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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GWHW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00103

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/25/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Gary Nederhoff, Unit Supervisor 04/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist 04/09/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/10/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/29/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN-24-5344

Post Certifiction revisits were completed to verify correction of deficiencies issued pursuant to a standard survey completed December 5, 2014 and an FMS completed on January 15, 2014, effectiveFebruary 10, 2014. Refer to the CMS 2567 for the results of this visit.

Effective February 10, 2014, the facility is certified for 55 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): Medicare Provider # 24-5344

April 9, 2014

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

Dear Ms. Sheeran:

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

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

Effective February 10, 2014 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds located in rooms

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 2, 2014

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

RE: Project Number S5344024

Dear Ms. Sheeran:

On December 18, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 5, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 15, 2014 a surveyor from the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) at your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F).

On January 28, 2014 CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicare admissions, effective March 5, 2014. (42 CFR 488.417 (b)).

Also, CMS notified you in their letter of January 28, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 5, 2014.

On January 21, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 25, 2014 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 December 5, 2013 and the Federal Monitoring Survey (FMS) completed on January 15, 2014. We presumed, based on your plan of correction, that

your facility had corrected these deficiencies as of February 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 5, 2013 and FMS completed on January 15, 2014, effective February 10, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of January 28, 2014. The CMS Region V office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicare admissions, effective March 5, 2014 be rescinded. (42 CFR 488.417 (b)).

In the CMS letter of January 28, 2014 , you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 5, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 10, 2014 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697
Email: anne.kleppe@state.mn.us

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245344	A. Building B. Wing	1/21/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/06/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/06/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **01/06/2014**
ID Prefix **F0365** Reg. # **483.35(d)(3)** LSC	Correction Completed **01/06/2014**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **01/06/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **01/06/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **01/06/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/AK	04/01/2014	10160	01/21/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/5/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245344	A. Building B. Wing **01 - MAIN BUILDING 01**	2/25/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **02/10/2014**	ID Prefix	Correction Completed **02/10/2014**	ID Prefix	Correction Completed **02/10/2014**
Reg. # **NFPA 101** LSC K0038		Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **02/10/2014**	ID Prefix	Correction Completed **02/10/2014**	ID Prefix	Correction Completed **02/10/2014**
Reg. # **NFPA 101** LSC K0143		Reg. # **NFPA 101** LSC K0144		Reg. # **NFPA 101** LSC K0147	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	04/01/2014	25822	02/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/15/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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 A. Building B. Wing	(Y3) Date of Revisit
245344	01 - MAIN BUILDING 01	2/25/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0018	Correction Completed **01/16/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	04/01/2014	25822	02/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
12/2/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GWHW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00103

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/05/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kyla Einertson, HPR Social Work Specialist — 01/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/27/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN-245344

At the time of the standard survey completed December 5, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to bea 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. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 7116

December 18, 2013

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

RE: Project Number S5344024

Dear Ms. Sheeran:

On December 5, 2013, 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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 14, 2014, 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 March 5, 2014 (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 June 5, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING _____ B. WING _____	12/05/2013

RECEIVED DEC 18 2013 MN Dept of Health Rochester

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 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 follow the care plan for 2 of 3 residents (R49 and R44) with repositioning, who were reviewed for pressure ulcers and 1 of 2 residents (R66) with toileting, who were reviewed for a decline in urinary incontinence. Findings include: R49 had not been repositioned as directed by the care plan. R49's significant change Minimum Data Set (MDS) dated 11/21/13, included diagnoses of end stage renal disease and pneumonia, required extensive assistance with bed mobility and transfers, and was at risk for developing pressure	F 282 1-16-14 GPN	F 282 Plan of Correction See Attachment 2	1-6-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jane Sheeran | TITLE: Administrator | (X6) DATE: 1-3-14

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.

ATTACHMENT #2

F 282-

Services by Qualified Persons/Per Care plan

Fairview Care Center of Dodge Center, MN assures that services are provided that meet professional standards of quality and are delivered by appropriately qualified persons (e.g., licensed, certified) in accordance with each residents written plan of care.

Resident #49 was placed on hourly repositioning dating back to 12/3/13 when it was discovered resident has an unstageable pressure ulcer as indicated on care plan and nursing assistant assignment sheets. Resident #49 has shown a history of refusals to turn and reposition as recommended.

Resident #44 was placed on hourly repositioning dating back to 10/14/13 when it was observed resident had pressure ulcer as indicated on care plan and nursing assistant assignment sheets. Resident #44 has shown a history of behaviors at times potentially related to Huntington's disease causing increase in difficultly to reposition resident. The care plan was reviewed and accurately reflects resident's needs.

Resident #66 was placed on a toileting program dating back to 11/14/13 as indicated in nursing progress notes and care plan due to significant change in overall health status.

All nursing staff is responsible for following each residents' individualized plan of care and following the nursing assistant assignment sheets. Nursing staff have been educated on 01/02/14 on the importance of following the plan of care with repositioning and toileting schedules.

The Director of Nursing and/or designee will randomly conduct audits on turning and repositioning schedules and on toileting schedules to assure compliance with plan of correction. Findings will be reviewed at the February, 2014 QAPI meeting.

Completion Date: January 6, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MN Dept of Health Rochester

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

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F 282	Continued From page 1 ulcers. R49's care plan dated 11/14/13 indicated R49 was at risk for skin breakdown and instructed staff to reposition every hour. During continuous observation on 12/5/13, R49 had been observed lying in bed on her right side from 8:15 a.m. to 9:46 a.m. (one hour and 31 minutes). R49 had not been assisted with, or encouraged to reposition. At 9:38 a.m. nursing assistant (NA)-E went into the room and asked R49 to put on call light when she was tired and wanted to be repositioned and left the room. However, NA-E had not offered to assist, or encouraged R49 to reposition at that time. When interviewed on 12/5/13, at 9:46 a.m. NA-E stated R49 will tell you when she wants to be repositioned and will ask to be repositioned. NA-E stated she last repositioned R49 at 8:00 a.m. NA-E stated, " I ask her if ok, and she says she is ok." R49 had not indicated she wanted to be repositioned at 9:46 a.m. When interviewed on 12/5/13, at 1:54 p.m. the DON stated staff should reposition R49 every hour as directed by the care plan. R44 had not been repositioned every hour as had been assessed after developing a pressure ulcer. Was not repositioned for two hours and 49 minutes and again for 1 hour and 44 minutes. R44's admission MDS dated 10/7/13, included a diagnosis of Huntington's disease (a brain wasting disease that causes cognitive, psychiatric and movement problems). The MDS indicated R44 had severe cognitive impairment, required	F 282		

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F 282	Continued From page 2 extensive assistance with bed mobility, total assistance for transfers, and was at risk for pressure ulcers. R44's mobility care plan instructed, "1-2 staff assist to reposition in chair and in bed." The care plan did not instruct staff on how often to assist R44 to reposition. However, an undated Nursing Assistant Care Sheet included repositioning R44 every hour. R44 was continuously observed sitting in tilt-n-space chair on 12/3/13, from 9:15 a.m. to 12:04 p.m., 2 hours and 49 minutes, and on 12/4/13, from 8:47 a.m. to 10:31 a.m., 1 hour and 44 minutes. R44 had not been offloaded (remove pressure from bony prominences) and repositioned, as directed by the Nursing Assistant Care Sheet. During interview on 12/3/13, at 10:29 a.m. NA-B indicated R44 had tilted the resident back in wheelchair only and not fully removes pressure to the bottom. During interview on 12/3/13, at 10:30 a.m. NA-A stated R44 was to be repositioned every hour, and NA-A had not repositioned R44 at this time. When interviewed on 12/4/13, at 11:12 a.m. the director of nursing stated R44 should be repositioned every hour and would expect staff to ensure that happens. A facility policy entitled, Repositioning dated 4/25/13, identified residents unable to reposition themselves independently would be turned and repositioned per facility tissue tolerance assessment.	F 282		

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F 282	Continued From page 3 R66 had not been assisted to the toilet as directed by the care plan. R66's quarterly MDS dated 11/18/13, included moderate cognitive impairment, required extensive assistance for toileting, and was frequent incontinent of urine. R66's toileting care plan dated 11/14/13, instructed staff to, "Assist to toilet upon risking, before and after meals, midafternoon, and at HS [bedtime]. Offer to assist when awake at night." R66 was observed continuously on 12/4/13, from 6:59 a.m. until 10:38 a.m., 3 hours and 39 minutes, and had not been assisted to the toilet. R66 was observed sitting in recliner in front of the television in lobby at 6:59 a.m. At 7:20 a.m. R66 was observed walking with one staff with the wheeled walker and one staff pushing wheelchair behind resident. At 7:33 a.m. R66 remained in the dining room eating breakfast. At 8:06 a.m. resident was assisted up from chair in the dining room and ambulated with staff assistance to the recliner in the lobby until 8:50 a.m. when R66 was walked to the therapy department. At 9:05 a.m. R66 remained in the therapy department performing pedaling exercises. At 9:17 a.m. R66 was performing sit to stand exercises. At 9:30 a.m. NA-C walked resident from the therapy department to the dining room for bingo. At 9:45 a.m. R66 remained in the dining room playing bingo. At 10:15 a.m. to 10:30 a.m. R66's wife was in the dining room standing next to resident while playing bingo. At 10:38 a.m. R66 was walked back from the dining room to resident room. R66 indicated had to go to the bathroom. NA-C walked resident into the bathroom; R66's incontinent product was saturated. NA-C verified	F 282	JAN 6 - 2013 MN Dept of Health Rochester	

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F 282	Continued From page 4 R66 had not been assisted to the toilet after breakfast as the care plan directed. During interview on 12/4/13, at 11:04 a.m. the director of nursing (DON) stated R66 should have been toileted after breakfast. A facility policy entitled Bladder Training policy dated 3/1/10 included a purpose of keeping the resident dry and free from odor.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 ensure each resident received timely assistance with repositioning for 2 of 3 residents (R49 and R44), and accurately assess pressure ulcers for 1 of 3 residents (R49) reviewed who had developed pressure ulcers. Findings include: R49 had not been repositioned according to assessed needs, and R49's pressure ulcer had been assessed incorrectly. R49's significant change Minimum Data Set	F 314	F 314 Plan of Correction See Attachment 3	1-6-14

ATTACHMENT #3

F 314-

Treatment/Services to Prevent/Heal Pressure Sores

Based on the comprehensive assessment Fairview Care Center ensures that a resident who enters the facility without pressure sores does not develop pressure sores unless the individuals 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.

Resident # 49 was placed on hourly repositioning dating back to 12/3/13 when it was observed resident has an unstageable pressure ulcer as indicated on care plan and nursing assistant assignment sheets. Resident #49 has shown a history of refusals to turn and reposition as recommended.

All nursing staff is responsible for following each residents individualized plan of care and nursing assistant assignment sheets. Nursing staff were re-educated on 01/02/14 on importance of following care plans with repositioning.

Clinical Nurse Managers are responsible for identifying residents at risk of developing pressure ulcers and to care plan accordingly.

All nursing staff were educated on SilverChair Course Pressure Ulcer Prevention and Management in August 2013. Clinical Nurse Manager involved in identifying at risk residents for developing pressure ulcers was provided with re-education on 01/02/14.

The Director of Nursing and/or designee will randomly conduct audits on residents turning and repositioning schedules to assure continued compliance with plan of correction. Findings will be reviewed at the February, 2014 QAPI meeting.

Completion Date: January 6, 2014

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F 314	Continued From page 5 (MDS) 11/21/13, included diagnoses of end stage renal disease and pneumonia. The MDS indicated R49 was independent in decision making skills, required extensive assistance with bed mobility and transfers, was at risk for developing pressure ulcers, but did not have a pressure ulcer. When interviewed on 12/2/13, at 1:46 p.m. licensed practical nurse (LPN)-A stated R49 had developed a stage 1 [intact skin with non-blanchable redness of a localized area] to her left heel on 12/2/13. R49's care plan dated 11/14/13, included, "Resident is at high risk for skin breakdown r/t [related to] decreased mobility, her legs often feel numb at times, she has been incontinent at times and using steroids at this time. She scores a 14 on the Braden Pressure Ulcer Risk Data Sheet [a scale used to determine pressure ulcer risk]." R49's goal was to maintain intact skin integrity. Staff was instructed to report skin conditions, follow protocol for treating breaks in skin, and to turn and reposition every hour. R49's care plan was updated on 12/3/13, to included, "Resident has a [sic] unstageable pressure area to her right heel." Staff was instructed to apply dressing as ordered, nutritional supplements, and to encourage to wear the heel float boots. On 12/1/13, LPN-A charted in progress notes, " Resident was found to have what appears to be a pressure ulcer on her right heel. She refused to have it measured and also refused to float the heel to relieve the pressure." On 12/2/13, LPN-A charted, " Checked residents heels this am. She was lying on her left side in bed. Noticed that she	F 314		

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F 314	Continued From page 6 had a black area to her left heel. Did allow me to measure area and it was 2.9 cm [centimeters] x 2.6. Black area is intact and she denied pain when asked. I did also check her right heel and no concerns noted. She declined to wear a heel float boot stating you can get one but I will not use it. When asked why she did not want the boot she just stared at the wall and would not answer me. Will continue to encourage her to reposition q [every] 1 hour and will encourage her to use float boot or vascular boot." On 12/2/13, LPN- A charted, " Reviewed pressure area that was found to resident ' s right heel. Area was noted to be gone this morning when checked but black area noted on left heel this am. See previous note. Resident is encouraged to reposition q [every] 1 hour. Declines to wear heel protectors or vascular boots. Resident also prefers to spend her time in her bed and often will decline to get up." On 12/2/13, LPN-A charted, Updated CNP [certified nurse practitioner], " About black area to residents left heel. At this time she has no new orders. Continue to encourage her to reposition and wear heel boot/vascular boots. Alert NP if area opens up." On 12/3/13, director of nursing (DON) charted in progress notes, " Writer assessed residents heel at this time. Area to L [left] [however, the ulcer is located on the right heel as observed by surveyor] heel is black in color and measures 2.9 cm x 2.6. Resident denies pain to the area. Encouraged to wear vascular boots and refused. Due to color on her heel- wound is considered unstageable [full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed] at this time. Supplements have been added to aid w[with]/wound healing. Residents appetite remains poor and staff continue to offer	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 7 snacks/drinks throughout the day. Continue w/ foam dressing to area." During continuous observation on 12/5/13, R49 had been observed lying in bed on her right side from 8:15 a.m. to 9:46 a.m. a total of one hour and 31 minutes. R49 had not been assisted with, or encouraged to reposition. At 9:38 a.m. nursing assistant (NA)-E went into the room and asked R49 to put on call light when she was tired and wanted to be repositioned and left the room. However, NA had not offered or encouraged R49 to reposition at that time. When interviewed on 12/5/13, at 9:46 a.m. NA-E stated R49 will tell you when she wants to be repositioned and will ask to be repositioned. NA-E stated she last repositioned R49 at 8:00 a.m. NA-E stated, " I ask her if ok, and she says she is ok." R49 had not indicated she wanted to be repositioned. When interviewed on 12/5/13, at 1:54 p.m. the DON verified R49's pressure ulcer had been originally assessed as a stage 1 ulcer on the left heel. However, it should have been assessed as an unstageable ulcer located on the right heel. The DON stated staff should reposition R49 every hour as directed by the care plan. R44 had not been repositioned every hour as had been determined as needed after developing a pressure ulcer. R44's admission MDS dated 10/7/13, included a diagnosis of Huntington's disease (a brain wasting disease that causes cognitive, psychiatric and movement problems). The MDS indicated R44 had severe cognitive impairment, required extensive assistance with bed mobility, total	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 8 assistance for transfers, had upper and lower extremity functional limits in range of motion, utilized a wheel chair for mobility, was frequently incontinent of bowel and bladder, was malnourished, was at risk for pressure ulcers, but did not have any current pressure ulcers. The Pressure Ulcer Care Area Assessment (CAA) dated 9/30/13, included he was at high risk for the development of pressure ulcers do to impaired mobility and urinary incontinence. A care plan would be developed to minimize these risks. R44's care plan dated 9/24/13, included, "Resident is at high risk for skin breakdown r/t [related to] incontinent of bowel and bladder and diagnosis of Huntington's. He scores a 14 on the Braden Pressure Ulcer Risk Data sheet. The goal for R44 was listed as to "Maintain intact skin integrity." Staff was instructed to report reddened skin, or open areas, and to cleanse perineal area with each incontinence episode. A toileting care plan was developed and instructed staff to check and change incontinent product and offer toileting upon rising, before and after meals, midafternoon and at bed time. R44's mobility care plan instructed "1-2 staff assist to reposition in chair and in bed." The care plan did not instruct staff on how often to assist R44 to reposition. The care plan also did not identify R44 had developed a pressure ulcer. R44's Tissue Tolerance Evaluation, dated 10/21/13, included, "Resident will be repositioned q [every] 1 hour R/T stage 2 [partial thickness tissue loss] PU [pressure ulcer] on coccyx." This was not added to the care plan, however, an undated Nursing Assistant Care Sheet included to reposition R44 every hour.	F 314		

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(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 9 R44 was continuously observed sitting in tilt-n-space chair on 12/3/13, from 9:15 a.m. to 12:04 p.m., 2 hours and 49 minutes, and on 12/4/13, from 8:47 a.m. to 10:31 a.m., 1 hour and 44 minutes. R44 had not been offloaded and repositioned, as directed by the Nursing Assistant Care Sheet and assessment dated 10/21/13. During interview on 12/3/13, at 10:29 a.m. NA-B indicated R44 was repositioned by tilting the resident back in wheelchair. NA-B did not reposition R44 at that time. During interview on 12/3/13, at 10:30 a.m. nursing assistant (NA)-A stated R44 was to be repositioned every hour, but she did not reposition R44 at that time. During interview on 12/3/13, at 11:18 a.m. the director of nursing (DON) indicated repositioning should be accomplished by offloading, which included getting resident out of wheelchair and stand them or can change degrees of tilt chair and that is considered offloading/repositioning. During interview on 12/4/13, at 11:12 a.m. the DON confirmed R44 was to be repositioned every hour. DON stated R44 ' s Huntington's movements, resident was offloading himself. The DON verified the resident had not been repositioned and off loaded. DON indicated the open area on coccyx probably started as shearing and developed from there as a pressure ulcer. DON would expect the nursing staff to follow the care guide sheets that had been updated to direct staff to turn and reposition resident every hour. During review of policy entitled Repositioning dated 4/25/13, identified residents unable to reposition themselves independently would be	F 314		

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	245344	A. BUILDING _____ B. WING _____	12/05/2013

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F 314	Continued From page 10 turned and repositioned per facility tissue tolerance assessment.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident was assisted with toileting timely to maintain or prevent urinary tract infections for 1 of 2 residents (R66) who had declined in urinary incontinence. Findings include: R66 was observed continuously on 12/4/13, from 6:59 a.m. until 10:38 a.m. a total of 3 hours and 39 minutes, and had not been assisted to the toilet during this time. R66's admission Minimum Data Set (MDS) dated 8/19/13, included a diagnosis of bipolar and seizure disorder. The MDS indicated moderate cognitive impairment, required extensive assistance to the toilet, and was occasionally (less than seven times in the assessment week) incontinent of urine. The next quarterly MDS	F 315	F 315 Plan of Correction See Attachment 4	1-6-14

ATTACHMENT #4

F 315-

No Catheter, Prevent UIT, Restore Bladder

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

Resident #66 was placed on a toileting program dating back to 11/14/13 when facility noted decrease in ADL status and ability to toilet self safely and remain continent of bowel and bladder. Resident #66 toileting program dating back to 11/14/13 states "Assist to toilet upon rising, before and after meals, mid afternoon and at HS. Offer to assist when awake at night. Residents toileting program reviewed on 12/30/13 and remains appropriate at this time.

All nursing staff is responsible for following each residents individualized plan of care and nursing assistant assignment sheets. All nursing were re-educated on 01/02/14 on the importance of following the residents plan of care and following nursing assistant assignment sheets related to residents toileting programs.

Clinical Nurse Managers and Restorative Nurse are responsible for identifying residents for decline in urinary incontinence.

The Director of Nursing and/or designee will conduct random audits on resident's toileting schedules to assure continued compliance with plan of correction. Findings will be reviewed at the February, 2014 QAPI meeting.

Completion Date: January 6, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 11 dated 11/18/13, indicated continued extensive assistance with toileting and was now frequently (more than seven times in the assessment week) incontinent of urine, which indicated a decline in urinary incontinence. R66's Bowel and Bladder 3-Day Screening form dated 11/12/13 through 11/14/13, indicated R66 was voiding routinely between 1:00 a.m. and 3:00 a.m., at 7:00 a.m., 10:00 a.m., 1:00 p.m., and 7:00 p.m. A Bowel and Bladder Evaluation form dated 11/14/13, indicated R66 had functional urinary incontinence (decreased mental awareness/decreased of loss of mobility or personal unwillingness). R66's toileting care plan dated 11/14/13, instructed staff to, "Assist to toilet upon rising, before and after meals, mid afternoon, and at HS [bedtime]. Offer to assist when awake at night." R66 was observed sitting in recliner in front of the television in lobby at 6:59 a.m. At 7:20 a.m. R66 was observed walking with one staff with the wheeled walker and one staff pushing wheelchair behind resident. At 7:33 a.m. R66 remained in the dining room eating breakfast. At 8:06 a.m. resident was assisted up from chair in the dining room and ambulated with staff assistance to the recliner in the lobby until 8:50 a.m. when R66 was walked to the therapy department. At 9:05 a.m. R66 remained in the therapy department performing pedaling exercises. At 9:17 a.m. R66 was performing sit to stand exercises. At 9:30 a.m. NA-C walked resident from the therapy department to the dining room for bingo. At 9:45 a.m. R66 remained in the dining room playing bingo. At 10:15 a.m. to 10:30 a.m. R66's wife was in the dining room standing next to resident while	F 315		

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F 315	Continued From page 12 playing bingo. At 10:38 a.m. R66 was walked back from the dining room to resident room. R66 indicated had to go to the bathroom. NA-C walked resident into the bathroom; R66's incontinent product was saturated. NA-C verified R66 had not been assisted to the toilet after breakfast as the care plan directed. During interview on 12/4/13, at 11:04 a.m. the director of nursing (DON) stated R66 should have been toileted after breakfast as directed by the care plan. A facility policy entitled Bladder Training policy dated 3/1/10, included the purpose was to keep the resident dry and free from odor.	F 315		
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure pureed meals were provided as assessed for 7 of 9 residents (R21, R55, R44, R24, R14, R9, and R52) who received pureed diets without the individualized consistency as ordered by the physician. Findings include: The supper menu for 12/2/13, called for grilled chicken on bun, potato chips, 3 bean salad, chilled peaches, coffee/sugar/creamer, and milk. On 12/2/13, the dietary aide (DA)-A was observed preparing pureed chicken for 9 residents. The	F 365	F 365 Plan of Correction See Attachment 5	1-6-14

ATTACHMENT #5

F-365

Food in form to meet individual needs.

Fairview Care Center ensures that each resident receives and the facility provides food prepared in a form designed to meet individual needs.

Prior to the evening meal being served on 12/2/2013, the Certified Dietary Manager observed the incorrect consistency of the pureed food and directed the cook to correct it. This was done and no resident was served pureed food of the incorrect consistency.

An in-service was held on December 12, 2013 which reviewed proper preparation of pureed food to provide proper nutritional value, consistency and serving portions.

The Certified Dietary Manager will monitor compliance through random direct observation of pureed food preparation and observation of the meal service. Findings will be reviewed at the February, 2014 QAPI meeting.

Completion date: January 6, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 365	Continued From page 13 recipe called for 10 servings to consist of 10 two-ounce sizes of chicken along with one-half cup of food thickener and 3 ¾ cups of water or stock. According to DA-A, the pureed chicken was made with 9 two-ounce pieces of chicken; three cups of water and 1 tablespoon of thicken. The prepared pureed chicken was observed as a slurry mixture that could be poured out of the container and had the consistency of thin orange juice with pulp. The bean salad recipe for a pureed diet called for 10 ½ cup servings of bean salad and 3 tablespoons plus 1 teaspoon of thickener. The mixture was so thick that the DA-A could not mix with the use of the electric blender so DA-A was observed to add 1 cup of water in ¼ cup increments to the mixture (The recipe did not call for water to be added.) The lunch menu on 12/3/13, called for hot roast beef sandwich, mashed potatoes, seasoned broccoli, apricot upside down cake, coffee/sugar/creamer, and milk. The meat being scooped out of the blender looked like nectar-thick liquid. The recipe called for a serving for 10 residents, to use ¼ cup plus 1 tablespoon of thickener, and 2.5 cups of water or stock. The recipe indicated 3 ounces should be served. On 12/03/13, at 12:13 p.m. cook-A was interviewed. Cook-A stated that she eye-balled the roast beef for the amount which she said was approximately 7 cups of meat. She used 5 cups of broth and 5 pieces of bread. She used the bread for a thickener. R21 had received the thin texture pureed food prepared as described above, for the evening meal on 12/2/13, and noon meal on 12/3/13. The food had not been prepared to retain national value, or at the appropriate consistency to	F 365		

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F 365	Continued From page 14 prevent aspiration for R21. R21's admission Diagnosis Listing dated 7/16/13, included he had pneumonia due to inhalation of food or vomitus. R21's quarterly Minimum Data Set (MDS) dated 10/18/13, included diagnoses of a stroke and malnutrition. R21's physician orders dated 12/4/13 included a regular pureed diet with honey thick liquids. R21's Nutrition Assessment dated 11/5/13, included R21 had a pureed diet with honey thick liquids, had been hospitalized in July 2013 for aspiration pneumonia. R55 had received thin textured pureed food, as described above, for the evening meal on 12/2/13, and noon meal on 12/3/13. The food had not been prepared to a pudding texture as assessed for R55. R55's admission Diagnosis Listing dated 11/29/13, included pneumonic due to inhaled food or vomitus. R55's quarterly MDS dated 10/15/13 included diagnoses of diabetes and dementia. The MDS indicated severe cognitive impairment, coughing or choking during meals, and received a therapeutic diet. R55's physician orders dated 12/4/13 included a low salt pureed diet and pudding thickened liquids due to aspiration risk. R55 also had orders for a tube feeding related to malnutrition. R55's speech therapy evaluation dated 12/3/13 indicated R55 had a delay in swallowing and required foods pureed to a pudding thick consistency. R44 had received thin consistency pureed food, as described above, for the evening meal on 12/2/13, and noon meal on 12/3/13. The food had not been prepared to a honey thick texture as assessed for R44. R44's admission Diagnosis Listing dated 9/24/13, included pneumonic due to inhalation of food or	F 365		

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F 365	Continued From page 15 vomitus. R44's admission MDS dated 10/7/13, included diagnoses of Huntington's disease [a brain wasting disease which causes cognitive decline and movement disorder] and malnutrition. The MDS indicated R44 was on a mechanically altered diet, had loss of liquids from mouth when eating/drinking, held food in mouth or cheeks, or had residual in mouth after meals. R44's physician orders dated 10/16/13 included a pureed diet with honey thick liquids and aspiration precautions. R44's speech therapy evaluation dated 10/2/13, recommended that all foods and liquids be of the consistency to coat a spoon. R44's Nutrition notes dated 11/2/13, indicated a history of aspiration pneumonia and required a pureed diet with honey thickened liquids. R24 had received thin textured pureed food, as described above, for the evening meal on 12/2/13, and noon meal on 12/3/13. The food had not been prepared to a nectar texture as assessed for R24. R24's admission Diagnosis Listing included dysphagia (difficult swallowing) and protein-calorie malnutrition. The annual MDS dated 11/14/13, included severe cognitive impairment with Alzheimer's disease, received a mechanically altered diet, had loss of liquids/solids from mouth while eating/drinking, and had coughing or choking during meals. R24's physician orders dated 11/11/13 included a pureed diet with nectar thickened liquids. R24's speech therapy evaluation dated 10/19/11 indicated a risk of aspiration, difficulty chewing food, problems with bolus formation, management of solids, and severe swallow reflex time. R14 had received thin textured pureed food, as described above, for the evening meal on	F 365		

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F 365	Continued From page 16 12/2/13, and noon meal on 12/3/13. The food had not been prepared to a nectar thickness as assessed for R14. R14's Diagnosis Listing dated 8/9/13, included dysphagia and nutritional marasmus (severe malnutrition). The significant change MDS dated 9/22/13, included severe cognitive impairment, diabetes, malnutrition, loss of liquids or solids from mouth when eating/drinking, significant weight loss in the previous six months, and was on a mechanically altered therapeutic diet. R14's physician orders dated 11/6/13 included a no concentrated sweets diet with pureed food and nectar thickened liquids. The orders also included aspiration precautions. R9 had received thin pureed food, as described above, for the evening meal on 12/2/13, and noon meal on 12/3/13. The food had not been prepared to a nectar thickness as assessed for R9. R9's Diagnosis Listing dated 8/22/13, included Barrettes esophagus (abnormal tissue in the esophagus) and Alzheimer's disease. The quarterly MDS dated 11/27/13, included severe cognitive impairment, a mechanically altered therapeutic diet R9's physician orders dated 11/20/13, included a low sodium pureed diet with nectar thickened liquids and aspiration precautions. R52 had received thin liquid type pureed food, as described above, for the evening meal on 12/2/13, and noon meal on 12/3/13. The food had not been prepared to a nectar thickness as assessed for R52. R52 Diagnosis Listing dated 8/28/13, included Huntington's disease. The quarterly MDS dated 12/5/13, included a mechanically altered diet, loss of liquid/solids from mouth. R52's physician orders dated 11/6/13 included a	F 365		

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F 365	Continued From page 17 pureed diet with nectar thick liquids. R52's nurse notes dated 10/18/13; included R52 had been started on an antibiotic for possible aspiration pneumonia. R52's Nutrition note dated 11/9/13 included the pureed diet with nectar thick liquids needed to be followed as R52 was at risk for aspiration. An undated facility policy entitled Pureed Diet - Level 1 NDD, Dysphagia Puree, included, food for a pureed diet are modified to a consistency that is "pudding-like." When interviewed on 12/3/13, at 9:39 a.m. the registered dietician (RD)-B stated the consistency of pureed food should look like baby food, with no lumps or pieces and should be consistency of pudding. When foods are pureed they should retain as much national value as possible, fortifying with gravy, broth, instead of water, and the recipes should be followed for making pureed foods. The standard practice per Living Strong recommendations, based on the American Dietetic Association dated August 2012, indicated pureed foods should be smooth, moist and easy to swallow. Instructions in preparing puree foods included to puree foods with as little liquid as possible. Puree foods should be a smooth consistency and blended with gravy, sauce, broth, fruit or vegetable juice, milk or half and half. This is to increase nutritive value of watered down foods.	F 365		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425	F 425 Plan of Correction See Attachment 6	1-6-14

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F 425	Continued From page 18 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a medication was given as prescribed for 1 of 8 residents (R66) observed for medication administration. Findings include: R66's Physician Progress Note dated 11/21/13, included, "Initiate carbidopa 25-levodopa [Sinemet] 100 mg [milligrams] - 0.5 [one half] tablets by mouth (empty stomach) three times daily, increasing by 0.5 tablets every five days to max [maximum] dose of 3 tablets 3 times a day." The physician directed the medication to be given on an empty stomach. Carbidopa is used for treating Parkinson ' s disease symptoms. R66's Physician Neurology Progress Note dated 11/21/13, included, a diagnosis of, "Parkinsonism with dementia, " and was being seen due a	F 425		

ATTACHMENT #6

F 425-

Pharmaceutical SVC- Accurate Procedures, RPH

Fairview Care Center shall provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) to meet the needs of each resident.

Resident #66 obtained physician's order for the medication Carbidopa 25- Levodopa 100mg to take 0.5mg tab by mouth, on empty stomach, three times a day, increasing by 0.5mg every five days to max dose of 3 tablets 3 times a day. The order was directed from the physician to take medication on empty stomach.

Resident #66 MAR reviewed to ensure directions of taking medication on empty stomach reflected the directions and no changes made to MAR.

All licensed nursing staff and TMA's are responsible for following physician orders and giving medications as ordered. All licensed nursing staff and TMA's were re-educated on following physician orders and giving medications as ordered on 01/02/14.

The Director of Nursing and/or designee will conduct random audits on residents medications passes to ensure medication orders are followed per physician orders to assure continued compliance with plan of correction. Findings will be reviewed at the February, 2014 QAPI meeting.

Completion Date: January 6, 2014

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F 425	Continued From page 19	F 425		

progressively shuffling gait pattern, tremor, and decreasing cognition. The note indicated R66 had developed a tremor of the hands, both at rest and with movement. The tremor was noted to be affecting R66's "activities of daily life." The neurologist ordered, "Carbidopa levodopa trial would be given with a slow titration, 0.5 tablets of carbidopa-25/levodopa-100 tablets given on an empty stomach (one hour prior or two hours after a meal) TID [three times daily] increasing 0.5 tablets every five days, maximum dose three tablets TID or until psychiatric symptoms develop."

R66 Medication Administration Record (MAR), dated 12/13, identified Sinemet 25/100 mg by mouth TID, one tab TID x five days (give on empty stomach) with start date of 12/1/13 and end date of 12/5/13. Times to be given had been 7:00 a.m., 11:00 a.m. and, 4:30 p.m.

R66 was observed being administered the Sinemet medication on 12/4/13, at 7:34 a.m. by licensed practical nurse (LPN)-B. R66 was in the dining room and had been eating eggs and a partially eaten plate of breakfast was in front of him. R66 continued to eat his breakfast after the Sinemet was administered.

During interview on 12/4/13, at 8:18 a.m. the director of nursing (DON) stated she would expect order to be followed, to give medication on empty stomach as ordered.

During interview on 12/5/13, at 9:55 a.m. the facility's consultant pharmacist stated Sinemet works best on empty stomach, optimally reaches brain better given on empty stomach, if medication is taken with protein, it is not as

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F 425	Continued From page 20 effective. Document review of the facility Medication Administration (Specific) dated 3/1/10, read "POLICY: To administer medication safely and effectively."	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F 441 Plan of Correction See Attachment 7	1-6-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING _____ B. WING _____	12/05/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure blood glucose monitoring was performed in a manner to prevent the spread of infection for 1 of 2 residents (R32) observed for blood glucose monitoring. Findings Include: R32 had received a blood glucose testing however; the monitor had not been disinfected to prevent the spread of blood borne pathogens. During observation of blood glucose testing for R32 on 12/3/13, at 11:29 a.m. Licensed practical nurse (LPN)-B performed a finger stick on R32's finger while wearing gloves, applied blood sample to a test strip which had been inserted into a glucometer. The test strip sticking out of the glucometer had visible blood on it; this was laid onto R32's bedside night stand with no barrier. LPN-B then removed her gloves, picked up the glucometer, and brought it out to medication cart. LPN-B then removed the test strip located on the bedside stand, which still contained visible blood, with her bare hands, placed the glucometer back onto the medication cart, without a barrier, and then cleaned the glucometer with a germicidal wipe. Following this LPN-B had not been observed to disinfect the medication cart, or R32's night stand, even though they had been	F 441		

ATTACHEMENT #7

F 441-

Infection Control, Prevent Spread, Linens

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

Resident #32 has order for accu-checks to be completed per physician orders.

All licensed nursing staff and TMA's are responsible for providing accurate infection control measures when caring for glucometers.

All licensed nursing staff and TMA's have been re-educated on 01/02/14 on proper cleaning/disinfecting glucometer. All licensed staff/TMA's have been required to demonstrate proper cleaning of glucometer to Director of Nursing.

The Director of Nursing and/or designee will conduct random audits on ensuring compliance of proper cleaning of glucometers per plan of correction. Findings will be reviewed at the February, 2014 QAPI meeting.

Completion Date: January 6, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING _____ B. WING _____	12/05/2013

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F 441	Continued From page 22 contaminated. Also LPN-B had not worn gloves or washes her hands during the disinfecting of the glucometer or removal of the blood soiled test strip. Interview following procedure LPN-B verified they had not worn gloves but should have, had a barrier in place for the glucometer and test strip before placing on clean surface, and washed her hands after handling soiled items. During interview on 12/3/13, at 1:40 p.m., director of nursing (DON) stated she would expect good infection control procedures including, gloves to be worn when exposure to any bodily/blood fluids. She would expect gloves to be worn when handling and cleaning equipment with potential for blood to be on, and would expect a barrier to be laid on nightstand for equipment to be set on. A facility policy entitled Universal Precautions, dated 12/15/11; included gloves were to be worn when there was potential to come into contact with blood or body fluids. Specifically, "Gloves are to be used for Glucometer or Accucheck testing." Along with immediate hand washing if contact with blood or body fluids.	F 441		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to ensure the surface of the resident use	F 465	F 465 Plan of Correction See Attachment 8	1-6-14

ATTACHEMENT #8

F 465-

Safe/Function/Sanitary/Comfortable Environment

Fairview Care Center shall provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

All handrails were sanded to a smooth surface, stained, and varnished.

The Director of Environmental Service or Designee will check monthly for any roughness or exposed wood to assure continued compliance with this plan of correction. Findings will be reviewed at the February, 2014 QAPI meeting.

Completion Date: January 6, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING _____ B. WING _____	12/05/2013

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F 465	Continued From page 23 handrails were maintained in a manor to ensure sanitation is effective comfortable for use by residents when needed to ambulate in hallways. This was noted on the 100 and 200 wing of the facility which would affect only the residents who utilize rails for stability. Findings include: Observed on 12/2/13 at 12:30 p.m., the handrails on 200 wing had varnish worn off with exposed wood. During the interview on 12/4/13 a.m. at 11:30 a.m. the maintenance director verified the handrails were worn down of varnish and that wood was exposed. He stated that the handrails were usually checked and painted each month and were wiped down routinely to be disinfected. The maintenance director also stated he currently was alone in the department and that he did not know when the handrails were last varnished. He stated that the disinfection product takes off the varnish. Observed on 12/5/13 at 10:45 a.m. that handrails on the 100 wing were worn down of varnish and the wood was exposed. During an interview on 12/5/13 a.m. at 11:00 a.m. the maintenance director verified that the handrails on the 100 wing had wood exposed and were also in need of varnishing.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/02/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Fairview Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok PS 1-8-14 RECEIVED JAN - 6 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 1-14-14

EXIT:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jane Sheeran — TITLE: Administrator — (X6) DATE: 1-3-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/02/2013**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Fairview Care Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1975 and was determined to be of Type II(000) construction. In 1997, addition was constructed to the North Wing that was determined to be of Type II(000) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 49 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has corridor doors that do not latch into their frames in accordance with the requirements of 2000 NFPA 101, Sections 19.3.6.3.2. The deficient practice could affect 25 out of 49 residents. FINDINGS INCLUDE:	K 018	K 018 Plan of Correction See Attachment 1	1-6-14

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K 018	Continued From page 3 On facility tour between 1:00 PM and 3:00 PM on 12/02/2013, observation revealed that the following doors (which opens into the corridor) do not positive latch: 1. # 304 - Copy room 2. Wing 1 - clean linen 3. # 311 - kitchen door These deficient practices were confirmed by the Director of Maintenance (GN) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 018		

ATTACHMENT #1

K 018-

NFPA 101 Life Safety Code Standards

Fairview Care Center shall assure corridor doors positively latch into their frames in accordance with the requirements of 2000 NFPA, Section 19.3.6.3.2.

#304- Copy room door lock set was replaced with a new complete lock set.

Wing 1, clean linen room door lock spring latch was replaced.

#311- Kitchen door lock spring latch was replaced.

All corridor doors were checked for a positive latch.

The Director of Environmental Services or Designee will check monthly corridor doors to assure continued compliance with this plan of correction. Findings will be reviewed at the February, 2014 QAPI meeting.

Completion Date: January 6, 2014