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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KPBW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00103

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245344**
2.STATE VENDOR OR MEDICAID NO.
(L2) **134240100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/23/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)
13.Total Certified Beds **55** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 01/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245344

January 29, 2016

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

Dear Ms. Sheeran:

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

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

Effective January 13, 2016 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
January 29, 2016

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

RE: Project Number S5344027

Dear Ms. Sheeran:

On December 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 10, 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 January 23, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 22, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 10, 2015, effective January 13, 2016 and therefore remedies outlined in our letter to you dated December 23, 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.

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245344 Y1	A. Building B. Wing Y2	1/23/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0272	Correction	ID Prefix F0282	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.20(b)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	01/13/2016	LSC	01/13/2016	LSC	01/13/2016
ID Prefix F0325	Correction	ID Prefix F0329	Correction	ID Prefix F0412	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.55(b)	Completed
LSC	01/13/2016	LSC	01/13/2016	LSC	01/13/2016
ID Prefix F0431	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	01/13/2016	LSC	01/13/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	1/29/2016	10160	01/23/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/10/2015

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245344 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/22/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 01/13/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 01/13/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 1/29/2016	SIGNATURE OF SURVEYOR 35482	DATE 1/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/9/2015	☐ 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: KPBW

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 **12/10/2015** (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 **55** (L18)
13.Total Certified Beds **55** (L17)

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 12/31/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

Electronically delivered
December 23, 2015

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

RE: Project Number S5344027, H5344019, H5344020

Dear Ms. Sheeran:

On December 10, 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. In addition, at the time of the December 10, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5344019 and H5344020 that were found to be unsubstantiated.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 19, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 10, 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 June 10, 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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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
Minnesota Department of Public Safety
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 related to this eNotice.

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

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 _____	12/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5344019 was completed. The complaint was not substantiated. An investigation of complaint H5344020 was completed. The complaint was not substantiated.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment of self administration of medication for 1 of 1	F 176	F 176 Deficiency with ID Prefix Tag F 176 shall be corrected. Fairview Care Center will	1/13/16

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

Electronically Signed | 12/30/2015

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 _____	12/10/2015

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F 176	Continued From page 1 resident (R50) who was observed to self-administer an oral medication. Finding include: R50 was observed on 12/8/15, at 12:17 p.m., when trained medication assistant (TMA)-A approached R50, who was sitting in the dining room at a table. TMA-A had placed the medication cup, containing medication on the table in front of R50 and walked out of the dining room. TMA-A failed to ensure R50 had taken the medication. R50's record, lacked an assessment or a physician's order indicating R50 was able to self-administer medications. During interview on 12/08/15, at 12:30 p.m., TMA-A verified she had placed a medication cup, containing medication on the table in front of R50, had walked out of the dining room and had not watched R50 take the medication. TMA-A stated she was not sure if R50 was able to self-administer medications. During interview on 12/08/15, at 12:33 p.m., registered nurse (RN)-B stated R50 was not able to self-administer medications and staff should watch R50 swallow the medication before walking away from R50. During interview on 12/08/15, at 12:35 p.m., registered nurse (RN)-A stated R50 had not been assessed to be able to self-administer medications. RN-A stated she would expect whoever is passing medications to stay with R50 until R50 had taken the medication.	F 176	ensure an assessment for self-administration of medications is completed and the resident is deemed appropriate for administering medications independently before leaving medications unattended with a resident. R50 is not deemed appropriate for self-administration of medications. R50 will be observed for ingestion of medications by personnel administering the medications. All residents will be directly observed to ingest their medications unless they are deemed appropriate to self-administer their medications. Residents who are deemed appropriate through an assessment are identified on the Medication Administration Record as able to self-administer. Policies and Procedures for Self-Administration of Medications and Medication Administration have been reviewed and found to be appropriate. All licensed staff and Trained Medications Aides will be reeducated on these policies. The importance of observing residents ingest their medications when not deemed appropriate for self-administration will be stressed. The Director of Nursing and Clinical Nurse Managers will monitor continued compliance with this plan of correction through random direct observation of medication administration. The results of these observations/audits will be reviewed at the February QAPI Meeting. Completion Date: January 13, 2015	

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F 176	Continued From page 2 On 12/9/15, at 1:37 p.m., the director of nursing (DON) stated she would expect staff to stay with a resident until the medication was taken, unless the resident was identified to be able to self-administer medication. The DON stated R50 was not able to self-administer medications. The facility policy Self Administration of Medication, dated 3/1/10, identified an evaluation will be done by interdisciplinary team. Physician will write an order indicating that the resident may administer medication after set up by a licensed staff.	F 176		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions;	F 272		1/13/16

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F 272	Continued From page 3 Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify broken teeth for an oral assessment for 1 of 2 residents (R50) reviewed for dental services. Findings include: R50's annual Minimum Data Set (MDS) dated 10/20/15, had identified for oral/dental status no oral concerns were present. During observation on 12/07/15, at 3:57 p.m., surveyor viewed R50's teeth and noted two upper front chipped teeth. During observation on 12/08/15, at 3:54 p.m., registered nurse (RN)-A verified R50 had two upper front chipped teeth. During interview on 12/08/15, at 3:54 p.m., RN-A stated she completed the oral assessment for	F 272	F 272 Deficiency with ID Prefix Tag 272 shall be corrected. Fairview Care Center shall ensure all residents receive an oral assessment to identify oral concerns. An oral assessment has been completed for R50 with the identification of the two broken teeth. All residents shall have an oral assessment completed upon admission, annually and with any significant changes in condition. The oral assessment will include condition of teeth, gums, mucous membranes and tongue. The Policy for Oral Assessments has been reviewed and found to be appropriate. Licensed personnel responsible for completing oral assessments shall be reeducated on thorough and accurate completion of the assessments.	

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F 272	Continued From page 4 R50 and the assessment would be documented in R50's progress notes. RN-A verified R50's annual assessment dated 10/20/15, failed to identify R50 had broken teeth. During interview on 12/09/15, at 1:12 p.m., registered nurse (RN)-A stated she had not documented the facility annual oral assessment for R50. During interview on 12/09/15, at 1:37 p.m., the director of nursing stated she would expect a visual assessment be completed for an oral assessment and the findings of the assessment to be documented on the MDS accurately. The facility policy Dental/Oral Services, dated 3/1/10, identified oral cavity evaluations will be done upon admission, annually and with significant changes in condition, and will include condition of teeth, gums, mucous membranes, and tongue.	F 272	The Director of Nursing shall monitor continued compliance with this plan of correction through random audits of oral assessments. The results of these audits will be reviewed at the February, 2016 QAPI meeting. Completion Date: January 13, 2016.	
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 offer ambulation for a restorative program as care planned for 1 of 1 resident (R58) reviewed for notification of change. In addition, the facility failed to reposition a	F 282	F 282 Deficiency with ID Prefix Tag F 282 shall be corrected. Fairview Care Center shall offer ambulation assistance and repositioning assistance in accordance	1/13/16

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F 282	Continued From page 5 resident every hour as care planned for 1 of 3 residents (R30) reveiwed for pressure ulcers. Findings include: R58's care plan, print date 12/9/15, identified CNA (certified nursing assistant) restorative program for transfers and ambulation staff assist of one with four wheeled walker for ambulation to all destinations in the facility, if resident is willing and able to participate. Document plan was followed, resident did participate or any reasons did not. R58's CNA restorative aide sheet, dated 12/2015, identified staff assist of one with four wheeled walker for ambulation to all destinations in facility. Document plan was followed, resident did not participate, or any reasons did not. During observation on 12/08/15, at 11:17 a.m., R58 was sitting in a wheelchair in R58's room. Nursing assistant (NA)-A had wheeled R58 into the bathroom and then assisted R58 to stand and pivot to sit on the toilet and then to sit back into R58's wheelchair. At 11:49 a.m., R58 was sitting in R58's wheelchair and NA-A had wheeled R58 into the dining room for lunch. NA-A failed to offer R58 assist to ambulate as per R58's care plan and restorative aide sheet indicated to all destinations in the facility. During observation on 12/9/15, at 9:01 a.m., nursing assistant (NA)-B assisted R58 with morning cares and then assisted R58 to sit in R58's wheelchair. NA-A then wheeled R58 out to the dining room for breakfast. NA-B failed to offer R58 assist to ambulate as per R58's care plan and restorative aide sheet indicated to all destinations in the facility. During interview on 12/9/15, at 9:33 a.m., NA-B stated when she was pushing R58 in the	F 282	with each residents' written plan of care. R58 shall be offered assistance with ambulation to all destinations as written in her plan of care. Restorative program for ambulation has been in R58s' plan of care since 8/6/15. R30 shall be offered assistance with repositioning every hour as written in her plan of care. R30 has been on hourly repositioning since 6/17/14. R30 does have a history of refusing to be repositioned. All residents needing assistance with ambulation and repositioning shall be offered the needed assistance according to their written plan of care. All nursing personnel shall be reeducated on the importance of following each residents' written plan of care and providing ambulation and repositioning assistance accordingly. The Director of Nursing and/or designee shall monitor for continued compliance with this plan of correction through random monitoring/observing of residents who are care planned to receive assistance with ambulation and repositioning to ensure they are receiving the appropriate assistance. The results of the monitoring/observing will be documented and reviewed at the February 2016 QAPI meeting. Completion Date: January 13, 2016	

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F 282	Continued From page 6	F 282		

wheelchair, she had said to R58 half way to the dining room, ok to ride to the dining room or walk? NA-B stated R58 replied I am ok in the wheelchair.
On 12/09/15, at 10:02 a.m., registered nurse (RN)-D verified R58's care plan and restorative aide sheet directed staff assist of one with four wheeled walker for ambulation to all destinations in the facility. RN-D stated staff should be offering R58 assist to ambulate to all destinations and if R58 refuses then staff should document R58 refused. RN-D stated offering to walk R58 while already pushing R58 in the wheelchair was not encouraging R58 to ambulate. RN-D stated the goal is always to be as independent as possible to maintain the highest level of mobility.
On 12/09/15 at 1:39 p.m., the director of nursing stated she would expect the care plan to be followed, offer to ambulate and if refused document why.

A policy was requested for following restorative program, but was not provided.
R30 had a diagnosis listed on the care plan dated 3/14/10 which included Alzheimer's disease and pressure ulcer of sacral region, stage 3. The annual Minimum Data Set dated 10/6/15 identified R30 had moderate cognitive impairment and needed extensive physical assist of two with bed and transfer mobility.

During observation on 12/8/15 at 9:48 a.m. R30 was seated in her wheelchair in the day area next to the dining area; a constant observation was started at this time. R30 remained in her wheelchair with the same positioning in the day area until 11:30 a.m. when she was propelled by a nursing assistant (NA) into the dining room where she remained in the same position in her

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F 282	Continued From page 7	F 282		

wheelchair until 12:28 p.m. when she was propelled by a NA into her room. During the constant observation time, two hours and 40 minutes, R30 was not repositioned.

R30's care plan, revised 10/6/15, indicated R30 is at high risk for skin breakdown and has a current pressure ulcer to coccyx. Care plan interventions included, turn and reposition every hour while sitting and lying; and to check and change incontinent product when repositioning R30 every one hour. Wing one nursing assistant care plan indicated R30 was to be repositioned every hour.

On 12/8/15 at 12:20 p.m. NA-D stated, "I don't know her [R30] at all. I work the other hall." At 12:22 p.m. NA-C stated, "I don't know her, I work with the front group." At 12:24 p.m. NA-A stated, "usually about every two hours [repositioned]." After checking NA care sheet added, "Every one hour she is on hospice. Not positive when the last time she was repositioned. I'm one of the three people, maybe they did it." At 12:25 p.m. NA-D stated, "Every hour [repositioned]. Probably around 11 I repositioned her, I re-tilted her in her chair." NA-D added that tilting R30's wheelchair is enough to off load her.

On 12/8/15 at 2:11 p.m. the director of nursing stated, "I think she is care planned for hourly. If in bed to off load in bed from side to side. I think they put her in her bed to reposition. I think they can tilt her chair to off load."

Facility policy, Repositioning dated 4/25/13, chair/bed repositioning reads, "Check the care plan, assignment sheet, to determine resident's specific positioning needs including special equipment, resident level of participation, and the

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F 282	Continued From page 8 number of staff required to complete the procedure."	F 282		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify weight loss for 1 of 3 residents (R58) reviewed for nutrition. Findings include: R58's admission Minimum Data Set (MDS) dated 8/9/15, identified admission date of 8/3/15, and a weight of 184 pounds. R58's quarterly MDS dated 11/3/15, identified a weight of 173 pounds. A nine pound weight loss in three months. R58's care plan dated revision 10/29/15, identified focus of risk for endocrine complications related to diagnosis of diabetes, current weight 173.6 pounds with interventions of diet as ordered, monitor intake and monitor weight.	F 325	F 325 Deficiency with ID Prefix Tag F 325 shall be corrected. Fairview Care Center shall identify weight loss in residents. Family, Physician and Dietician have been informed of R58's weight loss. Interventions have been reviewed and offered to resident and family. Care Plan has been updated accordingly. All resident weights will be reviewed monthly by the Dietary Manager and Clinical Nurse Managers. Any significant weight loss will be discussed at the weekly Interdisciplinary Team Meeting and reported to the Dietician and physician. Care Plans will be updated accordingly. Weight Loss Policy was reviewed and found to be appropriate. All nursing staff	1/13/16

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F 325	Continued From page 9 R58's nutritional quarterly review, dated 11/4/2015, identified resident is receiving a regular diet with regular texture. Diet changed to regular on 10/27/2015. Resident has no problems with chewing or swallowing, eats all meals in the dining room and is able to feed self. Weight has been stable between 173 pounds and 178 pounds over the last quarter. Suggested weight range is 112-138 pounds. Will monitor weight and intake. R58's weights and vitals summary (printed from the facility computer system) dated 12/8/15, identified 8/3/15, weight of 184 pounds standing and on 9/2/15, weight of 173 pounds standing and a five percent change (comparison weight 8/3/15, of 184 pounds, six percent change, loss of 11 pounds). Review of the facility monthly December 2015 weight list of residents on 12/8/15, identified residents had been weighed and R58 was not on the monthly weight list. Surveyor requested a current weight for R58. The director of nursing informed surveyor on 12/8/15, R58's current weight was 169 pounds. On 12/08/15, at 3:29 p.m., dietary manager (DM)-C verified R58's admission Minimum Data Set (MDS) dated 8/9/15, identified a weight of 184 pounds and R58's quarterly MDS dated 11/3/15, identified a weight of 173 pounds. DM-C reviewed R58's weights and stated R58's weight was 173 pounds back in September. DM-C calculated R58's weight and verified R58 had a greater than five percent weight loss in one month from admission. DM-C stated I was calculating the weight wrong, I thought R58 had a nine pound	F 325	will be reeducated on the Weight Loss Policy. The Director of Nursing and/or Clinical Nurse Managers will monitor continued compliance with this plan of correction through random audits of weights recorded in the clinical records with appropriate identification of any weight loss. Findings from the audits will be reviewed at the February, 2016 QAPI Meeting. Completion Date: January 13, 2015	

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weight loss, not an 11 pound weight loss. DM-C stated the registered dietician (RD) was not aware of the weight loss. DM-C stated I review the weights and inform the RD of any weight loss and then the RD would recommend a supplement. DM-C verified she had not implemented a supplement for R58.

On 12/09/15, at 2:22 p.m., RD-E stated she comes every month to the facility. RD-E stated she was not aware R58 had an 11 pound weight loss. RD-E stated DM-C gives me a list of residents with weight loss or pressure ulcers and that is what I review.

On 12/10/15, at 9:04 a.m., registered nurse (RN)-A verified R58's weight in the facility computer system on 9/2/15, and the system had indicated weight of 173 pounds standing and a five percent change of weight. RN-A stated the weights are input into the computer system by the unit secretary, DM-C reviews the weights would let me know if there was a change. We then decide if we need to continue to monitor weights or implement a supplement. RN-D stated an order was obtained for four ounces of glucerna (a supplement) to be given three times a day on 9/28/15, but was discontinued on 10/2/15 due to R58 did not like the supplement. RN-A stated we did not implement any other supplement after the glucerna was discontinued.

On 12/10/15, at 9:35 a.m., RN-A stated R58's weight recorded on a daily weight sheet indicated on 12/4/15, R58's weight was 178.8 pounds when weighed in wheelchair. RN-A stated she feels a standing weight is pretty accurate. RN-A stated she would expect if the admission weight for R58 of 184 pounds was a discrepancy it should be

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F 325	Continued From page 11 documented in R58's record the weight was inaccurate and then document what R58's true weight upon admission was. On 12/9/15, at 1:39 p.m., the director of nursing (DON) verified R58's name had not been on the resident monthly December weight list. The DON stated weights are done the first week of the month and weights are supposed to be checked against last weight and staff should reweigh at the time if the weight is off and report to the nurse as needed. DON verified 58's weight in the facility computer system on 9/2/15, and the system had indicated weight of 173 pounds standing and a five percent change of weight. DON stated DM-C reviews the weights and brings information to the interdisciplinary team. A policy for nutritional assessment for weight loss was requested, but not provided.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		1/13/16

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive sleep assessment to determine the need for a sleep aid ordered for insomnia for 1 of 5 residents (R71) reviewed for unnecessary medications. Findings Include: R71's admission record revealed R71 was admitted on 7/8/15 with diagnoses of dementia without behavioral disturbance, psychotic disorder not due to a substance or known physiological condition and anxiety. The quarterly Minimum Data Assessment (MDS) dated 10-13-15, indicated R71 did not display trouble falling asleep or staying asleep or sleeping too much, feeling tired or having little energy. R71 currently received melatonin (supplement used to help with sleep) 3 milligrams (MG) for insomnia. The current physician's orders reflected a start for melatonin as 12-2-15 and the resident had received the medication daily according to the medication administration record. R71's medical record lacked a comprehensive	F 329	329 Deficiency with ID Prefix Tag 329 shall be corrected. Fairview Care Center shall ensure a comprehensive sleep assessment to determine the need for a sleep aid is completed. R71 has been using a sleep aid since December 2, 2015. A Sleep Assessment was started with the initiation of the sleep aid to monitor effectiveness. All residents will have a sleep assessment completed prior to the use of a sleep aid. Policy for Hypnotic and Sedative Medication was reviewed and found appropriate. Clinical Nurse Managers were reeducated on the Hypnotic and Sedative Medication and Sleep Assessments. The Director of Nursing will monitor continued compliance with this plan of correction through random audits of residents using sleep aids to ensure a sleep assessment has been completed appropriately. Audit results will be reviewed at the February, 2016 QAPI meeting.	

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F 329	Continued From page 13 sleep assessment and analysis of sleep monitoring to initiate the use of melatonin. R71's nurse practitioner visit note dated 12/2/15 included, "...Nursing reports that she is not sleeping well. Often up pacing at night...It will certainly be important for her to be sleeping well. Staff reports that she does nap throughout the day, so staff is asked to try to keep her up during the day avoiding naps. Initiate melatonin 3 mg at bedtime..." On 12/08/2015 at 3:24 p.m. the director of nursing (DON) stated a sleep assessment should be completed for residents on melatonin. The DON stated nursing assistants document length of sleep and the nurse managers documented based on the assessment of sleep pattern. The DON stated a comprehensive sleep assessment should include a sleep pattern of the resident, any triggers that would keep them awake and non-pharmacological interventions used to help promote sleep. The DON verified R71 was started on melatonin on 12-2-15 and comprehensive sleep assessment was not completed prior to the initiation of the medication. The DON stated staff are in the process of completing sleep pattern monitoring at this time for the use of the medication. The DON stated her expectation was a comprehensive sleep assessment be completed prior to the initiation of a sleep medication. On 12/09/2015 at 8:11 a.m. licensed practical nurse (LPN)-B stated sleep assessments were completed upon admission, quarterly and anytime there was a concern with sleep for a resident. LPN-S stated a comprehensive sleep assessment was to be completed prior to the	F 329	Completion Date: January 13, 2016	

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F 329	Continued From page 14	F 329		

initiation of a medication for sleep. LPN- B stated, "Yes, I should have completed a sleep assessment prior to the initiation of melatonin for R71. "LPN-B stated a sleep assessment was started on 12-2-15 for R71 and stated the sleep assessment was based on the sleep pattern sheets. LPN-B stated she met with the DON yesterday and discussed the need for the sleep assessments to include more information than a resident's sleep pattern and stated she would now be including non-pharmacological interventions as a part of the comprehensive sleep assessment.

The Hypnotic /sleep medication therapy shall be used only when necessary to ensure restful sleep policy dated 10/3/12, directed staff to follow the following procedure.
"1. Sleep evaluation will be done upon admission, quarterly, with any noted change in sleep pattern or when a resident complains of sleeplessness.
2. Seven day sleep pattern data sheets will be initiated.
3. During the seven days, non- pharmacological interventions (warm blanket, repositioning, food or drink, back rub, r/o pain, ect) will be attempted and results noted.
4. After the seven day data is collected, results will be reviewed by a licensed nurse and summarized in the progress record,
5. Results will be reviewed with the NP/MD [nurse practitioner/ medical doctor]. If a sedative/sleep aid is prescribed, efficacy and sleep patterns will be monitored via the seven day data sheets and summarized by a Licensed Nurse in the progress record.
6. Seven day sleep data sheets will be initiated with any change in medication dosage, summarized by the Licensed Nurse in the

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F 329	Continued From page 15 progress record and communicated to the NP/MD [nurse practitioner/medical doctor]."	F 329		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure follow up recommendations for dental services for 1 of 2 residents (R50) reviewed for dental services. Findings include: R50 was observed on 12/07/15, at 3:57 p.m., surveyor viewed R50's teeth and noted two upper front chipped teeth. R50's annual Minimum Data Set (MDS) dated 10/20/15, did not identify R50 had any dental issues or problems with teeth. The MDS indicated R50 had severe cognitive impairment, was independent with personal hygiene and had diagnoses of Alzheimer's disease and heart failure. R50's care plan dated 10/26/15, did not identify R50 had any dental issues.	F 412	F 412 Deficiency with ID Prefix Tag 412 shall be corrected. Fairview Care Center shall ensure follow up to recommendations for dental services. Family of R50 has been notified of recommendations from Dentist. Facility has offered assistance in arranging for follow up services. Currently waiting for direction from family and resident as to what they will decide to have done. All residents who receive recommendations for dental services and/or follow up appointments shall have be offered timely assistance in obtaining the services either in house or off site. Progress notes from the Dentist shall be reviewed and initialed by the Clinical Nurse Managers prior to being filed in the	1/13/16

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F 412	Continued From page 16 R50's dental note, dated 5/27/15, identified natural dentition, number six extensive deep decay, and may not be restorable. If restorable, number six would need root canal treatment and a crown. As the tooth does not appear to bother the patient, no treatment is necessary at this time but tooth will eventually be lost and then may need to be replaced with a bridge or partial. Number nine and number ten have fractured part of the tooth or lost fillings. Patient sates these do not bother her so it is up to the family if would like these teeth restored. Recommend six month recall. R50's record lacked documentation of R50's family decision regarding treatment for R50's identified tooth decay and fractured teeth from R50's dental note dated, 5/27/15. In addition, R50's record failed to identify a follow up dental appointment had been scheduled in six months as recommended. On 12/08/15, at 8:56 a.m., registered nurse (RN)-A verified R50's record failed to include documentation regarding R50's family decision regarding treatment for R50's identified tooth decay and fractured teeth from R50's dental note dated, 5/27/15. RN-A verified a follow up dental appointment had not been scheduled for R50 as recommended in six months. On 12/9/15, at 10:36 a.m., the director of nursing stated the facility procedure was for dental notes to be given to the nurse managers for follow up. The nurse managers review and address concerns and schedule any follow up appointments needed. R50's dental note was filed and was not given to the nurse manager. The facility policy Dental/Oral Services, dated 3/1/10, indicated oral health services are available to meet the resident's needs. Routine and emergency dental services will be provided to	F 412	residents chart. Dental Services policy was reviewed and updated. Social Services, Clinical Nurse Managers and Nursing Unit Secretaries will be reeducated on the Dental Services Policy. The Director of Nursing shall monitor continued compliance with this plan of correction through random audits of Dental progress notes ensuring that recommendations are followed up on. The results of these audits will be reviewed at the QAPI meeting in February, 2016. Completion Date: January 13, 2016.	

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F 412	Continued From page 17 our resident's personal dentist or a community dentist. The director of nursing services or clinical nurse manager will notify social services designee of a resident's need for dental services. Social services will be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary.	F 412		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		1/13/16

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F 431	Continued From page 18 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to remove expired insulin from 1 of 2 medication carts resulting in 2 of 3 insulin dependent residents (R54, R58) receiving expired insulin from the 100 wing medication cart. Findings include: On 12/7/15 at 12:20 p.m. the 100 wing medication cart was found to have 1 vial Lantus insulin and 1 vial of Apidra insulin, both expired. R58's admission record included a diagnosis of type two diabetes. R58's Lantus insulin was labeled with an open date of 10/6/15. R54's admission record included a diagnosis of type two diabetes. R54's Apidra insulin was labeled with an open dated of 11/6/15. Both vials of insulin included on the manufacturer's label, "Use 28 days from initial use." Lantus insulin was opened on 10/6/15; according to manufacturer's label the Lantus insulin should not have been used past 11/2/15. Apidra insulin was opened on 11/6/15; according to manufacture's label the Apridra insulin should not have been used past 12/4/15.	F 431	431 Deficiency with ID Prefix Tag shall be corrected. Fairview Care Center shall ensure that expired insulin is removed from medication carts and disposed of per facility policy. R58's insulin was immediately removed, disposed of and a new vial was ordered R54's insulin was immediately removed, disposed of and a new vial was ordered. All insulin vials were checked at the time of this finding. No other expired vials were found. Policy and Procedures for Medication Storage and Medication Administration have been reviewed. Both appropriately address expired medications. All licensed nursing staff will be reeducated on monitoring for and disposal of expired insulin. All insulin vials will be checked three times a week to ensure expired vials are disposed. The Director of Nursing or designee shall monitor for continued compliance with this plan of correction through weekly monitoring of the insulin vials. Results of this monitoring will be reviewed at the QAPI meeting in February, 2016. Completion Date: January 13, 2016.	

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F 431	Continued From page 19 On 12/7/15 at 12:20 p.m. registered nurse (RN)-B, a nurse manager, stated "It's [Lantus] way expired. We mark them a month out. It [Apidra] should have been replaced yesterday. [R54] got Apridra this morning from this vial. The vial says use 28 days from initial use. [R58], I think she gets it [Lantus] in the evening, she would have got it at bedtime last night from that vial." On 12/8/15 at 3:43 p.m. the director of nursing stated, "It's [insulin] 28 days, no it should not be used after 28 days. [R58] should not have been getting insulin from that vial." On 12/9/15 at 9:22 a.m. the consultant pharmacist stated, "We default to 28 days is the shortest period it should be used after opening. I'm not aware of any problems with that. Should check blood sugars to see if there was a noticeable change, then there could be a problem there. Because it is a protein derivitive when it gets heated it loses it efficacy. It might be something that would cause high blood sugars." A facility policy on medication storage was requested but not provided.	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465		1/13/16

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F 465	Continued From page 20 by: Based on observation and interview, the facility failed to provide appropriate maintenance to 4 of 4 resident rooms (104, 101, 109 and 211), observed in disrepair. Findings include: On 12/09/2015, at 1:38 p.m. the director of maintenance (DM) stated he relies on each unit to fill out a work order when repairs are needed in the resident's room. He confirmed he does not do any routine inspection of the resident rooms. The DM confirmed he has not heard about 104, 101, 109 and 211 resident room issues before today except for the call light not functioning which was discovered during the survey process. DM stated housekeeping told him yesterday the call light in room 104 wasn't working. He said, "The short cord was faulty" so he replaced it. DM confirmed there is no current inspections to ensure the call light is functioning properly except what is reported through the AWARE Program (Work place accident injury reduction program). On 12/30/15, at 1:38 p.m., a tour of the facility was completed with the DM and Business Office Manager (BM), and the following was identified: · The ceiling tile in room 101 was hanging downward, out of its metal holder and the tile was discolored. · The bathroom in room 211 had a urine odor, there was also a black area on the floor around the toilet. DM said he can fix the urine odor and the black ring on the floor by changing the toilet ring. DM and BM both agreed there was a urine odor. The same bathroom was also missing three wall tiles. The wall behind the missing tiles was	F 465	F 465 Deficiency with ID Prefix Tag F 465 shall be corrected. Fairview Care Center shall ensure appropriate maintenance of facility including resident rooms. Ceiling tile in Room 101 has been replaced. Toilet ring and missing wall tile was replaced in Room 211. Bathroom in 211 was also cleaned. Missing wall tile in Room 109 will be replaced and stained area will be cleaned and painted. Any area of the building needing repairs will have the repairs completed in a reasonable time frame. Urgent repairs or repairs involving a safety issue will be completed immediately. A resident room check list will be prepared and each resident room will be checked quarterly by Maintenance for any needed repairs. All staff will be reeducated on their responsibility to complete a repair request form for needed repairs throughout the facility. A Call Light Function Check list has been prepared and Maintenance will check the function of all call lights throughout the facility on a monthly basis. The Administrator or designee shall monitor this plan of correction for continued compliance through direct observation of the resident rooms and monitoring of completed checklists. Completion Date: January 13, 2016	

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F 465	Continued From page 21	F 465		

rough, not cleanable and did not provide a homelike environment.
· Two tiles were missing by the sink in room 109 leaving behind the same unsightly, non-cleanable wall. There was a stain on the wall which was six inch square shaped, on the wall, near the toilet paper roll and call light. BO verified is was old tape from a previous sign.

An interview with the administrator on 12/10/15, at 8:41 a.m. who stated my expectation is when repairs need to be made, those repairs are made. The facility has service request and repair forms, those are used to report identified concerns to maintenance. Forms are to be completed by all staff and placed back into the wall file for maintenance to complete the repairs. I expect maintenance to check the wall file daily. Safety assessment forms are used by members of the Aware Program on a quarterly building. Stated each room was assessed for repairs on a quarterly basis.

A facility policy dated 9/2012 read, "It is the policy of Fairview Care Center to ensure a clean and safe environment. All staff are responsible to report needed repairs."

A form entitled Safety Assessment Form read, "Ceiling tile is in good repair with no staining or water spots present."

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	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/09/2015**

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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	EPOC	

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

Electronically Signed | 12/30/2015

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

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K 000	Continued From page 1	K 000		

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

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Fairview Care Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1975 and was determined to be of Type II(000) construction. In 1997, addition was constructed to the North Wing that was determined to be of Type II(000) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 monitored for automatic fire department notification. Fairview Care Center has elected to use the following categorical waivers - Extinguishing Requirements, Capacity of Means of Egress and Combustible decorations on walls, doors and ceilings. The facility has a capacity of 55 beds and had a census of 55 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1	K 154	K154 Deficiency with ID Prefix Tag K154 shall be corrected. Fairview Care Center shall have a single plan for the out of service plan for the fire sprinkler system. Current plan included "fire alarm/sprinkler system" in the same plan. A separate plan shall be included for fire sprinkler	1/13/16

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 _____	**12/09/2015**

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K 154	Continued From page 3 On facility tour between 1:00 PM and 4:00 PM on 12/09/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (Dave) at the time of discovery.	K 154	system. The Administrator shall monitor this plan of correction for continued compliance through review of the written plan. Completion Date: January 13, 2016	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 1:00 PM and 4:00 PM on 12/09/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system.	K 155	K155 Deficiency with ID Prefix Tag K154 shall be corrected. Fairview Care Center shall have a single plan for the out of service plan for the fire alarm system. Current plan included "fire alarm/sprinkler system" in the same plan. A separate plan shall be included for fire alarm system. The Administrator shall monitor this plan of correction for continued compliance through review of the written plan. Completion Date: January 13, 2016	1/13/16

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 _____	**12/09/2015**

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K 155	Continued From page 4 This deficient practice was confirmed by the Facility Maintenance Director (Dave) at the time of discovery.	K 155		