DEPARTMENT OF HEALT	TH AND HUMAN	SERVICES			CENTERS FOR M	EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: N664
MEDICARE/MEDICAID PROVID (L1) 245451 2.STATE VENDOR OR MEDICAID N (L2) 545740800	ER NO.	- TO BE COMP 3. NAME AND AE (L3) FAIRWAY (L4) 201 MARK I (L5) ORTONVIL	DDRESS OF FACI VIEW NEIGHI DRIVE	LITY	TE SURVEY AGENCY S (L6) 56278	Facility ID: 00771 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
 5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 06/ 	OWNERSHIP 08/2017 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	,	ORY 09 ESRD 10 NF	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATIO From (a) : To (b) : 12.Total Facility Beds	51 (L18)	Complian		S:	And/Or Approved Waivers Of TT 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI	6. Scope of Services Limit 7. Medical Director 8. Patient Room Size
13.Total Certified Beds	51 (L17)		mpliance with Prog and/or Applied Wa		5. Life Safety Code * Code: A *	9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNI 51		ICF	IID		 FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): 	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE <u>Gail Anderson, Unit Sup</u>			06/15/2017	(L19)	18. STATE SURVEY AGENCY	cation Specialist 08/25/2017
 DETERMINATION OF ELIGIBII X 1. Facility is Eligible to 2. Facility is not Eligible 	LITY 9 Participate	20. COM	MPLIANCE WITH GHTS ACT:			ncial Solvency (HCFA-2572) 91 Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEN	/IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 04/01/1987	BEGINNING	DATE	ENDING DAT	ΓE	VOLUNTARY 01 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATT A. Suspension B. Rescind Sus	n of Admissions:	(L25) (L44)		02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539		. DETERMINATION	OF APPROVAL D			
	(L32)	06/05/2017		(L33)	DETERMINATION APPR	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245451 June 15, 2017

Mr. David Rogers, Administrator Fairway View Neighborhoods 201 Mark Drive Ortonville, MN 56278

Dear Mr. Rogers:

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 March 15, 2017 the above facility is certified for or recommended for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 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.

Fairway View Neighborhoods June 15, 2017 Page 2

Sincerely,

Kato Comston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 15, 2017

Mr. David Rogers, Administrator Fairway View Neighborhoods 201 Mark Drive Ortonville, MN 56278

RE: Project Number S5451027

Dear Mr. Rogers:

On April 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 30, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On June 8, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 30, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 15, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 30, 2017, effective May 15, 2017 and therefore remedies outlined in our letter to you dated April 20, 2017, 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,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 7, 2017

Mr. David Rogers, Administrator Fairway View Neighborhoods 201 Mark Drive Ortonville, MN 56278

RE: Project Number S5451027

Dear Mr. Rogers:

On April 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 30, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

However, compliance with the Health deficiencies issued pursuant to the March 30, 2017 standard survey has not yet been verified. The most serious Health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 30, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 30, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 30, 2017. You should notify all

Fairway View Neighborhoods June 7, 2017 Page 2

Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Fairway View Neighborhoods is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 30, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 Fairway View Neighborhoods June 7, 2017 Page 3

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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 September 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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.

Feel free to contact me if you have questions.

Fairway View Neighborhoods June 7, 2017 Page 4

Sincerely,

ate Comston X

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697 cc: Licensing and Certification File

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		245451	B. WING			1	R / 08/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
	VIEW NEIGHBORHOOD			20	01 MARK DRIVE		
FAIRWAI		5		0	RTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 0	000}			
	the Federal requirement	he facility's plan of is back in compliance with ents identified as deficient at tification survey exited					
	signature is not requir page of the CMS-256 correction is required.	I in ePOC and therefore a red at the bottom of the first 7 form. Although no plan of , it is required that the facility of the electronic documents.					
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

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.

PRINTED: 06/13/2017

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			R
		00771	B. WING		06	/08/2017
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
AIRWAY		S	RK DRIVE VILLE, MN 56278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
{2 000}	Initial Comments		{2 000}			
	*****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcti pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of find the Minnesota Depart Determination of whe corrected requires co requirements of the ru number and MN Rule When a rule contains comply with any of the lack of compliance. L re-inspection with any result in the assessm	ther a violation has been				
	that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	INITIAL COMMENTS	:				
{2 302}	MN State Statute 144 or related disorder tra	.6503 Alzheimer's disease in	{2 302}			
	ALZHEIMER'S DISEA					

PRINTED: 06/13/2017 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00771	B. WING		06	R / 08/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
		201 MAF	RK DRIVE				
	VIEW NEIGHBORHOOD	ORTON	VILLE, MN 56278				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE	
{2 302}	Continued From page	e 1	{2 302}				
	MN St. Statute 144.6	503					
	Alzheimer's disease or related dis	y serves persons with sorders, whether in a al unit, the facility's direct					
		must be trained in dementia					
	related disorders; (2) assistance with a (3) problem solving w and (4) communication sł (c) The facility shall p written or electronic f training program, the trained, the frequence topics covered.	Alzheimer's disease and ctivities of daily living; vith challenging behaviors; kills. provide to consumers in orm a description of the categories of employees y of training, and the basic					
	this section.	locument compliance with					
{2 830}	MN Rule 4658.0520 Proper Nursing Care	Subp. 1 Adequate and ; General	{2 830}				
	receive nursing care custodial care, and s individual needs and	eneral. A resident must and treatment, personal and upervision based on preferences as identified in esident assessment and					

STATE FORM

6899

N66412

PRINTED: 06/13/2017 FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
						R
		00771	B. WING		06	/08/2017
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
AIRWAY	VIEW NEIGHBORHOOD	S	RK DRIVE VILLE, MN 56278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
{2 830}	Continued From page	e 2	{2 830}			
	4658.0405. A nursing of bed as much as po written order from the	ribed in parts 4658.0400 and g home resident must be out ossible unless there is a a attending physician that the in bed or the resident red.				
	This MN Requiremen by:	t is not met as evidenced				
{2 930}	MN Rule 4658.0525 Nasogastric, Gastros		{2 930}			
	and feeding syringes. Based on	tubes, gastrostomy tubes, the comprehensive resident g home must ensure that:				
	gastrostomy tube or f	ic abnormalities, and ers and to restore, if				
	This MN Requiremen by:	t is not met as evidenced				
{2 965}	MN Rule 4658.0600 -Nutritional Status	Subp. 2 Dietary Service	{2 965}			

PRINTED: 06/13/2017 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
						R	
		00771	B. WING		06	/08/2017	
IAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE			
AIRWAY	VIEW NEIGHBORHOOD	S	RK DRIVE VILLE, MN 56278				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
{2 965}	Continued From page	3	{2 965}				
	must ensure that a re which supplies the ca determined by the co assessment. Substitu	al status. The nursing home sident is offered a diet loric and nutrient needs as mprehensive resident utes of similar nutritive value sidents who refuse food					
	This MN Requiremen by:	t is not met as evidenced					
{21685}	MN Rule 4658.1415 S Housekeeping, Opera		{21685}				
	including walls, floors systems, and equipm continuous state of go with regard to the hea	bod repair and operation alth, comfort, safety, and dents according to a written					
	This MN Requiremen by:	t is not met as evidenced					

N66412

DEPARTMENT OF HEAL	FH AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: N664
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00771
1. MEDICARE/MEDICAID PROVI	DER	3. NAME AND AL				4. TYPE OF ACTION: $\underline{2}(L8)$
NO.(L1) 245451		(L3) FAIRWAY V		BORHOOI	DS	1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAI (L2) 545740800	D NO.	(L4) 201 MARK (L5) ORTONVIL			(L6) 56278	3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF	FOWNERSHIP	7. PROVIDER/SU	PPLIER CATEC	GORY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 03	/30/2017 ^(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATIO	NC	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia			And/Or Approved Waivers Of	
To (b):		ι Λ [°]	equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
		-			3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	51 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	
13.Total Certified Beds	51 (L17)	B. Not in Comp	liance with Progr	am	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied V	Waivers:	* Code: B	(L12)
14. LTC CERTIFIED BED BREAKD					15. FACILITY MEETS	
18 SNF 18/19 SNF 51	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Susan Bachleitner, HFE	NE II	0	5/19/2017	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 06/05/2017 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIB <u>X</u> 1. Facility is Eligible to 			IPLIANCE WITI ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligib	le (L21)					·
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
04/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	DD . 10		(L44)			00-Active
	B. Rescind Si	uspension Date:	(7.45)			
28. TERMINATION DATE:	20	9. INTERMEDIARY/	(L45)		30. REMARKS	
26. TERMINATION DATE.	25		CARRIER NO.		JU. REMARKS	
	(1.20)	03001		(1.21)		
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	L DATE		
	(L32)			(L33)	DETERMINATION APPE	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 20, 2017

Mr. David Rogers, Administrator Fairway View Neighborhoods 201 Mark Drive Ortonville, Minnesota 56278

RE: Project Number S5451027

Dear Mr. Rogers:

On March 30, 2017, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) has been electronically delivered.

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

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 May 9, 2017, 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 June 30, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

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

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		E SURVEY IPLETED
		245451	B. WING _			03/	/30/2017
NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS			ARK DRIVE DNVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	0			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 167 SS=C	on-site revisit of you validate that substa regulations has bee your verification. 483.10(g)(10)(i)(11)	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with RIGHT TO SURVEY LY ACCESSIBLE	F 16	7			5/15/17
	(g)(10) The residen						
	of the facility condu	sults of the most recent survey cted by Federal or State plan of correction in effect with ty; and					
	(g)(11) The facility r	nust					
	and family member	eadily accessible to residents, s and legal representatives of ts of the most recent survey of					
	certifications, and c respecting the facili years, and any plan	th respect to any surveys, complaint investigations made ty during the 3 preceding of correction in effect with ty, available for any individual uest; and					
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE
Electron	ically Signed						04/28/2017

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.

PRINTED: 05/19/2017

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245451	B. WING		03/3	30/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWAY		DODS		201 MARK DRIVE ORTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 167	Continued From pa	ige 1	F 1	67		
		ne availability of such reports in that are prominent and ublic.				
	(iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:					
	Based on observation, interview, a review, the facility failed to ensure s survey results were easily accessib residents in the facility which includ who utilized a wheelchair. This had	ailed to ensure State agency e easily accessible for all ility which included residents		The holder that was attached t was lowered and permanently a height to be accessible for al in the facility.	attached at	
		ent residents who resided in		The holder was lowered on 4/2		
	Findings include:			A written protocol was developed placement of the file wall pocket that the Survey results were re-	et to ensure	
	1:37 p.m. The facili	ur of the facility on 3/27/17, at ties "MN [Minnesota] Dept		accessible to residents and the Protocol was added to the Police	public. cy and	
	[Department] of Health Current Survey Results," was observed in a clear plastic shelf mounted to the wall of the main entrance in a binder and labeled "Federal And State Survey Plan Of			Procedure manual. All staff wa on new protocol on 5-15-17 rec placement of wall pocket that o survey results.	garding	
	were dated 1/14/16 The survey results measured five feet,	rvey results contained inside b, from the previous full survey. were located at a height which two inches from the floor, that		A Performance Improvement a been developed to ensure cont proper placement in the relation	inued nship to the	
	was not accessible wheelchair.	to residents seated in a		height of the Survey wall file po Director of Senior Services or o will audit and record results we	designee	
	"MN [Minnesota] D Current Survey Res height which measure	on 3/30/17 at 12:47 p.m. the ept [Department] of Health sults" remained at the same ured five feet, two inches from ey results remained at this ntire survey.		months or until 100% complian random audits will be complete results will be recorded month Assurance Performance Impro Committee.	ed. These y to Quality	
	Op 2/20/17 of 1.05	p.m. director of nursing (DON)		Staff educated at All Staff Meet	ina on	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245451 B. WING 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 MARK DRIVE FAIRWAY VIEW NEIGHBORHOODS **ORTONVILLE, MN 56278** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 167 Continued From page 2 F 167 confirmed findings of the survey results and 5/4/17 of the importance of the survey stated "it could be lowered." The DON indicated being at proper height for access to she thought it would be difficult for a resident persons in a wheelchair. seated in a wheelchair to be able to reach the survey results located in the plastic shelf. The DON also indicated maintenance had installed the clear plastic shelf and was probably not aware of how high the survey results were. On 3/30/17 at 1:05 p.m. requested facility policy for posting survey results, one was not provided. F 281 483.21(b)(3)(i) SERVICES PROVIDED MEET F 281 5/15/17 **PROFESSIONAL STANDARDS** SS=D (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the Resident R52 was a closed record facility failed to develop a temporary care plan to review. meet resident needs for weight monitoring in accordance with physician orders for 1 of 2 For all new admissions, a temporary care residents (R52) closed records reviewed. plan will be developed on day of admission. Findings include: Care Plans for all new admissions that were admitted after 3/27/17 were R52's admission Minimum Data Set (MDS) dated 11/3/16, identified R52 had diagnoses which reviewed for accuracy and inclusion of included heart failure. Diabetes Mellitus, and Physician Orders. localized edema. R52's MDS identified R52 had severe cognitive impairment and required Admission Policy has been updated to extensive assistance for activities of daily living include developing a temporary care plan (ADLs). Further, the MDS identified R52 had that is accurate and will reflect new

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		& MEDICAID SERVICES	(X2) MULT	TIPL	E CONSTRUCTION		0938-039 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				· · ·	PLETED
		245451	B. WING_			03/3	80/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS	201 MARK DRIVE ORTONVILLE, MN 56278				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 281	Continued From pa	ige 3	F 28	81			
	heart failure, but die breath.	d not have any shortness of			admission Physician Orders.		
	10/27/16, included used to remove flui (mg) orally twice a monitored 2 times of R52's Interagency 10/27/16, included to complete weights R52's facility transo Sheet dated 10/27/ resuscitate (DNR), and order for weigh be obtained on Tue R52's Admission C various intervention am/noon and weigh lacked any further of discharge orders fro twice a week. R52's Northridge R 10/27/16 to 11/4/16 signs [and] weight f [underlined]," and p	harge Summary dated orders for Lasix (medication d from the body) 40 milligrams day and weights to be weekly. Transfer Orders dated orders for nursing home staff s twice weekly on R52. Tribed Physician's Orders 16, identified orders for do not Lasix 40 mg orally twice a day at 2 X/WEEK [twice a week] to esday(s) and Friday(s). are Plan dated 10/27/16, listed as which included Lasix 40 mg n every week. The care plan direction pertaining to the om the physician to weigh R52 esidence flowsheet dated b, identified directions of, "Vital to be done WEEKLY provided two columns to record No further directions for			Admission Checklist was revised to include the development of a tempo care plan that includes specific Phy Order. By 5/15/17 Director of Nurse provide education to the Admission on the importance of accurate Care interventions, which include Physici Orders. All Staff meeting will be held on 05/ to educate on the importance of developing a temporary care plan of day of admission to include Physici Orders. Information was shared on deficiency regarding the lack of incl of Physician Orders. A Performance Improvement (PI) A has been developed to ensure a temporary care plan is developed of admission. This PI will audit for the development of temporary care plan all new admissions weekly for 3 mo until 100% compliant, then random will be completed. These results w reported monthly to the Quality Assurance/Performance Improvem Committee. This audit will be monit by Neighborhood Leader or designed	orary sician es will Team Plan an 04/17 on the an the usion udit in ns on onths or audits ill be ent ored	
	on the flowsheet. T recorded. On 10/2 weighed 156.6 pou weighed 162 pound weights on 10/28/10	two times a week were found he flowsheet had two weights 7/16 (day of admission), R52 nds and on 11/4/16, R52 ds. There were no recorded 6 (Friday), or 11/1/16 (the as directed by the physician					

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		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245451	B. WING			03/	30/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS			01 MARK DRIVE PRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 4	F 2	81			
	10/31/16, identified and Fri] WEIGHT" a congestive heart fa	neets (TAR) dated 10/1/16 to an order for 2 X/WEEK [Tues and listed a diagnosis of ilure. The provided spacing to 10/28/16, however, was not blank.					
	documentation of R 11/1/16 and listed a 11/3/16, and only w	1/1/16 to 11/30/16, lacked R52's collected weight on an order for daily weight dated reight documented was on pound weight gain in 8 days).					
	manager (CM)-A st medical record and obtained and monit physician orders ac stated weight monit	3/29/17, at 2:00 p.m. clinical ated she reviewed R52's R52's weights had not been ored in accordance with the lding, "[It] wasn't done." CM-A toring on a heart failure patient indard of practice," and staff, rder."					
	identified a purpose fluid balance," and staff to follow which physician orders. T	Output policy dated 10/15, e including, "To help maintain listed several instructions for n included to follow the The policy lacked any stion on collecting weights for a					
F 282 SS=D	and/or fluid monitor 483.21(b)(3)(ii) SEF	RVICES BY QUALIFIED	F 2	82			5/9/17
	(b)(3) Comprehens The services provic	ive Care Plans led or arranged by the facility,					

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		& MEDICAID SERVICES			<u>DMB NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	· /	E SURVEY PLETED
		245451	B. WING _		03/3	30/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS		201 MARK DRIVE ORTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 282	Continued From pa	age 5	F 28	2		
		comprehensive care plan,				
	accordance with ea	qualified persons in ach resident's written plan of NT is not met as evidenced				
	Based on observa review, the facility f interventions relate dense foods which noon meal and mo	tion, interview and document ailed to implement nutritional d to the provision of calorie included super potatoes at nitoring and recording ntake as directed by the care		Resident R59 Care Plan was upor reflect current nutritional approact was placed on Food Intake Monite electronic chart. The care plan was updated on 04/24/17.	tritional approaches. R59 ood Intake Monitoring via The care plan was	
	plan for 1 of 2 (R39 loss.) residents who had weight		Dietary Manager will review all ca and update to support the Suppor Residents with Weight Loss Polic	ting y and	
		ted 3/22/17, identified R39 had tritional problems related to		monthly weight monitoring entere chart. Current nutritional approact be reflected in the Care Plan.		
	dementia and adva nutritional diet/intak weight and consum and liquids and wo discomfort after dri plan listed various milk base Ensure v supplement, staff v spoken menu for c with tray set-up and eating, monitor wei	inced age, would maintain the along with maintain/improve the at least 75% of all solids uld be free of stomach nking supplement . The care interventions which included was to replace the fruit based were to assist R39 and use hoices at meals, assist R39 d food placement, encourage ght and food intake and report		Weights will be reviewed monthly Certified Dietary Manager. The Co Dietary Manager (CDM) will alert Consultant Registered Dietitian of significant weight changes so an assessment may be completed. resident is identified as having a significant 5% weight loss in 30 da a 10% loss in 180 days, OR a cor gradual weight loss, the Househo Leaders will be alerted by the Cer	ertified the any When a ays OR ttinuing	
	to dietary if R39's n care plan indicated diet with calorie der super cereal break noon, whole milk a snacks and 6 ounc	neal intake fell below 50%. The R39 was to receive a regular nse foods which included fast and super potatoes at t meals, afternoon and evening es (oz) of fruit drink nutritional ng, afternoon and evening.		Dietary Manager. The at-risk resident will be placed Food Intakes in electronic chart u condition is deemed stable by the Household Team.	on	

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		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245451	B. WING			03/3	30/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FAIRWA	Y VIEW NEIGHBORH	DODS			01 MARK DRIVE DRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	During observation: homemaker (HM)-/ setting up for the ne the HM's responsib wanted to eat and to orders. HM-A state Dining Preferencess binder next to the s She stated R39 red supplements TID fr nursing recorded hi She stated they did hi- protein nutrition present in the kitch currently there were hi-calorie, hi-protein -12:11 p.m. nursing the serving station loud to HM-A, "R39 NA-B told HM-A to meat. HM-A asked like a little hashbrow than mashed potate of rib meat, hashbrow than mashed potate of rib meat, hashbrow than delivered failed to provide su him choices of food -12:14 p.m. R39 w in his room, covere quilt. NA-B entered and set it on R39's recliner. NA-B rem	s on 3/29/17, at 11:32 a.m. A was present in the kitchen bon meal. She stated it was illity to ask residents what they ake their meal and drink d all residents had a Resident sheet which was kept in the erving area for staff to use. weived fruit based nutritional om nursing in his room and is intake of the supplements. n't have anyone on hi-calorie, interventions. HM-B was also en at that time and confirmed e no residents that received in nutrition interventions. assistant (NA)-B walked up to in the kitchen and stated out is going to eat in his room." only give him a little bit of NA-B, "Do you think he would wns, something a little different bes." HM-A put a couple bites owns and sweet potatoes on confirmed the serving sizes on e usual serving sizes for R39. from HM-A, left the kitchen meal to R39's room. Staff per potatoes and did not offer	F 2	282	The first-line of defense to stop the loss will be whole foods. These for include items like but are not limite smoothies, malts, favorite foods of resident, whole milk, cream, ice cr bakery items, desserts, milk shake puddings, extra butter, candy etc. foods will be offered on a regular to Residents with weight loss will be these whole foods at meals and be meals by the Household Team. A Whole Foods suggestion list is p each neighborhood inside a cupbor door. Residents requiring extra whole fo stop weight loss or increase weigh identified on a list inside a cupbor in every Neighborhood Kitchen. Th be updated monthly by the Certifie Dietary Manager. All Staff meeting will be held on 05 to educate on the importance of up care plans to meet individual nutrit approaches. A Performance Improvement (PI) h has been developed to ensure nut approaches in care plans are accu This PI will audit 2 care plans per v 3 months or until 100% compliant, random audits will be completed. results will be reported monthly to Quality Assurance/Performance Improvement Committee. This aud be monitored by Neighborhood Le designee	ods d to: f the eam, es, These basis. offered etween bosted in bard ods to t will be rd door nese will d /04/17 bdating ional Audit ritional irrate. week for then These the dit will	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARI					FORM	05/19/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245451	B. WING			03/:	30/2017
NAME OF PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
FAIRWAY VIEW NEIGHBORH	OODS			01 MARK DRIVE PRTONVILLE, MN 56278		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
 R39's reach, on the recliner. NA-B left inform R39 what for or describe food plant or describe food plant. -12:16 p.m. R39 prevent response for the plate. -12:26 p.m. R39 response for the plate. have it, " regarding attempt to eat his response for the plate. -12:27 p.m. unit me room and asked he R39 replied, "Not the on his plate and R4 food items. UM-B is she could get him She offered R39 he stated, "No, just lead does this and she his room. -12:30 p.m. R39 lead the room of the response for the drank his thick blobs of white to his recliner. R39 dozed off in his recliner. R39 dozed off in his real. On 3/29/17, at 122 in his room about 2 dining room once in the recliner is room. 	NA-B left the tray table out of e tray table in front of R39's R39's room. NA-B did not bods or beverages he received		282			

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		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245451	B. WING			03/;	30/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA	Y VIEW NEIGHBORHO	DODS			01 MARK DRIVE DRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	was a good ice creat generally received a meal or was offered which R39 generall HM-A stated homen recorded meal intal was not aware of sp R39's meals. She st toast, broth and ma She stated R39 did and stated she thou supplements. On 3/29/17, at 1:07 think R39 had lost a liked mashed potat and broth and woul peanut butter and is not do anything spe him any special foo supplements had b stated he never too not like meat or veg not aware of any re high-calorie, high-p On 3/29/17, at 2:01 eat good but would received a fruit sup drank it. She stated a recorded R39's me did not record meal not do anything elso meals other than su	am eater. She stated R39 supplements if he refused a d soup and a sandwich later ly didn't want that or anything. making staff had never kes for R39 She stated she pecial food or textures for stated R39 liked peanut butter ashed potatoes with butter. I not like meat or hot dishes	F 2	282			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245451 B. WING 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 MARK DRIVE FAIRWAY VIEW NEIGHBORHOODS **ORTONVILLE, MN 56278** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 9 F 282 On 3/30/17, at 12:30 p.m. registered dietitian (RD) stated she reviewed resident weights every month and stated if someone lost weight in-between the CDM would let her know. She stated the usual facility practice included to complete a comprehensive nutrition assessment on each resident annually, and she stated she had completed R39's last comprehensive assessment 11/7/16. RD stated R39 continued to lose weight and R39's current weight was 136 lbs. She stated R39's usual body weight was 150-155 lbs. RD stated R39 had sustained a significant weight loss in January and started super cereal and super mashed potatoes and double portion of peanut butter and jelly toast on 1/25/17. She stated the facility had tried Prostat (a protein powder supplement) on 2/9/17 and discontinued after 3 days as resident did not like it. She stated the Prostat was the last intervention they had tried until she ordered a nutritional supplement 3/29/17. She confirmed R39's care plan and nutrition interventions. She stated she expected R39's food and fluid intakes, Dining Preferences form to be recorded and accurate. She confirmed super cereal and super potatoes were on R39's care plan and stated she had never directed staff to provide these items. She stated R39's care plan identified R39 required supervision for meals yet R39 ate most meals in his room. RD indicated she felt R39's care plan needed to be revised. F 309 F 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES 5/8/17 FOR HIGHEST WELL BEING SS=D 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245451 B. WING 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 MARK DRIVE FAIRWAY VIEW NEIGHBORHOODS **ORTONVILLE, MN 56278** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 309 Continued From page 10 F 309 facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced bv: Based on interview and document review, the Resident R52 was a closed chart review. facility failed to provide ongoing weight monitoring in accordance with physician orders to prevent A review of all resident s Physician complications related to potential fluid overload Orders regarding weight monitoring will be for 1 of 2 residents (R52) whose closed record reviewed for accuracy of the electronic was reviewed. chart weight recording schedule.

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PRINTED: 05/19/2017

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY	
		245451	B. WING			00/00/00/17	
NAME OF F	PROVIDER OR SUPPLIER	243431	<u> </u>	STREET ADDRESS, CITY, STATE, ZIF		30/2017	
		DODS		201 MARK DRIVE ORTONVILLE, MN 56278			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIOI DATE	
F 309	 Continued From page 11 Findings include: R52's admission Minimum Data Set (MDS) dated 11/3/16, identified R52 had diagnoses which included heart failure, Diabetes Mellitus, and localized edema. R52's MDS identified R52 had severe cognitive impairment and required extensive assistance for activities of daily living (ADLs). Further, the MDS identified R52 had heart failure, but did not have any shortness of breath. R52's hospital Discharge Summary dated 10/27/16, identified R52 had several diagnoses which included chronic systolic congestive heart failure, renal insufficiency and Diabetes Mellitus. The form identified R52 had been hospitalized for medication adjustments for treatment of 		Admission Policy has been revise ensure inclusion of Physician wei monitoring orders. In addition a re was also made to include Physici ordered weight monitoring into ele chart for weight recording. All Staff meeting will be held on 0 to educate on the importance of fe Physician Orders for weight monitorial A Performance Improvement (PI)				
	course, R52's rena medication adjustm laboratory monitorin summary included used to remove flui (mg) orally twice a times weekly. Furth R52's weight record oz (ounces), bilater edema and clear lui follow up with physi rounds at the nursin R52's Interagency 10/27/16, identified as fair and included to complete weights R52's facility transo	ilure. During her hospital I function worsened also and nents were made and ng done. R52's discharge orders for Lasix (medication id from the body) 40 milligrams day weights to be monitored 2 her, the summary identified ded as 151 lbs (pounds) 14.4 ral one plus lower extremity ing sounds. The form listed ician would be done on routine ng home or sooner as needed. Transfer Orders dated R52's rehabilitation potential d orders for nursing home staff s twice weekly on R52.		This PI will audit 6 resider 3 months or until 100% co random audits will be com results will be reported mo Quality Assurance/Perforr Improvement Committee. be monitored by Neighbor designee	ompliant, then opleted. These onthly to the nance This audit will		

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		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245451	B. WING _			03/;	30/2017
NAME OF F	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS			01 MARK DRIVE RTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	resuscitate (DNR), and order for weigh be obtained on Tue R52's Admission Ca various intervention am/noon and weigh lacked any further of discharge orders fro twice a week. R52's Northridge R 10/27/16 to 11/4/16 signs [and] weight to [underlined]," and p the collected data. I weights to be done on the flowsheet. The recorded. On 10/27 weighed 156.6 pour weighed 162 pound weighed 163 pound weighed 164 pound weighed 164 pound weighed 164 pound weighed 162 pound weighed 162 pound weighed 162 pound weighed 163 pound weighed 164 poun	Lasix 40 mg orally twice a day at 2 X/WEEK [twice a week] to esday(s) and Friday(s). are Plan dated 10/27/16, listed as which included Lasix 40 mg nevery week. The care plan direction pertaining to the om the physician to weigh R52 esidence flowsheet dated by identified directions of, "Vital to be done WEEKLY provided two columns to record No further directions for two times a week were found he flowsheet had two weights 7/16 (day of admission), R52 nds and on 11/4/16, R52 ds. There were no recorded 6 (Friday), or 11/1/16 (the , as directed by the physician heets (TAR) dated 10/1/16 to an order for 2 X/WEEK [Tues and listed a diagnosis of ilure. The provided spacing to 10/28/16, however, was not	F 3(09			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/19/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		E SURVEY PLETED
		245451	B. WING			03/3	30/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWAY	VIEW NEIGHBORHO	DODS			01 MARK DRIVE RTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	with declining health -11/3/16, R52's lowe edema, and legs at Physician had adjus ordered daily weigh -11/4/16, R52 stated had been worsening had fine crackles in and an intramuscula per physician order -11/4/16, later in the and discussion made addition, the physic dose for R52. -11/5/16, R52 expire During interview on manager (CM)-A sta medical record and obtained and monit physician orders ad stated weight monit was a, "Nursing sta "Didn't follow the or A facility Intake and identified a purpose fluid balance," and I staff to follow which physician orders. T information or direc heart failure patient No further policies of	the following: hitted to facility from hospital h. er legs have three plus pitting bout to start weeping. Sted dose of Lasix and ts at that time. d she was short of breath and g for the past two days. R52 left lung, and oxygen applied ar injection of Lasix was given at that time. e day, family discussion held de not to hospitalize R52. In ian again adjusted the Lasix ed with family present. 3/29/17, at 2:00 p.m. clinical ated she reviewed R52's R52's weights had not been ored in accordance with the ding, "[It] wasn't done." CM-A oring on a heart failure patient ndard of practice," and staff, der." Output policy dated 10/15, including, "To help maintain listed several instructions for included to follow the 'he policy lacked any tion on collecting weights for a	F 3	309	DEFICIENCY)		
	No further policies of and/or fluid monitor						

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	CMB NO. 0938-039 (X3) DATE SURVEY		
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
		245451	B. WING	03/	30/2017	
NAME OF F	PROVIDER OR SUPPLIER					
FAIRWAY		DODS		201 MARK DRIVE ORTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 322	Continued From pa	ae 14	F 32	2		
F 322 SS=D		TREATMENT/SERVICES -	F 322			5/8/17
(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-						
	alone or with assist methods unless the demonstrates that	has been able to eat enough ance is not fed by enteral e resident's clinical condition enteral feeding was clinically ented to by the resident; and				
	receives the approp to restore, if possib prevent complication but not limited to as vomiting, dehydratiand nasal-pharyngo	is fed by enteral means priate treatment and services le, oral eating skills and to ons of enteral feeding including spiration pneumonia, diarrhea, on, metabolic abnormalities, eal ulcers. NT is not met as evidenced				
	Based on observa- review, the facility f administered throug administered separ facility policy to dec	tion, interview and document ailed to ensure medications gh a gastroenteral tube were ately in accordance with crease the risk of adverse sidents (R59) reviewed for		Resident R59 received a physicia on 04/17/17 to receive medications Facility currently does not have an resident with Gastrostomy Tube.	s orally.	
	feeding tube care. Findings include:			Tube Feeding Administration polic reviewed/revised on 05/02/17 by D of Nurses.		
	2/8/17, identified R	inimum Data Set (MDS) dated 59 had moderate cognitive ally dependent on staff for		All Staff meeting will be held on 05 to educate on the importance of fo the policy on medication administr	llowing	

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SIALEMENI	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G		COMPLETED	
		245451	B. WING		- 03/30/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	Ε		
FAIRWA		OODS		201 MARK DRIVE ORTONVILLE, MN 56278			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 322	 R59's Physician Oridentified R59 was and listed several r Lasix (medication body) 20 milligrams Metoprolol (medic pressure and chest twice a day; Omeprazole oral for stomach acid) 2 twice a day; Ferrous sulfate (imml) by gastric tube Guaifenesin (medic the lungs and throat three times a day. The signed Physicial lacked any directio administration of R the medications we for administration in During observation on 3/28/17, at 8:36 	a feeding tube for nutrition. rder Report signed 3/6/17, to have, "Nothing by mouth," medication orders including: a used to reduce fluid in the s (mg) orally every day; cation used for high blood t pain) 2.5 ml by gastric tube suspension (medication used 20 ml (40 mg) by gastric tube ron supplement) 66 mg (4.4 once a day, and; dication used to thin mucous in at) 400 mg by gastric tube ian Order Report dated 3/6/17, n or instruction on the 59's medications, including if per able to be mixed together	F 32		è if a es a ute of orrect. months or ents who ostomy ported ovement monitored		

		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245451	B. WING			03/:	30/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA	Y VIEW NEIGHBORHO	DODS			01 MARK DRIVE DRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 322	tablets from their pa and proceeded to p the same cup as th were in and mixed to a plastic spoon. RN administer the med R59's suspended fo auscultated placem going into R59's ab clear plastic syringe the syringe with pla per gravity, then po medications into the The medications dr flushed the syringe securing the cap or On 3/28/17, at 8:58 used a gastroentera abdomen directly in nutrition and medica admission to the face should not have any with speech therapy the medications tog through the tube for RN-A reviewed R55 and identified there physician directing together for adminis see." Further, RN-/ R59's physician and to mix the medication to mix the medication administration.	ackaging, crushed the tablets our the crushed tablets into e prepared liquid medications the medication together using I-A then entered R59's room to ications. RN-A disconnected ormula container and tent of a visible feeding tube domen, then attached a empty e to the tube port. RN-A filled in water, allowed it to empty ured the cup of prepared e syringe mixed with water. ained per gravity and RN-A with additional water before in the feeding tube port. a.m. RN-A indicated R59 al tube (inserted through the to the stomach) for all his ation administration since his cility. RN-A also indicated R59 ything by mouth except, "only y." RN-A indicated she mixed gether for administration. "J's signed physician orders e was no order from the the medications to be mixed stration and stated "not that I A indicated she would contact d make sure it was acceptable	F 3	222			

		AND HUMAN SERVICES					FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCT G	TION		(X3) DATE	E SURVEY PLETED
		245451	B. WING _				03/3	30/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP C	CODE		
FAIRWA		DODS		201 MARK DRI ORTONVILLE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF COF I CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 322	there is any interact CP indicated R59's did not have any kn together, however of practice. CP indicat difficulty having too medications given a clog the feeding tuk indicated although the medications didn't he clogging the tube, of not be added which Further, CP indicate administration throu- benefit to the facility On 3/29/17, at 1:38 (DON) confirmed tu should not be mixed unless a physician medication administ any reason, the sta medications had or Further, the DON s the policy," and administration polic purpose for, safe ad and medications, at will be administered practice. The policy medication administ including, "do not m Administer each me milliliters (mI) of wa order state different	tion, you take that out of play." five administered medications nown interactions if given verified this was not best ted some residents could have much fluid or mixed at once could have potential to be if administered together. CP the five administered have an increased risk of didn't mean something could n could have risk in the future. ed an in-service on medication ugh a feeding tube might be of y. p.m. the director of nursing ube feeding medications d together for administration has ordered it, in case the stration had to be stopped for ff would not know what had not been administered. tated staff "Should of followed ninistered R59's medications	F 32	2				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245451	B. WING	J			
	ROVIDER OR SUPPLIER	245451		STREET ADDRESS, CITY, STATE, ZIP CODE	03/30/2017		
	VIEW NEIGHBORH	DODS		201 MARK DRIVE ORTONVILLE, MN 56278	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET		
F 322		ge 18 cations, in-between each er the final medication is	F 32	2			
F 325 SS=D	483.25(g)(1)(3) MA UNLESS UNAVOID	INTAIN NUTRITION STATUS DABLE	F 32	5	5/9/17		
	(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-						
	status, such as usu body weight range the resident's clinic	otable parameters of nutritional nal body weight or desirable and electrolyte balance, unless al condition demonstrates that or resident preferences					
	nutritional problem orders a therapeuti	apeutic diet when there is a and the health care provider c diet. NT is not met as evidenced					
	Based on observative review, the facility for interventions relate dense foods which noon meal and more meal/supplement in further weight loss	tion, interview and document ailed to implement nutritional d to the provision of calorie included super potatoes at nitoring and recording ntake in order to prevent for 1 of 2 (R39) residents		Resident R39 continues to receive calorie nutritional interventions to or improve nutritional status. Mea are being recorded at all 3 meals Nutritional supplement intakes are recorded also.	maintain Il intakes e being		
	reviewed for signific Findings include:	cant weight loss.		Weight Loss policy has been dev by Dietitian.	eiopea		

Facility ID: 00771

STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245451	B. WING		03/	30/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 325	identified R39 had of leukemia, myalgia (carbohydrate absor- constipation. R39's annual Minim 11/7/16, identified F impairment. The M 73 inches (in) and v loss, was independ problems and had of R39's significant ch- identified R39 had a The MDS further in (in) and weighed 14 loss, required supe eating problems and diet. R39's Care Area As 1/30/17, identified F dependence with a related to weakness poor coordination, v The CAA further into assistance, supervi encouragement wit unplanned significa- to identify R39's cu limitations, mental p problems, dental pr medications which and nutritional need had no appetite, co foods, sometimes r	dementia, chronic lymphocytic (muscle pain), intestinal rption disorder and hum Data Set (MDS) dated R39 had severe cognitive DS further indicated R39 was weighed 152#, had no weight lent with eating, had no eating no alterations to his diet. hange MDS dated 1/30/17, severe cognitive impairment. dicated R39 was 73 inches 41#, had significant weight rvision with eating, had no id had no alterations to his essessment (CAA) dated R39 had an increased ctivities of daily living (ADLs) s, limited range of motion, visual impairment and pain. dicated R39 required set-up	F 32	 5 reviewed by Dietary Manager wh follow the Supporting Residents Weight Loss Policy. After reviewing all residents, those identified with significant weight been placed on meal intake more All Staff meeting will be held on the to educate on the Weight Loss F the importance of monitoring the of meals and supplements. A Performance Improvement (PI has been developed to ensure m supplement intakes are being re This PI audit will monitor the intate of a different resident = each weat has been identified as needing intervention to ensure completion months or until 100% compliant, random audits will be completed results will be reported monthly the Quality Assurance/Performance Improvement Committee. This at be monitored by Neighborhood I designee. 	with se oss have itoring. 05/04/17 Policy and intakes) Audit heal and corded. ke record ek who n, for 3 then . These o the udit will	

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		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245451	B. WING			03/;	30/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS			01 MARK DRIVE RTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	R39's care plan dat the potential for nut dementia and adva nutritional diet/intak weight and consum and liquids and wou discomfort after drin plan listed various in milk base Ensure w supplement, staff w spoken menu for ch with tray set-up and eating, monitor weig to dietary if R39's m care plan indicated diet with calorie der super cereal breakf noon, whole milk at snacks and 6 ounce supplement mornin During observations homemaker (HM)-A setting up for the no the HM's responsib wanted to eat and to orders. HM-A stated Dining Preferences binder next to the s She stated R39 rec supplements TID fr nursing recorded hi She stated they did hi- protein nutrition present in the kitcher currently there were hi-calorie, hi-protein	age 20 ted 3/22/17, identified R39 had tritional problems related to inced age, would maintain the along with maintain/improve the at least 75% of all solids ald be free of stomach inking supplement . The care interventions which included vas to replace the fruit based vere to assist R39 and use hoices at meals, assist R39 d food placement, encourage ght and food intake and report heal intake fell below 50%. The R39 was to receive a regular hase foods which included fast and super potatoes at timeals, afternoon and evening es (oz) of fruit drink nutritional ig, afternoon and evening. s on 3/29/17, at 11:32 a.m. A was present in the kitchen bon meal. She stated it was sility to ask residents what they take their meal and drink d all residents had a Resident is sheet which was kept in the erving area for staff to use. every fruit based nutritional om nursing in his room and is intake of the supplements. In't have anyone on hi-calorie, interventions. HM-B was also en at that time and confirmed e no residents that received in nutrition interventions.	F3	325			

		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245451	B. WING			03/;	30/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA	Y VIEW NEIGHBORHO	DODS			01 MARK DRIVE DRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	the serving station i loud to HM-A, "R39 NA-B told HM-A to meat. HM-A asked like a little hashbrow than mashed potato of rib meat, hashbrow than mashed potato of rib meat, hashbrow than mashed potato of rib meat, hashbrow R39's plate. HM-A of R39's plate were th NA-B took the plate area and delivered failed to provide sup him choices of food -12:14 p.m. R39 we in his room, covere- quilt. NA-B entered and set it on R39's recliner. NA-B rem water and milk and cover R39's shirt. N R39's reach, on the recliner. NA-B left F inform R39 what foo or describe food plate -12:16 p.m. R39 po "Look at it." R39 reach kind, R39 wasn't sup were on the plate. F have it, " regarding attempt to eat his m -12:27 p.m. unit ma room and asked him R39 replied, "Not to on his plate and R3 food items. UM-B o	in the kitchen and stated out is going to eat in his room." only give him a little bit of NA-B, "Do you think he would wns, something a little different oes." HM-A put a couple bites owns and sweet potatoes on confirmed the serving sizes on the usual serving sizes for R39. If from HM-A, left the kitchen meal to R39's room. Staff per potatoes and did not offer d and fluids. as reclined back in his recliner d up to his neck with a plaid R39's room with meal on tray tray table in front of the loved the white lids from R39's applied a clothing protector to IA-B left the tray table out of tray table in front of R39's R39's room. NA-B did not ods or beverages he received acement.	F3	325			

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CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		FORM MB NO.	05/19/2017 APPROVED 0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	```				PLETED
		245451	B. WING			03/:	30/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS			201 MARK DRIVE DRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	She offered R39 his stated, "No, just leave does this and she we his room. -12:30 p.m. R39 le his glass of milk. He After he drank his no thick blobs of white to his recliner. R39 dozed off in his recl his water or ate any adequate supervision his meal. R39"s current Phys 3/1/17, identified R3 Report failed to incl orders. R39's Nutritional Ex Collection form date weight was relative gain of 10-15# wou underweight based and R39 had a fair room. Review of R39's we 3/28/17, identified F loss over 30 days fr 5.9% of his body we record revealed the	a milk in his hand and R39 we it there." She stated R39 would check back later and left aned forward and picked up e consumed all of his milk. hilk, he started spitting large phlegm into a trashcan next sat back in the recliner, and iner. R39 had not drank any of of his food. R39 did not have on or encouragement during ician Order Report dated 39 was on a regular diet. The ude any other nutritional valuation History and Data ed 11/8/16 identified R39's y stable overall but a weight Id be beneficial as R39 was on his body mass index (BMI) meal intake in the main dining eight records from 10/1/17, to R39 had a significant weight following weight loss trend, o sustained further weight loss at 12 days:	F	325			

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	-	AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					00	
		245451	B. WING		03/:	30/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWAY	Y VIEW NEIGHBORHO	DODS		01 MARK DRIVE DRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa -3/16/17 weight 140 -3/2/17 weight 136. -3/16/17 weight 136. -3/16/17 weight 140 -2/23/17 weight 142 -1/26/17 weight 142 -1/26/17 weight 143 -12/22/16 weight 143 -12/22/16 weight 143 -12/15/16 weight 143 -11/1/16 to 10/31/10 0% of his breakfast entrees and meats. R39 did not receive consumed at least 3 14/31 noon meals.	sc identifying information) lige 23) lbs 9 lbs 2 lbs 2.6 lbs 1.3 lbs 3 lbs 44.2 lbs		CROSS-REFERENCED TO THE APPROPE		
	0% of his breakfast to none of entrees a indicated R39 did n	6, R39 refused or consumed t, meats at lunch and minimal at supper. The record further ot receive nutritional nsumed all of his super				

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		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	1	(X3) DATE	E SURVEY IPLETED
		245451	B. WING			03/:	30/2017
NAME OF F	PROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE		
FAIRWAY		DODS		201 MARK DRIVE ORTONVILLE, M	IN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	ER'S PLAN OF CORRECTIC RRECTIVE ACTION SHOULI ERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	Continued From pa mashed potatoes.	ge 24	F 32	5			
	intake records and his desserts, milk, v	R39 had incomplete meal identified R39 consumed all of water and super mashed rd did not identify if R39 al supplement.					
	intake records and his desserts, milk, v	R39 had incomplete meal identified R39 consumed all of water and super mashed rd did not identify if R39 al supplement.					
	intake records and his desserts, milk, v potatoes. The facilit	R39 had incomplete meal identified R39 consumed all of water and super mashed ty failed to record R39's meal ', and did not identify if R39 al supplement.					
	History (MAR) from R39 had received F supplement) twice a 2/5/17 and 2/6/17 a percentages(%) fro	edication Administration 1/1/17 to 3/30/17 revealed Prostat (protein powder a day on 2/3/17 , 2/4/17, and consumed varying om 1- 25 % to 75-100%. No ion of the Prostat was found					
	forms from 1/1/17,	atment Adminsitration History to 3/30/17, revealed the supplement intake.					
		he form did not identify any ents had been offered or given th.					
	2/1/17 to 1/28/17, th	he form did not identify any					

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		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245451	B. WING			03/;	30/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS			01 MARK DRIVE DRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	nutritional supplement to R39 for the mont 3/1/17 to 3/30/17, the received or been of supplements until 3 supplements until 3 supplement was sta Documentation indi supplement three ti 3/30/17, and had co Review of R39's pro 3/29/17 revealed: -11/7/16, indicated I completed this date manager (CDM) an regular diet and rec potatoes, and 6 oz's The note further inco own choices using to current weight was over the last year. Thave his meals in the and evening and inco breakfast in his root -1/25/17, indicated for nutritional risk. Twas gradually losing was 144 lbs, which month and R39 had days. The note ider regular diet with hig super cereal, doubli- breakfast, super ma fruit based nutrition	ents had been offered or given	F3	325			

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		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245451	B. WING			03/;	30/2017
NAME OF	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWA		DODS			01 MARK DRIVE DRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	The note further inc goodies, they would resident in hope of continue to assess. -1/30/17, indicated with R39's daughte small snack 1-2 hou and dietary could he regular meal and ta refusal. The note fu R39's favorite foods and jelly toast, ice of flavored nutritional -2/9/17, indicated R supplement and the high calorie intervent indicated R39's last weight gain was de interventions were p increased intake. Review of the current Preferences form p as homemaker referint included cold break with peanut butter a dinner, he had no for juice, milk and water water for lunch and indicated R39 had I interventions to ma to identify R39 required interventions were for interventions were for	dicated family brought in d encourage family to eat with increasing his intake and registered dietitian (RD) spoke r and staff would offer R39 a urs after meals if he refused old a small sampling of the ake it to his room after a meal urther indicated R39's identified s which included peanut butter cream, fruit sauce, and apple supplement. R39 refused protein ey would continue with other ntions. The note further t weight was 141# and gradual sired for R39 and new put in place to promote ent Resident Dining provided by the facility, utilized erence for resident diets and ified R39's food preferences cfast cereal and white toast and jelly, his favorite meal was ood dislikes, received orange er for breakfast and milk and supper. The form further high calorie-protein intain weight. The facility failed uired whole milk and did not	F	325			

Facility ID: 00771

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245451	B. WING	i		03/:	30/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FAIRWAY		DODS			01 MARK DRIVE DRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	himself and other re	age 27 elated nutrition information	F३	325			
	in his room about 2 dining room once in had not been to the She stated R39 did was a good ice crea generally received s meal or was offered which R39 generall HM-A stated homer recorded meal intal was not aware of s R39's meals. She s toast, broth and ma	49 p.m. HM-A stated R39 ate 2/3 of time and came out to the n a "blue moon." She stated he e dining room since Sunday. In't eat much and stated he am eater. She stated R39 supplements if he refused a d soup and a sandwich later ly didn't want that or anything. making staff had never kes for R39 She stated she pecial food or textures for stated R39 liked peanut butter ashed potatoes with butter. I not like meat or hot dishes ught he drank his					
	think R39 had lost a liked mashed potate and broth and woul peanut butter and ic not do anything spe him any special foo supplements had b stated he never too not like meat or veg not aware of any re	7 p.m. HM-B stated she did not any weight and stated R39 coes, would usually drink milk ld sometimes eat toast with ce cream. She stated staff did ecial for R39's meals or give ods. She stated fruit been offered in the past and ok them. She stated R39 did getables. She stated she was esidents who received protein interventions.					
	eat good but would received a fruit sup drank it. She stated	p.m. NA-C stated R39 did not drink fluids. She stated he plement 6 times a day and he would usually eat soup decent portions of foods at					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245451 B. WING 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 MARK DRIVE FAIRWAY VIEW NEIGHBORHOODS **ORTONVILLE, MN 56278** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 325 Continued From page 28 F 325 meals. She stated she was not sure if the HM's recorded R39's meal intake and stated nursing did not record meal intakes. She stated staff did not do anything else special for R39's foods or meals other than supplements and trying to find foods he wanted and encouraged him. On 3/30/17, at 12:30 p.m. registered dietitian (RD) stated she reviewed resident weights every month and stated if someone lost weight in-between the CDM would let her know. She stated the usual facility practice included to complete a comprehensive nutrition assessment on each resident annually, and she stated she had completed R39's last comprehensive assessment 11/7/16. RD stated R39 continued to lose weight and R39's current weight was 136 lbs. She stated R39's usual body weight was 150-155 lbs. RD stated R39 had sustained a significant weight loss in January and started super cereal and super mashed potatoes and double portion of peanut butter and jelly toast on 1/25/17. She stated the facility had tried Prostat (a protein powder supplement) on 2/9/17 and discontinued after 3 days as resident did not like it. She stated the Prostat was the last intervention they had tried until she ordered a nutritional supplement 3/29/17. She confirmed R39's care plan and nutrition interventions. She stated she expected R39's food and fluid intakes, Dining Preferences form to be recorded and accurate. She confirmed super cereal and super potatoes were on R39's care plan and stated she had never directed staff to provide these items. She stated R39's care plan identified R39 required supervision for meals yet R39 ate most meals in his room. RD indicated she felt R39's care plan needed to be revised.

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		AND HUMAN SERVICES				FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245451	B. WING			03/3	30/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWAY	VIEW NEIGHBORHC	DODS			01 MARK DRIVE PRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	Continued From pa	ge 29	FЗ	325			
F 356 SS=C	3/30/17. The facility	veight loss was requested y failed to provide a policy. OSTED NURSE STAFFING	FЗ	856			5/9/17
		nformation ents. The facility must post ation on a daily basis:					
	(i) Facility name.						
	(ii) The current date	> .					
	by the following cate	er and the actual hours worked egories of licensed and staff directly responsible for hift:					
	(A) Registered nurs	es.					
		cal nurses or licensed as defined under State law)					
	(C) Certified nurse	aides.					
	(iv) Resident censu	S.					
	(2) Posting requiren	nents.					
	specified in paragra	post the nurse staffing data aph (g)(1) of this section on a eginning of each shift.					
	(ii) Data must be po	osted as follows:					
	(A) Clear and reada	able format.					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FC	ORM APF	/19/2017 PROVED 38-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´) DATE SU COMPLET	RVEY
		245451	B. WING	i		03/30/2	2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FAIRWAY		DODS			01 MARK DRIVE RTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) MPLETION DATE
F 356	Continued From pa	ge 30	F	356			
	(B) In a prominent presidents and visito	blace readily accessible to rs.					
	The facility must, up make nurse staffing	o posted nurse staffing data. Soon oral or written request, g data available to the public not to exceed the community					
	facility must mainta staffing data for a m required by State la	ention requirements. The in the posted daily nurse ninimum of 18 months, or as w, whichever is greater. NT is not met as evidenced					
	Based on observat review, the facility fa	ion, interview and document ailed to post the required daily which included daily census			Posting of daily staffing information wi be completed daily including census.	ill	
	in the facility. This h	had the potential to affect all y in addition to the 48			Daily Nurse Staffing Form Policy has b revised by Director of Nurses to include census.		
		s on 3/27/17, at 1:37 p.m. the			All Staff meeting will be held on 05/04/ to educate on the Daily Nurse Staffing Form Policy and the importance of		
	entrance on the war plastic self mounted posting was dated 3 current census. At staff posting remain	posting was in the main Il and was placed in a clear d to the wall. The nursing staff B/26/17 and did not include the 7:40 p.m., the required nursing ned the daily posting dated include the facility census.			completing daily nurse staffing form. A Performance Improvement (PI) Audi has been developed to ensure daily nu staffing form is completed and posted daily. This PI will audit one time per we for 3 months or until 100% compliant, to random audits will be completed. These	urse eek then	
	3/15/17 - 3/29/17 re not been included c	y nursing hour postings dated wealed the facility census had on 12 of the 15 days reviewed. a.m. director of nursing (DON)			results will be reported monthly to the Quality Assurance/Performance Improvement Committee. This audit will be monitored by Director of Nurses or designee.	ill	

Facility ID: 00771

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245451 B. WING 03/30/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 201 MARK DRIVE FAIRWAY VIEW NEIGHBORHOODS **ORTONVILLE, MN 56278** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 356 Continued From page 31 F 356 confirmed the nurse staff posting were inaccurate. The DON indicated the night shift staff was responsible for filling out the nurse staff posting form, posting it and each nurse on each shift was responsible for updating the form during the day. During follow up interview at 1:00 p.m., the DON indicated she would expect staff to include the current census on the form, and to reflect the current date on the nurse staff posting for the correct day and placed in the holder. Review of the facility policy titled, Posting Daily Nursing Staffing Form, dated 3/20/17, indicated the DON or designee will ensure that the number of registered nurses, licensed practical nurses and certified nurses aides (caregivers and medication aides) scheduled for each day was posted at the entrance of the community. The policy lacked direction to include the current resident census on the nursing staffing form. F 465 483.90(i)(5) F 465 5/9/17 SS=D SAFE/FUNCTIONAL/SANITARY/COMFORTABL **E ENVIRON** (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document On 03/31/17 Resident R25 was fitted for

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPL	E CONSTRUCTION	(X3) DATE	0938-039 SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMI	PLETED
		245451	B. WING _			03/3	80/2017
NAME OF I	PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FAIRWA		OODS			01 MARK DRIVE PRTONVILLE, MN 56278		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 465	Continued From pa	age 32	F 46	35			
	equipment was kep	ailed to ensure resident care ot in a clean and sanitary residents (R25) observed to			a new wheelchair by Occupational Therapy.		
	have a wheelchair Findings include:				All wheelchairs will be assessed we for disrepair at Neighborhood s we wheelchair cleaning. Any wheelcha found in need of repair will be repo	eekly irs	
: k r	3/13/17, identified I	nimum Data Set (MDS) dated R25 had frequent urinary and and used a wheelchair for a			Neighborhood Leader. All Staff meeting will be held on 05/		
	mobility device.				to educate on the importance of ke equipment in clean and sanitary co	eping	
	frequent incontiner	ted 7/26/16, indicated R25 had at episodes of bowel and ed by saturation of incontinent			and free from disrepair. A Performance Improvement (PI) A	udit	
	products. The care extensive assistant needs, and directed	e plan indicated R25 required ce of one staff for toileting d staff to offer R25 toileting n as possible, at least every			has been developed to ensure equ in clean and sanitary condition and from disrepair. This PI will audit 2 wheelchairs per week for 3 months	ipment free	
	two hours, to preve places. The care p	ban indicated R25 required a motion, and was able to propel			100% compliant, then random audi be completed. These results will be reported monthly to the Quality	ts will	
		ependently throughout the			Assurance/Performance Improvem Committee. This audit will be monit by Neighborhood Leader or design	tored	
		edge of the seat was tattered posing a light yellow fabric.					
	6 inches long and 2 12:40 p.m. R25's w	2 inches wide. On 3/30/17, at wheelchair seat remained rellow fabric exposed.					
	(NA)-A reported R2 and bladder and w	l9 a.m. nursing assistant 25 was incontinent of bowel ore an incontinent product at served R25's tattered					

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		AND HUMAN SERVICES & MEDICAID SERVICES						FORM	05/19/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			DNSTRUCTION		(X3) DATE	E SURVEY PLETED
		245451	B. WING	÷				03/:	30/2017
NAME OF F	PROVIDER OR SUPPLIER					ET ADDRESS, CITY, STATE, ZIP CO	DE		
FAIRWAY		DODS				ARK DRIVE DNVILLE, MN 56278			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 465	had exposed paddia stated the therapy of was trying to get a r stated R25's wheeld with urine before, a to the bathroom in i the hallway. NA-As down the wheelcha stated the wheelcha stated the wheelcha to the missing cove night shift staff was resident care equip updated so they car replaced, especially On 3/30/17, at 12:1 (DON) reported who resident care equip updated so they car replaced, especially On 3/30/17, at 12:3 confirmed she was seat condition. CM incontinent product could not verbalize and had been know wastebaskets and i would have known a would have been re to R25's incontinent the wheelchair seat surface. On 3/30/17, at 1:03 services (DSS) con was not aware of R disrepair, and confir	d stated the wheelchair seat ng for a couple of months, and department was aware and new chair for R25. NA-A chair seat had been saturated nd stated R25 at times will go nappropriate places such as stated staff had tried to wipe ir seat when it was soiled, and air seat was hard to clean due ring. Further, NA-A stated the responsible to clean the ment every two weeks. 2 p.m. the director of nursing en staff identify damaged ment, therapy was to be n get equipment repaired or	F	465	5				

If continuation sheet Page 34 of 35

		AND HUMAN SERVICES					FORM	05/19/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRU				E SURVEY PLETED
		245451	B. WING				03/3	30/2017
NAME OF F	PROVIDER OR SUPPLIER				RESS, CITY, STATE,	, ZIP CODE		
FAIRWA	VIEW NEIGHBORH	DODS		201 MARK D ORTONVIL	LE, MN 56278			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA)	ROVIDER'S PLAN O CH CORRECTIVE AG S-REFERENCED TO DEFICIEN	CTION SHOULD	BE	(X5) COMPLETION DATE
F 465	DSS stated staff we with the therapy de equipment issues a	ere expected to communicate partment when resident are identified. t care equipment maintenance	F 4	65				

Facility ID: 00771

If continuation sheet Page 35 of 35

		AND HUMAN SERV & MEDICAID SERV		Ŧ	5451028	FORM	01/10/2017 APPROVED .0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1. 7	LE CONSTRUCTION 6 02 - FAIRWAY VIEW RHOODS	(X3) DATE S COMPLI	
		245451		B. WING		01/0	4/2017
	ROVIDER OR SUPPLIER	HOODS	201 MO	RESS, CITY, S RK DRIVE VILLE, MN			6
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCI			PROVIDER'S PLAN OF CORRI	CTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL I INTIFYING INFORMATION)	REGULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	COMPLETION DATE
K 000	INITIAL COMMENT	ΓS		K 000			
	FIRE SAFETY						
	was conducted by t Public Safety, State January 04, 2017. Fairway View Neigh compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) Standard 1	y Code Certification a the Minnesota Depart Fire Marshal Division At the time of this sum borhoods was found requirements for particular and at 42 CFR, Subpart at 42 CFR, Subpart ty from Fire, and the Fire Protection Associ 01, Life Safety Code g Health Care Occup	tment of on, on irvey, d to be in articipation art = 2012 ciation (LSC),			71	
	Fairway View Neigh under the LSC 200 one-story in height,	nborhoods was built 0 Regulations, and is has no basement, is and was determined	in 2016 s s fully fire				
2	detection in the cor corridors which is n department notifica	re alarm system with ridors and spaces of nonitored for automa tion. The facility has and had a census of	ben to the atic fire a				
17	The requirement at MET.	t 42 CFR, Subpart 48	33.70(a) is				
4		* s [*]	_				-
					· · · · ·		
LABORATO	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 20, 2017

Mr. David Rogers, Administrator Fairway View Neighborhoods 201 Mark Drive Ortonville, Minnesota 56278

Re: State Nursing Home Licensing Orders - Project Number S5451027

Dear Mr. Rogers:

The above facility was surveyed on March 27, 2017 through March 30, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Fairway View Neighborhoods April 20, 2017 Page 2

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, <u>you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us</u>.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

cc: Licensing and Certification File

Minnesc	ota Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00771	B. WING		03/3	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIRWA	Y VIEW NEIGHBORHO	DODS 201 MARK ORTONVI	K DRIVE LLE, MN 56	278		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 04/28/17

Electronically Signed

If continuation sheet 1 of 27

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/	30/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AIRWA		CODS	RK DRIVE VILLE, MN 562	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must them State licensure pro- completion date, th corrected prior to e Minnesota Departm On 3/27/17, 3/28/12 of this Department" provider and the fol issued. Please ind correction that you and identify the dat Minnesota Department the State Licensing federal software. Ta	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available fo indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 7, 3/29/17, 3/30/17 surveyors s staff, visited the above llowing correction orders are icate in your electronic plan of have reviewed these orders, e when they will be completed nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for	r			
	The assigned tag n column entitled "ID statute/rule out of o "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follor are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN	ARD THE HEADING OF THE				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/:	30/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
AIRWAY		DODS	RK DRIVE VILLE, MN 562	78		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.	-			
2 302	MN State Statute 14 or related disorder t	44.6503 Alzheimer's disease rain	2 302			4/27/17
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144.					
	Alzheimer's disease or related o segregated or gene care staff	ity serves persons with lisorders, whether in a ral unit, the facility's direct rs must be trained in dementi	a			
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall	of Alzheimer's disease and activities of daily living; with challenging behaviors; skills. provide to consumers in				
	training program, th trained, the frequen topics covered.	form a description of the e categories of employees cy of training, and the basic document compliance with				
	This MN Requireme	ent is not met as evidenced				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00771	B. WING		03/30/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY,	STATE, ZIP CODE	
		DODS	RK DRIVE VILLE, MN 56	3278	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLET
2 302	Continued From pa	ge 3	2 302		
	facility failed to ensign information regarding dementia training, i training program, the trained, the frequent topics covered in the	, and document review, the ure consumers were provided ng Alzheimer's disease and ncluding a description of the ne categories of employees ncy of training and the basic ne training in a written or his had the potential to affect I their families.	1	This has been corrected.	
1	Findings include:				
	training program, th documentation that (resident and famili description of Alzhe	the facility's Alzheimer's here was no information or indicated that the consumers es) were provided a eimer's training program, byees trained, frequency of sic topics covered.	5		
c t () v r a s s s s s s	verified the facility of regards to Alzheime and their families. T social worker (SW) admission and was	p.m. director of nursing (DON did not provide information in er's/dementia to consumers The DON stated the licensed met with families on unaware of the training. She othing, yes we should be too."	1)		
	admission packet a regards to providing and their families in	tia training and indicated she	n		
		requested policy on g, one was not provided.			
	SUGGESTED MET	HOD OF CORRECTION:			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:				E SURVEY PLETED
		00771	B. WING		03/	30/2017
NAME OF I	PROVIDER OR SUPPLIER	STRI	EET ADDRESS, CITY, S	STATE, ZIP CODE		
FAIRWA		DODS	MARK DRIVE FONVILLE, MN 56	278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 302	Continued From pa	ige 4	2 302			
	regarding staff train packet so consume information. The DO staff about this requ ensure compliance	nee could add information ning to the resident admiss ers were aware of this ON or designee could edu uirement and conduct aud R CORRECTION: Twenty	icate its to			
2 830	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 1 Adequate and re; General	2 830			4/27/17
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal supervision based on id preferences as identifie resident assessment and scribed in parts 4658.0400 ing home resident must be possible unless there is a he attending physician that ain in bed or the resident in bed.	l and d in l) and e out a			
	by: Based on interview facility failed to prov in accordance with complications relate	ent is not met as evidenc and document review, the vide ongoing weight monit physician orders to preve ed to potential fluid overloo (R52) whose closed reco	e oring nt ad	This has been corrected.		
	Findings include:					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/	30/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		DODS 201 MAR ORTONV	K DRIVE ILLE, MN 562	278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	11/3/16, identified F included heart failu localized edema. R severe cognitive im extensive assistance (ADLs). Further, th heart failure, but did breath. R52's hospital Disc 10/27/16, identified which included chro failure, renal insuffi The form identified medication adjustm congestive heart fa course, R52's renal medication adjustm laboratory monitorin summary included used to remove flui (mg) orally twice a times weekly. Furth R52's weight record oz (ounces), bilater edema and clear lui follow up with physi rounds at the nursii R52's Interagency 10/27/16, identified as fair and included to complete weights R52's facility transo	age 5 inimum Data Set (MDS) dated R52 had diagnoses which re, Diabetes Mellitus, and 52's MDS identified R52 had pairment and required be for activities of daily living the MDS identified R52 had d not have any shortness of tharge Summary dated R52 had several diagnoses onic systolic congestive heart ciency and Diabetes Mellitus. R52 had been hospitalized for nents for treatment of ilure. During her hospital I function worsened also and neg done. R52's discharge orders for Lasix (medication d from the body) 40 milligrams day weights to be monitored 2 her, the summary identified ded as 151 lbs (pounds) 14.4 al one plus lower extremity ing sounds. The form listed ician would be done on routine ng home or sooner as needed. Transfer Orders dated R52's rehabilitation potential d orders for nursing home staff s twice weekly on R52.	2 830	DEFICIENC	·Υ)	
nesota D		at 2 X/WEEK [twice a week] to esday(s) and Friday(s).				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	00771		B. WING		03/30/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		OODS	RK DRIVE VILLE, MN 562	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	R52's Admission Care Plan dated 10/27/16, listed various interventions which included Lasix 40 mg am/noon and weigh every week. The care plan lacked any further direction pertaining to the discharge orders from the physician to weigh R52 twice a week. R52's Northridge Residence flowsheet dated 10/27/16 to 11/4/16, identified directions of, "Vital signs [and] weight to be done WEEKLY [underlined]," and provided two columns to record the collected data. No further directions for weights to be done two times a week were found on the flowsheet. The flowsheet had two weights recorded. On 10/27/16 (day of admission), R52 weighed 156.6 pounds and on 11/4/16, R52 weighed 162 pounds. There were no recorded weights on 10/28/16 (Friday), or 11/1/16 (the following Tuesday), as directed by the physician orders.		2 d			
	10/31/16, identified and Fri] WEIGHT" congestive heart fa	heets (TAR) dated 10/1/16 to an order for 2 X/WEEK [Tues and listed a diagnosis of ilure. The provided spacing to 10/28/16, however, was not blank.				
	documentation of F 11/1/16 and listed a 11/3/16, and only w	1/1/16 to 11/30/16, lacked R52's collected weight on an order for daily weight dated reight documented was on 5 pound weight gain in 8 days)				
	Review of R52's pr to 11/5/16 revealed	ogress notes from 10/27/116 I the following:				
	-10/27/16, R52 adn with declining healt	nitted to facility from hospital				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/30/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		DODS	RK DRIVE /ILLE, MN 562	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 7	2 830			
	edema, and legs at Physician had adjust ordered daily weigh -11/4/16, R52 states had been worsening had fine crackles in and an intramuscul per physician order -11/4/16, later in the and discussion made addition, the physic dose for R52. -11/5/16, R52 expire During interview on manager (CM)-A st medical record and obtained and monit physician orders and stated weight monit was a, "Nursing states" "Didn't follow the or A facility Intake and identified a purpose fluid balance," and staff to follow which physician orders. T information or direct heart failure patient No further policies of and/or fluid monitor SUGGESTED MET	d she was short of breath and g for the past two days. R52 left lung, and oxygen applied ar injection of Lasix was given at that time. e day, family discussion held de not to hospitalize R52. In ian again adjusted the Lasix ed with family present. 3/29/17, at 2:00 p.m. clinical ated she reviewed R52's R52's weights had not been ored in accordance with the lding, "[It] wasn't done." CM-A coring on a heart failure patien ndard of practice," and staff, der." Output policy dated 10/15, e including, "To help maintain listed several instructions for i included to follow the The policy lacked any tion on collecting weights for a				
	resident needs are	ures to ensure individual met based on comprehensive irector of nursing or her				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING		(X3) DATE S COMPLE	
		00771	B. WING		03/30/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AIRWA		DODS 201 MAR ORTONV	K DRIVE ILLE, MN 56	278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 8	2 830			
	these policies and p nursing or her desig	icate all appropriate staff on procedures. The director of gnee could develop monitoring ongoing compliance.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty one				
2 930	MN Rule 4658.052 Nasogastric, Gastro	5 Subp. 7 B. Rehab - ostomy tubes	2 930			4/27/17
	and feeding syringes. Based o	ric tubes, gastrostomy tubes, n the comprehensive resident sing home must ensure that:				
	gastrostomy tube o appropriate treatme aspiration pneumor dehydration, metab	who is fed by a nasogastric or r feeding syringe receives the ent and services to prevent nia, diarrhea, vomiting, olic abnormalities, and lcers and to restore, if eding function.				
	by: Based on observati	ent is not met as evidenced ion, interview and document ailed to ensure medications		This has been corrected.		
	administered throug administered separ facility policy to dec	alled to ensure medications gh a gastroenteral tube were ately in accordance with crease the risk of adverse sidents (R59) reviewed for				
	Findings include:					

STATE FORM

N66411

If continuation sheet 9 of 27

STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/	30/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					03/	50/2017
FAIRWA		201 MAF	RK DRIVE /ILLE, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 930	Continued From pa	age 9	2 930			
	2/8/17, identified R impairment and tot eating, and utilized R59's Physician Or identified R59 was	inimum Data Set (MDS) dated 59 had moderate cognitive ally dependent on staff for a feeding tube for nutrition. der Report signed 3/6/17, to have, "Nothing by mouth,"				
	- Lasix (medication	nedication orders including: used to reduce fluid in the s (mg) orally every day;				
		cation used for high blood t pain) 2.5 ml by gastric tube				
		suspension (medication used 20 ml (40 mg) by gastric tube				
	- Ferrous sulfate (ir ml) by gastric tube	on supplement) 66 mg (4.4 once a day, and;				
		lication used to thin mucous in it) 400 mg by gastric tube				
	lacked any direction administration of R	an Order Report dated 3/6/17, n or instruction on the 59's medications, including if ere able to be mixed together n the feeding tube.				
	on 3/28/17, at 8:36 prepared R59's me outside his room w (RN-B). RN-A mea	of medication administration a.m. registered nurse (RN)-A edications in the hallway ith an orientating nurse asured and poured the liquid sulfate and omeprazole into				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00771	B. WING		03/30/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
FAIRWA		CODS 201 MAR	K DRIVE ILLE, MN 562	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
2 930	Continued From pa	age 10	2 930			
	separate medication administration cups a then combined each of them into a small of cup. RN-A removed guaifenesin and furos tablets from their packaging, crushed the t and proceeded to pour the crushed tablets the same cup as the prepared liquid medic were in and mixed the medication together a plastic spoon. RN-A then entered R59's administer the medications. RN-A disconr R59's suspended formula container and auscultated placement of a visible feeding going into R59's abdomen, then attached a clear plastic syringe to the tube port. RN-A the syringe with plain water, allowed it to e per gravity, then poured the cup of prepare medications into the syringe mixed with wa The medications drained per gravity and R flushed the syringe with additional water be securing the cap on the feeding tube port.					
	used a gastroenter abdomen directly ir nutrition and medic admission to the fa should not have an with speech therap the medications tog through the tube fo RN-A reviewed R55 and identified there physician directing together for admini see." Further, RN- R59's physician and to mix the medicati administration.	-				
Discoto D		0 a.m. consulting pharmacist ould be best practice to				
TE FOR	•		⁶⁸⁹⁹ N	66411	If continuati	on sheet 11 c

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	00771		B. WING		03/	30/2017
NAME OF F	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, ST	TATE, ZIP CODE		
		DODS	ARK DRIVE NVILLE, MN 562	78		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
2 930	Continued From pa	ge 11	2 930			
	administer medicati	ions separately with water				
		and stated "just so that if				
		tion, you take that out of pla	y."			
	CP indicated R59's	five administered medication				
		own interactions if given				
		verified this was not best				
		ted some residents could ha	ive			
		much fluid or mixed	to			
		at once could have potential be if administered together.				
		the five administered				
		have an increased risk of				
		didn't mean something could	1			
		could have risk in the futur				
	Further, CP indicate	ed an in-service on medicati	ion			
	administration throu benefit to the facility	ugh a feeding tube might be y.	of			
		p.m. the director of nursing ube feeding medications				
		d together for administration	n			
		has ordered it, in case the	•			
		stration had to be stopped fo	r			
		ff would not know what				
		had not been administered				
		tated staff "Should of follow				
		ninistered R59's medication	S			
	separately through	the feeding tube.				
	Review of the facilit	ty policy titled, Tube Feeding	g			
		y dated 12/16, identified a				
	purpose for, safe a	dministration of tube feeding				
		long with ensuring medication	ons			
		according to standard of				
		y identified steps to follow fo	or 🛛			
		stration by feeding tube				
		nix medications together." edication separately with 30				
	milliliters (ml) of wa					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
		00771	B. WING		03/30/2017	
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE		
AIRWA		nons	ARK DRIVE NVILLE, MN 562	278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
2 930	Continued From pa	age 12	2 930			
	administering medi	eding tube with water before cations, in-between each er the final medication is				
	Director of Nursing the policies and pro of medications thro and could provide of the administration of tube. Ongoing audi	THOD OF CORRECTION: THe or her designee could review ocedures for the administration ough the Gastrostomy Tube ongoing staff training regarding of medications through the its of the procedure for all be performed to ensure	w on			
	TIME PERIOD FOI (14) days.	R CORRECTION: Fourteen				
2 965	MN Rule 4658.060 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			4/27/17
	must ensure that a which supplies the determined by the assessment. Subs	onal status. The nursing hom resident is offered a diet caloric and nutrient needs as comprehensive resident stitutes of similar nutritive valu residents who refuse food	5			
	by: Based on observat review, the facility f interventions relate dense foods which	ent is not met as evidenced ion, interview and document failed to implement nutritiona id to the provision of calorie included super potatoes at nitoring and recording		This has been corrected.		

STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00771	B. WING		03/	30/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
FAIRWA		OODS	RK DRIVE VILLE, MN 562	78		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	age 13	2 965			
		ntake in order to prevent for 1 of 2 (R39) residents cant weight loss.				
	Findings include:					
	identified R39 had	agnoses Report dated 3/1/17, dementia, chronic lymphocytic (muscle pain), intestinal rption disorder and				
	11/7/16, identified F impairment. The M 73 inches (in) and v loss, was independ	num Data Set (MDS) dated R39 had severe cognitive DS further indicated R39 was weighed 152#, had no weight lent with eating, had no eating no alterations to his diet.				
	identified R39 had s The MDS further in (in) and weighed 14 loss, required supe	hange MDS dated 1/30/17, severe cognitive impairment. Idicated R39 was 73 inches 41#, had significant weight rivision with eating, had no id had no alterations to his				
	1/30/17, identified F dependence with a related to weaknes poor coordination, w The CAA further ind assistance, supervi encouragement wit unplanned significa to identify R39's cu	th eating and had an ant weight loss. The CAA failed rrent eating pattern, functional				
	problems, dental pr	problems, communication roblems, diseases, labs or could affect R39's appetite				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/30/2017	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AIRWA		DODS	RK DRIVE /ILLE, MN 562	78		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 965	Continued From pa	ige 14	2 965			
	had no appetite, co foods, sometimes r	ds. The CAA indicated R39 nsumed small portions of refused his favorite foods and oods 1-2 hours after he				
refused t R39's ca the poter dementia nutritiona weight ar and liquid discomfo plan liste milk base suppleme spoken n with tray eating, m to dietary care plan diet with super ce noon, wh	the potential for nut dementia and adva nutritional diet/intak weight and consum and liquids and wou discomfort after drin plan listed various i milk base Ensure w supplement, staff w spoken menu for cl with tray set-up and eating, monitor weig to dietary if R39's m care plan indicated diet with calorie der super cereal breakt noon, whole milk at snacks and 6 ounce	ted 3/22/17, identified R39 had initional problems related to inced age, would maintain a along with maintain/improve the at least 75% of all solids uld be free of stomach inking supplement . The care interventions which included was to replace the fruit based vere to assist R39 and use hoices at meals, assist R39 d food placement, encourage ght and food intake and report heal intake fell below 50%. The R39 was to receive a regular inse foods which included fast and super potatoes at t meals, afternoon and evening es (oz) of fruit drink nutritional ing, afternoon and evening.				
	homemaker (HM)-A setting up for the no the HM's responsib wanted to eat and t orders. HM-A state Dining Preferences	s on 3/29/17, at 11:32 a.m. A was present in the kitchen bon meal. She stated it was ility to ask residents what they ake their meal and drink d all residents had a Resident sheet which was kept in the erving area for staff to use.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00771	B. WING		03/	03/30/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
AIRWA		nne	RK DRIVE /ILLE, MN 562	278			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
2 965	Continued From pa	ge 15	2 965				
	currently there were	en at that time and confirmed e no residents that received n nutrition interventions.					
	the serving station loud to HM-A, "R39 NA-B told HM-A to meat. HM-A asked like a little hashbrow than mashed potate of rib meat, hashbrow R39's plate. HM-A R39's plate were th NA-B took the plate area and delivered	assistant (NA)-B walked up to in the kitchen and stated out o is going to eat in his room." only give him a little bit of NA-B, "Do you think he would wns, something a little differen- oes." HM-A put a couple bites owns and sweet potatoes on confirmed the serving sizes or ue usual serving sizes for R39. From HM-A, left the kitchen meal to R39's room. Staff per potatoes and did not offer and fluids.	ıt 1				
	in his room, covere quilt. NA-B entered and set it on R39's recliner. NA-B rem water and milk and cover R39's shirt. N R39's reach, on the recliner. NA-B left F	as reclined back in his recline d up to his neck with a plaid R39's room with meal on tray tray table in front of the oved the white lids from R39's applied a clothing protector to IA-B left the tray table out of tray table in front of R39's R39's room. NA-B did not ods or beverages he received acement.	3				
	"Look at it." R39 re kind, R39 wasn't su were on the plate. I	pinted to his food and said, cognized he had meat of some ire what the other food items R39 stated, "Eeeeeew you car his foods. R39 did not neal or beverages.					
		anager (UM-B) entered R39's m if he was going to eat lunch					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/30/2017			
		00771	B. WING					
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
		201 MAF						
AIRWAI		OCDS ORTON	/ILLE, MN 562	278				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 965	Continued From pa	age 16	2 965					
	on his plate and R3 food items. UM-B c she could get him a She offered R39 hi stated, "No, just lea does this and she v his room. -12:30 p.m. R39 lea his glass of milk. H After he drank his r thick blobs of white to his recliner. R39 dozed off in his rec his water or ate any	bday." She told him what was 39 stated he didn't want the offered R39 ice cream and if anything, R39 replied, "No." s milk in his hand and R39 ve it there." She stated R39 would check back later and lef eaned forward and picked up e consumed all of his milk. milk, he started spitting large e phlegm into a trashcan next sat back in the recliner, and liner. R39 had not drank any o y of his food. R39 did not have on or encouragement during	ſ					
	3/1/17, identified R	sician Order Report dated 39 was on a regular diet. The lude any other nutritional						
	Collection form dat weight was relative gain of 10-15# wou underweight based	valuation History and Data ed 11/8/16 identified R39's ly stable overall but a weight ld be beneficial as R39 was l on his body mass index (BMI meal intake in the main dining						
	3/28/17, identified I loss over 30 days f 5.9% of his body w record revealed the	eight records from 10/1/17, to R39 had a significant weight rom 12/15/16 to 1/12/17 or eight. R39's weekly weight e following weight loss trend, 9 sustained further weight loss st 12 days:						

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/	30/2017
NAME OF I	PROVIDER OR SUPPLIER		T ADDRESS, CITY, S	TATE, ZIP CODE		
FAIRWA		DODS	ARK DRIVE NVILLE, MN 562	278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 965	Continued From pa	age 17	2 965			
	-3/28/17 weight 136	6 lbs				
	-3/16/17 weight 14() lbs				
	-3/2/17 weight 136.	9 lbs				
	-3/16/17 weight 140					
	-2/23/17 weight 142					
	-1/26/17 weight 14					
	-1/12/17 weight 143					
	-12/22/16 weight 14					
	-12/15/16 weight 1					
		eal intake records from , revealed the following:				
	0% of his breakfast entrees and meats R39 did not receive	6, R39 refused or consumed t meals or lunch and supper . The record further indicate e nutritional supplement and s super mashed potatoes.	d			
	0% of his breakfast entrees and meats R39 did not receive consumed at least 14/31 noon meals.	6, R39 refused or consumed t meals or lunch and supper . The record further indicate e nutritional supplement and 50% super mashed potatoe The record failed to identify per mashed potatoes for 4	d s			
	0% of his breakfast	6, R39 refused or consumed t, meats at lunch and minima at supper. The record furthe	al			

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/3	30/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIRWA	Y VIEW NEIGHBORHO	DODS	RK DRIVE /ILLE, MN 562	278		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	ge 18	2 965			
		ot receive nutritional nsumed all of his super				
	intake records and his desserts, milk, v	R39 had incomplete meal identified R39 consumed all o water and super mashed rd did not identify if R39 al supplement.	f			
	intake records and his desserts, milk, v	R39 had incomplete meal identified R39 consumed all o water and super mashed rd did not identify if R39 al supplement.	f			
	intake records and his desserts, milk, v potatoes. The facili	R39 had incomplete meal identified R39 consumed all o water and super mashed ty failed to record R39's meal ', and did not identify if R39 al supplement.	f			
	History (MAR) from R39 had received F supplement) twice a 2/5/17 and 2/6/17 a percentages(%) fro	edication Administration 1/1/17 to 3/30/17 revealed Prostat (protein powder a day on 2/3/17, 2/4/17, and consumed varying m 1- 25 % to 75-100%. No ion of the Prostat was found				
	forms from 1/1/17,	atment Adminsitration History to 3/30/17, revealed the supplement intake.				
		he form did not identify any ents had been offered or giver th.	ı			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00771	B. WING	B. WING		30/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIRWA	Y VIEW NEIGHBORHO	DODS	RK DRIVE /ILLE, MN 562	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	nge 19	2 965			
2 300	2/1/17 to 1/28/17, tl	e he form did not identify any ents had been offered or giver				
	received or been of supplements until 3 supplement was sta Documentation indi supplement three ti	he form did not identify R39 ffered any nutritional 8/29/17, when an order for a arted for three times a day. icated R39 had received the imes on 3/29/17 and once on onsumed 75-100% each time.				
	Review of R39's pr 3/29/17 revealed:	ogress notes from 11/7/16 to				
	completed this date manager (CDM) an regular diet and rec potatoes, and 6 oz' The note further inc own choices using current weight was over the last year. T have his meals in th and evening and in	R39's annual review was by the certified dietary id identified R39 was on a ceived super cereal and super s of fruit drink supplement TID dicated R39 would make his the spoken menu and R39's 152 lbs and R39 had lost 9 lbs The note identified R39 would he main dining room for noon dicated R39 usually ate m or activities room.				
	for nutritional risk. T was gradually losing was 144 lbs, which month and R39 had days. The note ider regular diet with hig super cereal, doubl breakfast, super ma fruit based nutrition	R39 was assessed this date The note further indicated R39 g weight, his current weight was down from 151 lbs last d lost 11 lbs over the last 90 ntified R39 was to receive a gh calorie interventions of e portion of toast with jelly at ashed potatoes at noon and al supplement 3 times per day d was to provided by nursing.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00771	B. WING			30/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIRWA		DODS	RK DRIVE /ILLE, MN 562	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 965	Continued From pa	ige 20	2 965			
	goodies, they would	dicated family brought in d encourage family to eat with increasing his intake and				
	with R39's daughte small snack 1-2 ho and dietary could h regular meal and ta refusal. The note fu R39's favorite foods	registered dietitian (RD) spoke r and staff would offer R39 a urs after meals if he refused old a small sampling of the ake it to his room after a meal urther indicated R39's identified s which included peanut butter cream, fruit sauce, and apple supplement.	b			
	high calorie interve indicated R39's las weight gain was de	R39 refused protein ey would continue with other ntions. The note further t weight was 141# and gradua sired for R39 and new put in place to promote	I			
	as homemaker refe interventions, ident included cold break with peanut butter a dinner, he had no fe juice, milk and wate	provided by the facility, utilized erence for resident diets and ified R39's food preferences cfast cereal and white toast and jelly, his favorite meal was ood dislikes, received orange er for breakfast and milk and supper. The form further				
	interventions to ma to identify R39 required identify what high-co- interventions were devices or methods	intain weight. The facility failed ired whole milk and did not				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/30/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIRWA		DODS	K DRIVE ILLE, MN 562	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 965	Continued From pa	ige 21	2 965			
	was left blank.					
	dining room once ir had not been to the She stated R39 did was a good ice crea generally received a meal or was offered which R39 generall HM-A stated homer recorded meal intal was not aware of s R39's meals. She s toast, broth and ma She stated R39 did and stated she thou supplements.	-				
	think R39 had lost a liked mashed potat and broth and woul peanut butter and ic not do anything spe- him any special foo supplements had b stated he never too not like meat or veg not aware of any re	7 p.m. HM-B stated she did no any weight and stated R39 oes, would usually drink milk d sometimes eat toast with ce cream. She stated staff did ecial for R39's meals or give ods. She stated fruit een offered in the past and ok them. She stated R39 did getables. She stated she was isidents who received rotein interventions.	t			
	eat good but would received a fruit sup drank it. She stated and try to give him meals. She stated s	p.m. NA-C stated R39 did not drink fluids. She stated he plement 6 times a day and I he would usually eat soup decent portions of foods at she was not sure if the HM's al intake and stated nursing				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00771	B. WING		03/	03/30/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S				
AIRWA		DODS	RK DRIVE /ILLE, MN 562	278			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 965	Continued From pa	age 22	2 965				
	not do anything els meals other than se	l intakes. She stated staff did e special for R39's foods or upplements and trying to find nd encouraged him.					
	(RD) stated she rev month and stated it in-between the CDI stated the usual fac complete a compre- on each resident at had completed R39 assessment 11/7/1 lose weight and R3 lbs. She stated R39 150-155 lbs. RD sta significant weight los uper cereal and sta double portion of per 1/25/17. She stated (a protein powder st discontinued after 3 it. She stated the P they had tried until supplement 3/29/1 plan and nutrition in expected R39's for Preferences form to She confirmed sup were on R39's care never directed staff stated R39's care p supervision for mea	30 p.m. registered dietitian viewed resident weights every f someone lost weight M would let her know. She cility practice included to ehensive nutrition assessment nnually, and she stated she 9's last comprehensive 6. RD stated R39 continued to 9's current weight was 136 9's usual body weight was ated R39 had sustained a boss in January and started uper mashed potatoes and eanut butter and jelly toast on d the facility had tried Prostat supplement) on 2/9/17 and 3 days as resident did not like trostat was the last intervention she ordered a nutritional 7. She confirmed R39's care neterventions. She stated she bod and fluid intakes, Dining o be recorded and accurate. er cereal and super potatoes e plan and stated she had f to provide these items. She blan identified R39 required als yet R39 ate most meals in ated she felt R39's care plan ed.					
						1	

STATEMENT OF DEFIC			/SUPPLIER/CLIA TION NUMBER:	(X2) MULTIPI A. BUILDING			E SURVEY PLETED	
		00771		B. WING		03/	30/2017	
AME OF PROVIDER	OR SUPPLIER	•••••	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	03/30/2017		
AIRWAY VIEW N	EIGHBORHC	DODS	201 MAR	K DRIVE ILLE, MN 56	278			
PREFIX (EAC	H DEFICIENCY	Tement of Defi Must be prece Sc identifying I	CIENCIES EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 965 Continu	ed From pa	ge 23		2 965				
The Dir develop to ensu appropr determi assessr educate procedu systems	ector of Nui and implem re residents jate interver ned necessa nent. The D all appropri- res. The DC to ensure of ERIOD FOF	rsing (DON) c nent policies a at nutritonal r ntions to main ary by their ind ON or her de- iate staff on th DN could deve ongoing comp	tain nutrition as dividualized signee could ne policies and elop monitoring					
21685 MN Rul Housek		5 Subp. 2 Plar eration, & Mai		21685			4/27/17	
includin systems continue with reg well-bei	g walls, floo s, and equip bus state of ard to the he ng of the re	plant. The phy rs, ceilings, al ment must be good repair a ealth, comfort sidents accor e and repair p	I furnishings, kept in a nd operation t, safety, and ding to a written					
by: Based of review t equipm conditio have a	on observation he facility fa ent was kep n for 1 of 1 wheelchair s	on, interview a iled to ensure t in a clean ar	5) observed to		This has been corrected.			
_	s include: uarterly Mini	imum Data Se	et (MDS) dated					
	identified F							

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/	30/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
FAIRWA		DODS	RK DRIVE /ILLE, MN 562	78		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLET
21685	Continued From pa	ge 24	21685			
	bowel incontinence mobility device.	and used a wheelchair for a				
	frequent incontinen bladder as evidence products. The care extensive assistance needs, and directed assistance as often two hours, to preve places. The care p wheelchair for locon the wheelchair inde facility. During observation	ted 7/26/16, indicated R25 had t episodes of bowel and ed by saturation of incontinent e plan indicated R25 required ce of one staff for toileting d staff to offer R25 toileting as possible, at least every nt urinate in inappropriate lan indicated R25 required a motion, and was able to prope ependently throughout the on 3/27/17, at 5:30 p.m. R25 wheelchair in the hallway. The				
	wheelchair seat had however, the front e and worn away exp The tattered area o 6 inches long and 2 12:40 p.m. R25's w	d a blue vinyl type covering, edge of the seat was tattered osing a light yellow fabric. In the seat was approximately 2 inches wide. On 3/30/17, at theelchair seat remained ellow fabric exposed.				
	(NA)-A reported R2 and bladder and wo all times. NA-A obs wheelchair seat and had exposed paddi stated the therapy of was trying to get a stated R25's wheel	9 a.m. nursing assistant 5 was incontinent of bowel ore an incontinent product at served R25's tattered d stated the wheelchair seat ng for a couple of months, and department was aware and new chair for R25. NA-A chair seat had been saturated				
	to the bathroom in i the hallway. NA-A down the wheelcha	nd stated R25 at times will go inappropriate places such as stated staff had tried to wipe ir seat when it was soiled, and air seat was hard to clean due				

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00771	B. WING		03/	30/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AIRWA		DODS	RK DRIVE /ILLE, MN 562	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21685	-	-	21685			
	night shift staff was	ering. Further, NA-A stated the responsible to clean the oment every two weeks.)			
	(DON) reported wh resident care equip	2 p.m. the director of nursing en staff identify damaged ment, therapy was to be n get equipment repaired or y wheelchairs.				
	confirmed she was seat condition. CM incontinent of bowe incontinent product could not verbalize and had been know wastebaskets and i would have known would have been re to R25's incontinen	⁸² p.m. clinical manger (CM)-A not aware of R25's wheelchai A-A confirmed R25 was al and bladder and wore an at all times. CM-A stated R24 his needs to go the bathroom vn in the past to urinate in in corners. CM-A stated if she about the wheelchair seat, it eplaced. CM-A confirmed due uce and inappropriate voiding, t was no longer a cleanable	r 5			
	services (DSS) con was not aware of R disrepair, and confi ordered to fix or rep DSS stated staff we	8 p.m. the director of senior affirmed the therapy departmen 25's wheelchair seat being in armed nothing had been place the wheelchair seat. The ere expected to communicate partment when resident are identified.				
	A policy for residen was requested, but	t care equipment maintenance not provided.	9			
	The director of nurs develop and impler	THOD OF CORRECTION: sing or her designee could ment policies and procedures priate staff to ensure that the				

Minnesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
0		00771	B. WING		03/30/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, STATE, ZIP CODE			
FAIRWAY VIEW NEIGHBORHOODS 201 MARK DRIVE ORTONVILLE, MN 56278						
(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 SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	OULD BE COMPLETE	
	clean, functional, co monitoring and reco equipment is kept in system to audit the basis to ensure cor adherence to these	ent was maintained in a safe, omfortable manner. Ongoing ord keeping to ensure that the n good repair. Develop a equipment on an ongoing npliance and monitor staff for policies. R CORRECTION: Twenty-one				
Minnesota De	partment of Health					