs.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For the facility residents who have deficit needs identified as a part of their MDS assessment, the current care plan interventions identified to assist the resident will be monitored for proper implementation. This will be done by observational audits.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policy and procedure for Positioning the resident, Toileting, Bedpan/Urinal Offering/Removal were each reviewed on 11/18/2015, by the QA/QI Committee. Monitoring of staff in regards to the Provision of Care with in plan of care will be performed by supervising nurses, the director of nursing, and/or administration. Licensed staff were trained starting 11/10/2015 and ongoing regarding their responsibilities. Training for other staff was held on 11/03/15 and 10/28/2015. Specific items include incident reporting and completion of a thorough investigation, assessing and care planning for resident vulnerabilities, care plan development, and follow through reporting to supervisors. Also included focuses were toileting, repositioning, grooming, ambulation, and many generalized resident cares.
How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	Random observation audits will be conducted randomly monthly for two months. Audit findings will be shared with QA Committee at its next scheduled meeting for review and make further recommendations.

Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 11/30/2015

F Tag 323 Free of Accident, Hazards/Supervision, Devices

It is the policy of Fairfax Community Home to utilize 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 following:

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).

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For Resident R 17, the care plan was reviewed and revised. The Interdisciplinary Team has developed a list of post fall interventions. This is a list which will be a continuing work in progress. Interventions will vary depending on the unique situation. Reassessment with referrals to appropriate therapies for eval and follow up Comprehensive care plans will be updated with appropriate interventions. Assessments are performed quarterly, annually, or if Significant change in status by the MDS nurse/coordinator.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	For any other resident this could affect a thorough review and potential new assessment would be completed with the addition on updating the care plan. Care plans are reviewed quarterly or in the event of a significant change.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The policies for Comprehensive Care Plans/ Interdisclinary Team Meetins has been reviewed by the QA/QI Committee and the Interdisciplinary Team. Care plans are reviewed quarterly or if a significant change is noted.
How the facility plans to monitor its	Care plan audits will be completed randomly for two months to ensure continued compliance with

performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.	results reported to the QA/QI Committee for review and further recommendations.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 11/30/2015

FORM APPROVED
OMB NO. 0938-0391

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

F533025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245333	A. BUILDING 01 - MAIN BUILDING B. WING	10/21/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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 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 YOU 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, Fairfax Community Home 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	POC ok 12-23-15 LAST DATE 11/18/15	

RECEIVED
NOV 2 2 2015
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Judy Dansdman	ADMINISTRATOR	11-19-15

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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	245333	A. BUILDING 01 - MAIN BUILDING B. WING _____	10/21/2015

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and 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 Fairfax Community Home was constructed as follows: The original building was constructed in 1965 and is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction. The nursing home is separated from an assisted living facility by a two-hour fire wall assembly. Also, the 1965 building of Type II(111) construction is separated from the 1995 addition of Type V(111) construction by a two-hour fire wall assembly. The facility has a fire alarm system with smoke detection at smoke barrier doors and all spaces open to the corridors, which is monitored for	K 000		

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	245333	A. BUILDING 01 - MAIN BUILDING B. WING	10/21/2015

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

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K 000	Continued From page 2 automatic fire department notification. The facility also has single-station, battery-operated smoke detection in all Resident Rooms. The facility has a capacity of 50 beds and had a census of 23 at time of the survey. Because the original building and the one addition met the construction types allowed for existing buildings, the facility was surveyed as one building and one (1) Form CMS-2786R booklet was completed.	K 000		
K 054 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all 23 residents, visitors, and staff. Findings Include: Between 9:00 AM and 12:30 PM on 10/21/2015, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could	K 054	See Attached	

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K 054	Continued From page 3 not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detectors located throughout the facility. This deficient practice was verified by the Facility Maintenance Director (DK).	K 054		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Observations revealed that some electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. This deficiency could negatively effect any resident, staff and visitors in this area of the facility. Findings include: On facility tour between the hours of 9:00 am and 12:30 AM on 10/21/2015, observations revealed that in the laundry room, there was a multi-plug adapter in use for the washing machine and soap dispensers. This deficient practice was verified by the Facility Maintenance Director (DK).	K 147	See Attached	

Fairfax Community Home, Inc.

K054

The licensed contractor for testing of the smoke detector system was contacted. The contractor performed the required sensitivity test on the smoke detectors on November 3, 2015, with appropriate documentation on file at the facility.

Completion Date: November 3, 2015

The Maintenance Supervisor is responsible for correction and monitoring to prevent reoccurrence of this deficiency.

K147

The Maintenance Supervisor engaged the electrician contractor to replace the multi-plug adapter with a 4 gang outlet for use for plugging in the washing machines and soap dispensers. New outlet was installed on November 18, 2015.

Completion Date: November 18, 2015

The Maintenance Supervisor is responsible for the correction and monitoring to prevent reoccurrence of this deficiency.