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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N664

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00771

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245451**

2.STATE VENDOR OR MEDICAID NO.
(L2) **545740800**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRWAY VIEW NEIGHBORHOODS**
(L4) **201 MARK DRIVE**
(L5) **ORTONVILLE, MN** (L6) **56278**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/08/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 06/15/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 08/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/05/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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.

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

MDH
Minnesota
Department
of Health

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

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

MDH
Minnesota
Department
of Health

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

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 https://dab.efile.hhs.gov 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

(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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	R 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based on review of the facility's plan of correction, the facility is back in compliance with the Federal requirements identified as deficient at the time of their recertification survey exited [date]. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00771	A. BUILDING: _____ B. WING _____	R 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS:	{2 000}		
{2 302}	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING:	{2 302}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00771	A. BUILDING: _____ B. WING _____	R 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 302}	Continued From page 1 MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	{2 302}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00771	A. BUILDING: _____ B. WING _____	R 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 2 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by:	{2 830}		
{2 930}	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by:	{2 930}		
{2 965}	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	{2 965}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00771	A. BUILDING: _____ B. WING _____	R 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 965}	Continued From page 3 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by:	{2 965}		
{21685}	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by:	{21685}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N664

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00771

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245451**

2. STATE VENDOR OR MEDICAID NO. (L2) **545740800**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRWAY VIEW NEIGHBORHOODS**
(L4) **201 MARK DRIVE**
(L5) **ORTONVILLE, MN** (L6) **56278**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/30/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE NE II 05/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/05/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 167		5/15/17

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

Electronically 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.

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F 167	Continued From page 1 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (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, and document review, the facility failed to ensure State agency survey results were easily accessible for all residents in the facility which included residents who utilized a wheelchair. This had the potential to affect all 48 current residents who resided in the facility. Findings include: During the initial tour of the facility on 3/27/17, at 1:37 p.m. The facilities "MN [Minnesota] Dept [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 Correction." The survey results contained inside were dated 1/14/16, from the previous full survey. The survey results were located at a height which measured five feet, two inches from the floor, that was not accessible to residents seated in a wheelchair. During observation on 3/30/17 at 12:47 p.m. the "MN [Minnesota] Dept [Department] of Health Current Survey Results" remained at the same height which measured five feet, two inches from the floor. The survey results remained at this height during the entire survey. On 3/30/17 at 1:05 p.m. director of nursing (DON)	F 167	The holder that was attached to the wall was lowered and permanently attached at a height to be accessible for all residents in the facility. The holder was lowered on 4/27/17. A written protocol was developed for the placement of the file wall pocket to ensure that the Survey results were readily accessible to residents and the public. Protocol was added to the Policy and Procedure manual. All staff was educated on new protocol on 5-15-17 regarding placement of wall pocket that displays survey results. A Performance Improvement audit has been developed to ensure continued proper placement in the relationship to the height of the Survey wall file pocket. The Director of Senior Services or designee will audit and record results weekly for 3 months or until 100% compliant. Then random audits will be completed. These results will be recorded monthly to Quality Assurance Performance Improvement Committee. Staff educated at All Staff Meeting on	

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F 167	Continued From page 2 confirmed findings of the survey results and stated "it could be lowered." The DON indicated she thought it would be difficult for a resident 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 167	5/4/17 of the importance of the survey being at proper height for access to persons in a wheelchair.	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (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 facility failed to develop a temporary care plan to meet resident needs for weight monitoring in accordance with physician orders for 1 of 2 residents (R52) closed records reviewed. 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	F 281	Resident R52 was a closed record review. For all new admissions, a temporary care plan will be developed on day of admission. Care Plans for all new admissions that were admitted after 3/27/17 were reviewed for accuracy and inclusion of Physician Orders. Admission Policy has been updated to include developing a temporary care plan that is accurate and will reflect new	5/15/17

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F 281	Continued From page 3 heart failure, but did not have any shortness of breath. R52's hospital Discharge Summary dated 10/27/16, included orders for Lasix (medication used to remove fluid from the body) 40 milligrams (mg) orally twice a day and weights to be monitored 2 times weekly. R52's Interagency Transfer Orders dated 10/27/16, included orders for nursing home staff to complete weights twice weekly on R52. R52's facility transcribed Physician's Orders Sheet dated 10/27/16, identified orders for do not resuscitate (DNR), Lasix 40 mg orally twice a day and order for weight 2 X/WEEK [twice a week] to be obtained on Tuesday(s) and Friday(s). 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.	F 281	admission Physician Orders. Admission Checklist was revised to include the development of a temporary care plan that includes specific Physician Order. By 5/15/17 Director of Nurses will provide education to the Admission Team on the importance of accurate Care Plan interventions, which include Physician Orders. All Staff meeting will be held on 05/04/17 to educate on the importance of developing a temporary care plan on the day of admission to include Physician Orders. Information was shared on the deficiency regarding the lack of inclusion of Physician Orders. A Performance Improvement (PI) Audit has been developed to ensure a temporary care plan is developed on admission. This PI will audit for the development of temporary care plans on all new admissions weekly for 3 months or until 100% compliant, then random audits will be completed. These results will be reported monthly to the Quality Assurance/Performance Improvement Committee. This audit will be monitored by Neighborhood Leader or designee.	

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F 281	Continued From page 4 R52's Treatment Sheets (TAR) dated 10/1/16 to 10/31/16, identified an order for 2 X/WEEK [Tues and Fri] WEIGHT" and listed a diagnosis of congestive heart failure. The provided spacing to record a weight on 10/28/16, however, was not completed and left blank. R52's TAR dated 11/1/16 to 11/30/16, lacked documentation of R52's collected weight on 11/1/16 and listed an order for daily weight dated 11/3/16, and only weight documented was on 11/4/16 as 162 (a 5 pound weight gain in 8 days). During interview on 3/29/17, at 2:00 p.m. clinical manager (CM)-A stated she reviewed R52's medical record and R52's weights had not been obtained and monitored in accordance with the physician orders adding, "[It] wasn't done." CM-A stated weight monitoring on a heart failure patient was a, "Nursing standard of practice," and staff, "Didn't follow the order." A facility Intake and Output policy dated 10/15, identified a purpose including, "To help maintain fluid balance," and listed several instructions for staff to follow which included to follow the physician orders. The policy lacked any information or direction on collecting weights for a heart failure patient. No further policies or procedures for weight and/or fluid monitoring were provided.	F 281		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 282		5/9/17

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F 282	Continued From page 5 as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement nutritional interventions related to the provision of calorie dense foods which included super potatoes at noon meal and monitoring and recording meal/supplement intake as directed by the care plan for 1 of 2 (R39) residents who had weight loss. Finding include: R39's care plan dated 3/22/17, identified R39 had the potential for nutritional problems related to dementia and advanced age, would maintain nutritional diet/intake along with maintain/improve weight and consume at least 75% of all solids and liquids and would be free of stomach discomfort after drinking supplement . The care plan listed various interventions which included milk base Ensure was to replace the fruit based supplement, staff were to assist R39 and use spoken menu for choices at meals, assist R39 with tray set-up and food placement, encourage eating, monitor weight and food intake and report to dietary if R39's meal intake fell below 50%. The care plan indicated R39 was to receive a regular diet with calorie dense foods which included super cereal breakfast and super potatoes at noon, whole milk at meals, afternoon and evening snacks and 6 ounces (oz) of fruit drink nutritional supplement morning, afternoon and evening.	F 282	Resident R59 Care Plan was updated to reflect current nutritional approaches. R59 was placed on Food Intake Monitoring via electronic chart. The care plan was updated on 04/24/17. Dietary Manager will review all care plans and update to support the Supporting Residents with Weight Loss Policy and monthly weight monitoring entered into chart. Current nutritional approaches will be reflected in the Care Plan. Weights will be reviewed monthly by the Certified Dietary Manager. The Certified Dietary Manager (CDM) will alert the Consultant Registered Dietitian of any significant weight changes so an assessment may be completed. When a resident is identified as having a significant 5% weight loss in 30 days OR a 10% loss in 180 days, OR a continuing gradual weight loss, the Household Leaders will be alerted by the Certified Dietary Manager. The at-risk resident will be placed on Food Intakes in electronic chart until the condition is deemed stable by the Household Team.	

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F 282	Continued From page 6 During observations on 3/29/17, at 11:32 a.m. homemaker (HM)-A was present in the kitchen setting up for the noon meal. She stated it was the HM's responsibility to ask residents what they wanted to eat and take their meal and drink orders. HM-A stated all residents had a Resident Dining Preferences sheet which was kept in the binder next to the serving area for staff to use. She stated R39 received fruit based nutritional supplements TID from nursing in his room and nursing recorded his intake of the supplements. She stated they didn't have anyone on hi-calorie, hi- protein nutrition interventions. HM-B was also present in the kitchen at that time and confirmed currently there were no residents that received hi-calorie, hi-protein nutrition interventions. -12:11 p.m. nursing assistant (NA)-B walked up to the serving station in the kitchen and stated out loud to HM-A, "R39 is going to eat in his room." NA-B told HM-A to only give him a little bit of meat. HM-A asked NA-B, "Do you think he would like a little hashbrowns, something a little different than mashed potatoes." HM-A put a couple bites of rib meat, hashbrowns and sweet potatoes on R39's plate. HM-A confirmed the serving sizes on R39's plate were the usual serving sizes for R39. NA-B took the plate from HM-A, left the kitchen area and delivered meal to R39's room. Staff failed to provide super potatoes and did not offer him choices of food and fluids. -12:14 p.m. R39 was reclined back in his recliner in his room, covered up to his neck with a plaid quilt. NA-B entered R39's room with meal on tray and set it on R39's tray table in front of the recliner. NA-B removed the white lids from R39's water and milk and applied a clothing protector to	F 282	The first-line of defense to stop the weight loss will be whole foods. These foods include items like but are not limited to: smoothies, malts, favorite foods of the resident, whole milk, cream, ice cream, bakery items, desserts, milk shakes, puddings, extra butter, candy etc. These foods will be offered on a regular basis. Residents with weight loss will be offered these whole foods at meals and between meals by the Household Team. A Whole Foods suggestion list is posted in each neighborhood inside a cupboard door. Residents requiring extra whole foods to stop weight loss or increase weight will be identified on a list inside a cupboard door in every Neighborhood Kitchen. These will be updated monthly by the Certified Dietary Manager. All Staff meeting will be held on 05/04/17 to educate on the importance of updating care plans to meet individual nutritional approaches. A Performance Improvement (PI) Audit has been developed to ensure nutritional approaches in care plans are accurate. This PI will audit 2 care plans per week for 3 months or until 100% compliant, then random audits will be completed. These results will be reported monthly to the Quality Assurance/Performance Improvement Committee. This audit will be monitored by Neighborhood Leader or designee	

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F 282	Continued From page 7	F 282		

cover R39's shirt. NA-B left the tray table out of R39's reach, on the tray table in front of R39's recliner. NA-B left R39's room. NA-B did not inform R39 what foods or beverages he received or describe food placement.

-12:16 p.m. R39 pointed to his food and said, "Look at it." R39 recognized he had meat of some kind, R39 wasn't sure what the other food items were on the plate. R39 stated, "Eeeeeew you can have it, " regarding his foods. R39 did not attempt to eat his meal or beverages.

-12:27 p.m. unit manager (UM-B) entered R39's room and asked him if he was going to eat lunch. R39 replied, "Not today." She told him what was on his plate and R39 stated he didn't want the food items. UM-B offered R39 ice cream and if she could get him anything, R39 replied, "No." She offered R39 his milk in his hand and R39 stated,"No, just leave it there." She stated R39 does this and she would check back later and left his room.

-12:30 p.m. R39 leaned forward and picked up his glass of milk. He consumed all of his milk. After he drank his milk, he started spitting large thick blobs of white phlegm into a trashcan next to his recliner. R39 sat back in the recliner, and dozed off in his recliner. R39 had not drank any of his water or ate any of his food. R39 did not have adequate supervision or encouragement during his meal.

On 3/29/17, at 12:49 p.m. HM-A stated R39 ate in his room about 2/3 of time and came out to the dining room once in a "blue moon." She stated he had not been to the dining room since Sunday. She stated R39 didn't eat much and stated he

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was a good ice cream eater. She stated R39 generally received supplements if he refused a meal or was offered soup and a sandwich later which R39 generally didn't want that or anything. HM-A stated homemaking staff had never recorded meal intakes for R39 She stated she was not aware of special food or textures for R39's meals. She stated R39 liked peanut butter toast, broth and mashed potatoes with butter. She stated R39 did not like meat or hot dishes and stated she thought he drank his supplements.

On 3/29/17, at 1:07 p.m. HM-B stated she did not think R39 had lost any weight and stated R39 liked mashed potatoes, would usually drink milk and broth and would sometimes eat toast with peanut butter and ice cream. She stated staff did not do anything special for R39's meals or give him any special foods. She stated fruit supplements had been offered in the past and stated he never took them. She stated R39 did not like meat or vegetables. She stated she was not aware of any residents who received high-calorie, high-protein interventions.

On 3/29/17, at 2:01 p.m. NA-C stated R39 did not eat good but would drink fluids. She stated he received a fruit supplement 6 times a day and drank it. She stated he would usually eat soup and try to give him decent portions of foods at 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.

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F 282	Continued From page 9 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 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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	F 309		5/8/17

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F 309	Continued From page 10 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. (l) 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 by: Based on interview and document review, the facility failed to provide ongoing weight monitoring in accordance with physician orders to prevent complications related to potential fluid overload for 1 of 2 residents (R52) whose closed record was reviewed.	F 309	Resident R52 was a closed chart review. A review of all resident□s Physician Orders regarding weight monitoring will be reviewed for accuracy of the electronic chart weight recording schedule.	

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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 congestive heart failure. During her hospital course, R52's renal function worsened also and medication adjustments were made and laboratory monitoring done. R52's discharge summary included orders for Lasix (medication used to remove fluid from the body) 40 milligrams (mg) orally twice a day weights to be monitored 2 times weekly. Further, the summary identified R52's weight recorded as 151 lbs (pounds) 14.4 oz (ounces), bilateral one plus lower extremity edema and clear lung sounds. The form listed follow up with physician would be done on routine rounds at the nursing home or sooner as needed. R52's Interagency Transfer Orders dated 10/27/16, identified R52's rehabilitation potential as fair and included orders for nursing home staff to complete weights twice weekly on R52. R52's facility transcribed Physician's Orders Sheet dated 10/27/16, identified orders for do not	F 309	All residents with physician orders to complete weight monitoring will be completed as ordered. Admission Policy has been revised to ensure inclusion of Physician weight monitoring orders. In addition a revision was also made to include Physician ordered weight monitoring into electronic chart for weight recording. All Staff meeting will be held on 05/04/17 to educate on the importance of following Physician Orders for weight monitoring. A Performance Improvement (PI) Audit has been developed to ensure that weight monitoring is being completed as ordered. This PI will audit 6 residents per week for 3 months or until 100% compliant, then random audits will be completed. These results will be reported monthly to the Quality Assurance/Performance Improvement Committee. This audit will be monitored by Neighborhood Leader or designee	

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resuscitate (DNR), Lasix 40 mg orally twice a day and order for weight 2 X/WEEK [twice a week] to be obtained on Tuesday(s) and Friday(s).

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.

R52's Treatment Sheets (TAR) dated 10/1/16 to 10/31/16, identified an order for 2 X/WEEK [Tues and Fri] WEIGHT" and listed a diagnosis of congestive heart failure. The provided spacing to record a weight on 10/28/16, however, was not completed and left blank.

R52's TAR dated 11/1/16 to 11/30/16, lacked documentation of R52's collected weight on 11/1/16 and listed an order for daily weight dated 11/3/16, and only weight documented was on 11/4/16 as 162 (a 5 pound weight gain in 8 days).

Review of R52's progress notes from 10/27/116

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to 11/5/16 revealed the following:

-10/27/16, R52 admitted to facility from hospital with declining health.
-11/3/16, R52's lower legs have three plus pitting edema, and legs about to start weeping. Physician had adjusted dose of Lasix and ordered daily weights at that time.
-11/4/16, R52 stated she was short of breath and had been worsening for the past two days. R52 had fine crackles in left lung, and oxygen applied and an intramuscular injection of Lasix was given per physician order at that time.
-11/4/16, later in the day, family discussion held and discussion made not to hospitalize R52. In addition, the physician again adjusted the Lasix dose for R52.
-11/5/16, R52 expired with family present.

During interview on 3/29/17, at 2:00 p.m. clinical manager (CM)-A stated she reviewed R52's medical record and R52's weights had not been obtained and monitored in accordance with the physician orders adding, "[It] wasn't done." CM-A stated weight monitoring on a heart failure patient was a, "Nursing standard of practice," and staff, "Didn't follow the order."

A facility Intake and Output policy dated 10/15, identified a purpose including, "To help maintain fluid balance," and listed several instructions for staff to follow which included to follow the physician orders. The policy lacked any information or direction on collecting weights for a heart failure patient.

No further policies or procedures for weight and/or fluid monitoring were provided.

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F 322	Continued From page 14	F 322		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (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- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications administered through a gastroenteral tube were administered separately in accordance with facility policy to decrease the risk of adverse effects for 1 of 1 residents (R59) reviewed for feeding tube care. Findings include: R59's admission Minimum Data Set (MDS) dated 2/8/17, identified R59 had moderate cognitive impairment and totally dependent on staff for	F 322	Resident R59 received a physician order on 04/17/17 to receive medications orally. Facility currently does not have any other resident with Gastrostomy Tube. Tube Feeding Administration policy was reviewed/revised on 05/02/17 by Director of Nurses. All Staff meeting will be held on 05/04/17 to educate on the importance of following the policy on medication administration.	5/8/17

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F 322	Continued From page 15 eating, and utilized a feeding tube for nutrition. R59's Physician Order Report signed 3/6/17, identified R59 was to have, "Nothing by mouth," and listed several medication orders including: - Lasix (medication used to reduce fluid in the body) 20 milligrams (mg) orally every day; - Metoprolol (medication used for high blood pressure and chest pain) 2.5 ml by gastric tube twice a day; - Omeprazole oral suspension (medication used for stomach acid) 20 ml (40 mg) by gastric tube twice a day; - Ferrous sulfate (iron supplement) 66 mg (4.4 ml) by gastric tube once a day, and; - Guaifenesin (medication used to thin mucous in the lungs and throat) 400 mg by gastric tube three times a day. The signed Physician Order Report dated 3/6/17, lacked any direction or instruction on the administration of R59's medications, including if the medications were able to be mixed together for administration in the feeding tube. During observation of medication administration on 3/28/17, at 8:36 a.m. registered nurse (RN)-A prepared R59's medications in the hallway outside his room with an orientating nurse (RN-B). RN-A measured and poured the liquid metoprolol, ferrous sulfate and omeprazole into separate medication administration cups and then combined each of them into a small drinking cup. RN-A removed guaifenesin and furosemide	F 322	A Performance Improvement (PI) Audit has been developed to ensure if a resident is admitted or receives a Gastrostomy Tube that the route of medication administration is correct. This PI will audit weekly for 3 months or until 100% compliant on residents who receive medication per Gastrostomy Tube. These results will be reported monthly to the Quality Assurance/Performance Improvement Committee. This audit will be monitored by Neighborhood Nurse Leader.	

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tablets from their packaging, crushed the tablets and proceeded to pour the crushed tablets into the same cup as the prepared liquid medications were in and mixed the medication together using a plastic spoon. RN-A then entered R59's room to administer the medications. RN-A disconnected R59's suspended formula container and auscultated placement of a visible feeding tube going into R59's abdomen, then attached a empty clear plastic syringe to the tube port. RN-A filled the syringe with plain water, allowed it to empty per gravity, then poured the cup of prepared medications into the syringe mixed with water. The medications drained per gravity and RN-A flushed the syringe with additional water before securing the cap on the feeding tube port.

On 3/28/17, at 8:58 a.m. RN-A indicated R59 used a gastroenteral tube (inserted through the abdomen directly into the stomach) for all his nutrition and medication administration since his admission to the facility. RN-A also indicated R59 should not have anything by mouth except, "only with speech therapy." RN-A indicated she mixed the medications together for administration through the tube for, "ease of administration." RN-A reviewed R59's signed physician orders and identified there was no order from the physician directing the medications to be mixed together for administration and stated "not that I see." Further, RN-A indicated she would contact R59's physician and make sure it was acceptable to mix the medications together for administration.

On 3/29/17, at 11:30 a.m. consulting pharmacist (CP) indicated it would be best practice to administer medications separately with water flushes in between and stated "just so that if

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there is any interaction, you take that out of play." CP indicated R59's five administered medications did not have any known interactions if given together, however verified this was not best practice. CP indicated some residents could have difficulty having too much fluid or mixed medications given at once could have potential to clog the feeding tube if administered together. CP indicated although the five administered medications didn't have an increased risk of clogging the tube, didn't mean something could not be added which could have risk in the future. Further, CP indicated an in-service on medication administration through a feeding tube might be of benefit to the facility.

On 3/29/17, at 1:38 p.m. the director of nursing (DON) confirmed tube feeding medications should not be mixed together for administration unless a physician has ordered it, in case the medication administration had to be stopped for any reason, the staff would not know what medications had or had not been administered. Further, the DON stated staff "Should of followed the policy," and administered R59's medications separately through the feeding tube.

Review of the facility policy titled, Tube Feeding Administration policy dated 12/16, identified a purpose for, safe administration of tube feeding and medications, along with ensuring medications will be administered according to standard of practice. The policy identified steps to follow for medication administration by feeding tube including, "do not mix medications together." Administer each medication separately with 30 milliliters (ml) of warm water unless physician order state differently. Further, the policy directed staff to flush the feeding tube with water before

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F 322	Continued From page 18 administering medications, in-between each medication and after the final medication is provided.	F 322		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (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- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement nutritional interventions related to the provision of calorie dense foods which included super potatoes at noon meal and monitoring and recording meal/supplement intake in order to prevent further weight loss for 1 of 2 (R39) residents reviewed for significant weight loss. Findings include: Review of R39's Diagnoses Report dated 3/1/17,	F 325	Resident R39 continues to receive high calorie nutritional interventions to maintain or improve nutritional status. Meal intakes are being recorded at all 3 meals. Nutritional supplement intakes are being recorded also. Weight Loss policy has been developed by Dietitian. Dietary Manager will review all care plans. Monthly weight monitoring will be	5/9/17

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F 325	Continued From page 19 identified R39 had dementia, chronic lymphocytic leukemia, myalgia (muscle pain), intestinal carbohydrate absorption disorder and constipation. R39's annual Minimum Data Set (MDS) dated 11/7/16, identified R39 had severe cognitive impairment. The MDS further indicated R39 was 73 inches (in) and weighed 152#, had no weight loss, was independent with eating, had no eating problems and had no alterations to his diet. R39's significant change MDS dated 1/30/17, identified R39 had severe cognitive impairment. The MDS further indicated R39 was 73 inches (in) and weighed 141#, had significant weight loss, required supervision with eating, had no eating problems and had no alterations to his diet. R39's Care Area Assessment (CAA) dated 1/30/17, identified R39 had an increased dependence with activities of daily living (ADLs) related to weakness, limited range of motion, poor coordination, visual impairment and pain. The CAA further indicated R39 required set-up assistance, supervision, cueing and encouragement with eating and had an unplanned significant weight loss. The CAA failed to identify R39's current eating pattern, functional limitations, mental problems, communication problems, dental problems, diseases, labs or medications which could affect R39's appetite and nutritional needs. The CAA indicated R39 had no appetite, consumed small portions of foods, sometimes refused his favorite foods and staff were to offer foods 1-2 hours after he refused to eat.	F 325	reviewed by Dietary Manager who will follow the Supporting Residents with Weight Loss Policy. After reviewing all residents, those identified with significant weight loss have been placed on meal intake monitoring. All Staff meeting will be held on 05/04/17 to educate on the Weight Loss Policy and the importance of monitoring the intakes of meals and supplements. A Performance Improvement (PI) Audit has been developed to ensure meal and supplement intakes are being recorded. This PI audit will monitor the intake record of a different resident□ each week who has been identified as needing intervention to ensure completion, for 3 months or until 100% compliant, then random audits will be completed. These results will be reported monthly to the Quality Assurance/Performance Improvement Committee. This audit will be monitored by Neighborhood Leader or designee.	

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R39's care plan dated 3/22/17, identified R39 had the potential for nutritional problems related to dementia and advanced age, would maintain nutritional diet/intake along with maintain/improve weight and consume at least 75% of all solids and liquids and would be free of stomach discomfort after drinking supplement . The care plan listed various interventions which included milk base Ensure was to replace the fruit based supplement, staff were to assist R39 and use spoken menu for choices at meals, assist R39 with tray set-up and food placement, encourage eating, monitor weight and food intake and report to dietary if R39's meal intake fell below 50%. The care plan indicated R39 was to receive a regular diet with calorie dense foods which included super cereal breakfast and super potatoes at noon, whole milk at meals, afternoon and evening snacks and 6 ounces (oz) of fruit drink nutritional supplement morning, afternoon and evening.

During observations on 3/29/17, at 11:32 a.m. homemaker (HM)-A was present in the kitchen setting up for the noon meal. She stated it was the HM's responsibility to ask residents what they wanted to eat and take their meal and drink orders. HM-A stated all residents had a Resident Dining Preferences sheet which was kept in the binder next to the serving area for staff to use. She stated R39 received fruit based nutritional supplements TID from nursing in his room and nursing recorded his intake of the supplements. She stated they didn't have anyone on hi-calorie, hi- protein nutrition interventions. HM-B was also present in the kitchen at that time and confirmed currently there were no residents that received hi-calorie, hi-protein nutrition interventions.

-12:11 p.m. nursing assistant (NA)-B walked up to

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the serving station in the kitchen and stated out loud to HM-A, "R39 is going to eat in his room." NA-B told HM-A to only give him a little bit of meat. HM-A asked NA-B, "Do you think he would like a little hashbrowns, something a little different than mashed potatoes." HM-A put a couple bites of rib meat, hashbrowns and sweet potatoes on R39's plate. HM-A confirmed the serving sizes on R39's plate were the usual serving sizes for R39. NA-B took the plate from HM-A, left the kitchen area and delivered meal to R39's room. Staff failed to provide super potatoes and did not offer him choices of food and fluids.

-12:14 p.m. R39 was reclined back in his recliner in his room, covered up to his neck with a plaid quilt. NA-B entered R39's room with meal on tray and set it on R39's tray table in front of the recliner. NA-B removed the white lids from R39's water and milk and applied a clothing protector to cover R39's shirt. NA-B left the tray table out of R39's reach, on the tray table in front of R39's recliner. NA-B left R39's room. NA-B did not inform R39 what foods or beverages he received or describe food placement.

-12:16 p.m. R39 pointed to his food and said, "Look at it." R39 recognized he had meat of some kind, R39 wasn't sure what the other food items were on the plate. R39 stated, "Eeeeeew you can have it, " regarding his foods. R39 did not attempt to eat his meal or beverages.

-12:27 p.m. unit manager (UM-B) entered R39's room and asked him if he was going to eat lunch. R39 replied, "Not today." She told him what was on his plate and R39 stated he didn't want the food items. UM-B offered R39 ice cream and if she could get him anything, R39 replied, "No."

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She offered R39 his milk in his hand and R39 stated,"No, just leave it there." She stated R39 does this and she would check back later and left his room.

-12:30 p.m. R39 leaned forward and picked up his glass of milk. He consumed all of his milk. After he drank his milk, he started spitting large thick blobs of white phlegm into a trashcan next to his recliner. R39 sat back in the recliner, and dozed off in his recliner. R39 had not drank any of his water or ate any of his food. R39 did not have adequate supervision or encouragement during his meal.

R39"s current Physician Order Report dated 3/1/17, identified R39 was on a regular diet. The Report failed to include any other nutritional orders.

R39's Nutritional Evaluation History and Data Collection form dated 11/8/16 identified R39's weight was relatively stable overall but a weight gain of 10-15# would be beneficial as R39 was underweight based on his body mass index (BMI) and R39 had a fair meal intake in the main dining room.

Review of R39's weight records from 10/1/17, to 3/28/17, identified R39 had a significant weight loss over 30 days from 12/15/16 to 1/12/17 or 5.9% of his body weight. R39's weekly weight record revealed the following weight loss trend, which included R39 sustained further weight loss of 2.9% over the last 12 days:

-3/28/17 weight 136 lbs

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-3/16/17 weight 140 lbs

-3/2/17 weight 136.9 lbs

-3/16/17 weight 140 lbs

-2/23/17 weight 142.6 lbs

-1/26/17 weight 141.3 lbs

-1/12/17 weight 143 lbs

-12/22/16 weight 144.2 lbs

-12/15/16 weight 150.8 lbs

Review of R39's meal intake records from 10/1/16, to 3/19/17, revealed the following:

-10/1/16 to 10/31/16, R39 refused or consumed 0% of his breakfast meals or lunch and supper entrees and meats. The record further indicated R39 did not receive nutritional supplement and consumed all of his super mashed potatoes.

-11/1/16 to 11/30/16, R39 refused or consumed 0% of his breakfast meals or lunch and supper entrees and meats. The record further indicated R39 did not receive nutritional supplement and consumed at least 50% super mashed potatoes 14/31 noon meals. The record failed to identify R39's intake of super mashed potatoes for 4 days.

-12/1/16 to 12/31/16, R39 refused or consumed 0% of his breakfast, meats at lunch and minimal to none of entrees at supper. The record further indicated R39 did not receive nutritional supplement and consumed all of his super

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mashed potatoes.

-1/1/17 to 1/31/17, R39 had incomplete meal intake records and identified R39 consumed all of his desserts, milk, water and super mashed potatoes. The record did not identify if R39 received a nutritional supplement.

-2/1/17 to 2/28/17, R39 had incomplete meal intake records and identified R39 consumed all of his desserts, milk, water and super mashed potatoes. The record did not identify if R39 received a nutritional supplement.

-3/1/17 to 3/19/17, R39 had incomplete meal intake records and identified R39 consumed all of his desserts, milk, water and super mashed potatoes. The facility failed to record R39's meal intake after 3/19/17, and did not identify if R39 received a nutritional supplement.

Review of R39's Medication Administration History (MAR) from 1/1/17 to 3/30/17 revealed R39 had received Prostat (protein powder supplement) twice a day on 2/3/17 , 2/4/17, 2/5/17 and 2/6/17 and consumed varying percentages(%) from 1- 25 % to 75-100%. No further documentation of the Prostat was found on the MARs.

Review of 31's Treatment Adminsitration History forms from 1/1/17, to 3/30/17, revealed the following nutritional supplement intake.

1/1/17 to 1/31/17, the form did not identify any nutritional supplements had been offered or given to R39 for the month.

2/1/17 to 1/28/17, the form did not identify any

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nutritional supplements had been offered or given to R39 for the month.

3/1/17 to 3/30/17, the form did not identify R39 received or been offered any nutritional supplements until 3/29/17, when an order for a supplement was started for three times a day. Documentation indicated R39 had received the supplement three times on 3/29/17 and once on 3/30/17, and had consumed 75-100% each time.

Review of R39's progress notes from 11/7/16 to 3/29/17 revealed:

-11/7/16, indicated R39's annual review was completed this date by the certified dietary manager (CDM) and identified R39 was on a regular diet and received super cereal and super potatoes, and 6 oz's of fruit drink supplement TID. The note further indicated R39 would make his own choices using the spoken menu and R39's current weight was 152 lbs and R39 had lost 9 lbs over the last year. The note identified R39 would have his meals in the main dining room for noon and evening and indicated R39 usually ate breakfast in his room or activities room.

-1/25/17, indicated R39 was assessed this date for nutritional risk. The note further indicated R39 was gradually losing weight, his current weight was 144 lbs, which was down from 151 lbs last month and R39 had lost 11 lbs over the last 90 days. The note identified R39 was to receive a regular diet with high calorie interventions of super cereal, double portion of toast with jelly at breakfast, super mashed potatoes at noon and fruit based nutritional supplement 3 times per day between meals and was to provided by nursing.

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The note further indicated family brought in goodies, they would encourage family to eat with resident in hope of increasing his intake and continue to assess.

-1/30/17, indicated registered dietitian (RD) spoke with R39's daughter and staff would offer R39 a small snack 1-2 hours after meals if he refused and dietary could hold a small sampling of the regular meal and take it to his room after a meal refusal. The note further indicated R39's identified R39's favorite foods which included peanut butter and jelly toast, ice cream, fruit sauce, and apple flavored nutritional supplement.

-2/9/17, indicated R39 refused protein supplement and they would continue with other high calorie interventions. The note further indicated R39's last weight was 141# and gradual weight gain was desired for R39 and new interventions were put in place to promote increased intake.

Review of the current Resident Dining Preferences form provided by the facility, utilized as homemaker reference for resident diets and interventions, identified R39's food preferences included cold breakfast cereal and white toast with peanut butter and jelly, his favorite meal was dinner, he had no food dislikes, received orange juice, milk and water for breakfast and milk and water for lunch and supper. The form further indicated R39 had high calorie-protein interventions to maintain weight. The facility failed to identify R39 required whole milk and did not identify what high-calorie, high-protein interventions were required for R30 and assistive devices or methods to improve ability to fed

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himself and other related nutrition information was left blank.

On 3/29/17, at 12:49 p.m. HM-A stated R39 ate in his room about 2/3 of time and came out to the dining room once in a "blue moon." She stated he had not been to the dining room since Sunday. She stated R39 didn't eat much and stated he was a good ice cream eater. She stated R39 generally received supplements if he refused a meal or was offered soup and a sandwich later which R39 generally didn't want that or anything. HM-A stated homemaking staff had never recorded meal intakes for R39 She stated she was not aware of special food or textures for R39's meals. She stated R39 liked peanut butter toast, broth and mashed potatoes with butter. She stated R39 did not like meat or hot dishes and stated she thought he drank his supplements.

On 3/29/17, at 1:07 p.m. HM-B stated she did not think R39 had lost any weight and stated R39 liked mashed potatoes, would usually drink milk and broth and would sometimes eat toast with peanut butter and ice cream. She stated staff did not do anything special for R39's meals or give him any special foods. She stated fruit supplements had been offered in the past and stated he never took them. She stated R39 did not like meat or vegetables. She stated she was not aware of any residents who received high-calorie, high-protein interventions.

On 3/29/17, at 2:01 p.m. NA-C stated R39 did not eat good but would drink fluids. She stated he received a fruit supplement 6 times a day and drank it. She stated he would usually eat soup and try to give him decent portions of foods at

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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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F 325	Continued From page 29 A facility policy for weight loss was requested 3/30/17. The facility failed to provide a policy.	F 325		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 356		5/9/17

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F 356	Continued From page 30 (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required daily staffing information which included daily census in the facility. This had the potential to affect all visitors to the facility in addition to the 48 residents residing in the facility. Findings include: during observations on 3/27/17, at 1:37 p.m. the facility nursing staff posting was in the main entrance on the wall and was placed in a clear plastic self mounted to the wall. The nursing staff posting was dated 3/26/17 and did not include the current census. At 7:40 p.m., the required nursing staff posting remained the daily posting dated 3/26/17 and did not include the facility census. Review of the facility nursing hour postings dated 3/15/17 - 3/29/17 revealed the facility census had not been included on 12 of the 15 days reviewed. On 3/29/17 at 9:30 a.m. director of nursing (DON)	F 356	Posting of daily staffing information will be completed daily including census. Daily Nurse Staffing Form Policy has been revised by Director of Nurses to include census. All Staff meeting will be held on 05/04/17 to educate on the Daily Nurse Staffing Form Policy and the importance of completing daily nurse staffing form. A Performance Improvement (PI) Audit has been developed to ensure daily nurse staffing form is completed and posted daily. This PI will audit one time per week for 3 months or until 100% compliant, then random audits will be completed. These results will be reported monthly to the Quality Assurance/Performance Improvement Committee. This audit will be monitored by Director of Nurses or designee.	

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F 356	Continued From page 31 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 356		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE 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	F 465	On 03/31/17 Resident R25 was fitted for	5/9/17

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F 465	Continued From page 32 review the facility failed to ensure resident care equipment was kept in a clean and sanitary condition for 1 of 1 residents (R25) observed to have a wheelchair seat in disrepair. Findings include: R25's quarterly Minimum Data Set (MDS) dated 3/13/17, identified R25 had frequent urinary and bowel incontinence and used a wheelchair for a mobility device. R25's care plan dated 7/26/16, indicated R25 had frequent incontinent episodes of bowel and bladder as evidenced by saturation of incontinent products. The care plan indicated R25 required extensive assistance of one staff for toileting needs, and directed staff to offer R25 toileting assistance as often as possible, at least every two hours, to prevent urinate in inappropriate places. The care plan indicated R25 required a wheelchair for locomotion, and was able to propel the wheelchair independently throughout the facility. During observation on 3/27/17, at 5:30 p.m. R25 was seated in his wheelchair in the hallway. The wheelchair seat had a blue vinyl type covering, however, the front edge of the seat was tattered and worn away exposing a light yellow fabric. The tattered area on the seat was approximately 6 inches long and 2 inches wide. On 3/30/17, at 12:40 p.m. R25's wheelchair seat remained tattered with light yellow fabric exposed. On 3/30/17, at 11:19 a.m. nursing assistant (NA)-A reported R25 was incontinent of bowel and bladder and wore an incontinent product at all times. NA-A observed R25's tattered	F 465	a new wheelchair by Occupational Therapy. All wheelchairs will be assessed weekly for disrepair at Neighborhood□s weekly wheelchair cleaning. Any wheelchairs found in need of repair will be reported to Neighborhood Leader. All Staff meeting will be held on 05/04/17 to educate on the importance of keeping equipment in clean and sanitary condition and free from disrepair. A Performance Improvement (PI) Audit has been developed to ensure equipment in clean and sanitary condition and free from disrepair. This PI will audit 2 wheelchairs per week for 3 months or until 100% compliant, then random audits will be completed. These results will be reported monthly to the Quality Assurance/Performance Improvement Committee. This audit will be monitored by Neighborhood Leader or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	03/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW NEIGHBORHOODS	201 MARK DRIVE ORTONVILLE, MN 56278

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F 465	Continued From page 33	F 465		

wheelchair seat and stated the wheelchair seat had exposed padding for a couple of months, and stated the therapy department was aware and was trying to get a new chair for R25. NA-A stated R25's wheelchair seat had been saturated with urine before, and stated R25 at times will go to the bathroom in inappropriate places such as the hallway. NA-A stated staff had tried to wipe down the wheelchair seat when it was soiled, and stated the wheelchair seat was hard to clean due to the missing covering. Further, NA-A stated the night shift staff was responsible to clean the resident care equipment every two weeks.

On 3/30/17, at 12:12 p.m. the director of nursing (DON) reported when staff identify damaged resident care equipment, therapy was to be updated so they can get equipment repaired or replaced, especially wheelchairs.

On 3/30/17, at 12:32 p.m. clinical manger (CM)-A confirmed she was not aware of R25's wheelchair seat condition. CM-A confirmed R25 was incontinent of bowel and bladder and wore an incontinent product at all times. CM-A stated R25 could not verbalize his needs to go the bathroom and had been known in the past to urinate in wastebaskets and in corners. CM-A stated if she would have known about the wheelchair seat, it would have been replaced. CM-A confirmed due to R25's incontinence and inappropriate voiding, the wheelchair seat was no longer a cleanable surface.

On 3/30/17, at 1:03 p.m. the director of senior services (DSS) confirmed the therapy department was not aware of R25's wheelchair seat being in disrepair, and confirmed nothing had been ordered to fix or replace the wheelchair seat. The

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	245451	A. BUILDING _____ B. WING _____	03/30/2017

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FAIRWAY VIEW NEIGHBORHOODS	**201 MARK DRIVE ORTONVILLE, MN 56278**

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F 465	Continued From page 34 DSS stated staff were expected to communicate with the therapy department when resident equipment issues are identified. A policy for resident care equipment maintenance was requested, but not provided.	F 465		

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	245451	A. BUILDING **02 - FAIRWAY VIEW NEIGHBORHOODS** B. WING _____	**01/04/2017**

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FAIRWAY VIEW NEIGHBORHOODS	**201 MORK DRIVE ORTONVILLE, MN 56278**

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K 000	INITIAL COMMENTS FIRE SAFETY An Initial Life Safety Code Certification Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 04, 2017. At the time of this survey, Fairway View Neighborhoods was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Fairway View Neighborhoods was built in 2016 under the LSC 2000 Regulations, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 0 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.

MDH
Minnesota
Department
of Health

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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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

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, **you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us**.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00771	A. BUILDING: _____ B. WING _____	03/30/2017

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FAIRWAY VIEW NEIGHBORHOODS	201 MARK DRIVE ORTONVILLE, MN 56278

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 3/27/17, 3/28/17, 3/29/17, 3/30/17 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		4/27/17

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2 302	Continued From page 3 Based on interview, and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. This had the potential to affect all 48 residents and their families. Findings include: During a review of the facility's Alzheimer's training program, there was no information or documentation that indicated that the consumers (resident and families) were provided a description of Alzheimer's training program, categories of employees trained, frequency of training and the basic topics covered. On 3/30/17 at 1:21 p.m. director of nursing (DON) verified the facility did not provide information in regards to Alzheimer's/dementia to consumers and their families. The DON stated the licensed social worker (SW) met with families on admission and was unaware of the training. She stated "they have nothing, yes we should be doing it if we have too." On 3/30/17 at 1:23 p.m. SW reviewed the facility admission packet and found no documentation in regards to providing information to the consumers and their families in regards to Alzheimer's/dementia training and indicated she did not talk to consumers about it. On 3/30/17 at 1:30 requested policy on Alzheimer's training, one was not provided. SUGGESTED METHOD OF CORRECTION:	2 302	This has been corrected.	

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2 302	Continued From page 4 The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information. The DON or designee could educate staff about this requirement and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide ongoing weight monitoring in accordance with physician orders to prevent complications related to potential fluid overload for 1 of 2 residents (R52) whose closed record was reviewed. Findings include:	2 830	This has been corrected.	4/27/17

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2 830	Continued From page 5 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 congestive heart failure. During her hospital course, R52's renal function worsened also and medication adjustments were made and laboratory monitoring done. R52's discharge summary included orders for Lasix (medication used to remove fluid from the body) 40 milligrams (mg) orally twice a day weights to be monitored 2 times weekly. Further, the summary identified R52's weight recorded as 151 lbs (pounds) 14.4 oz (ounces), bilateral one plus lower extremity edema and clear lung sounds. The form listed follow up with physician would be done on routine rounds at the nursing home or sooner as needed. R52's Interagency Transfer Orders dated 10/27/16, identified R52's rehabilitation potential as fair and included orders for nursing home staff to complete weights twice weekly on R52. R52's facility transcribed Physician's Orders Sheet dated 10/27/16, identified orders for do not resuscitate (DNR), Lasix 40 mg orally twice a day and order for weight 2 X/WEEK [twice a week] to be obtained on Tuesday(s) and Friday(s).	2 830		

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2 830	Continued From page 6 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. R52's Treatment Sheets (TAR) dated 10/1/16 to 10/31/16, identified an order for 2 X/WEEK [Tues and Fri] WEIGHT" and listed a diagnosis of congestive heart failure. The provided spacing to record a weight on 10/28/16, however, was not completed and left blank. R52's TAR dated 11/1/16 to 11/30/16, lacked documentation of R52's collected weight on 11/1/16 and listed an order for daily weight dated 11/3/16, and only weight documented was on 11/4/16 as 162 (a 5 pound weight gain in 8 days). Review of R52's progress notes from 10/27/116 to 11/5/16 revealed the following: -10/27/16, R52 admitted to facility from hospital with declining health.	2 830		

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2 830	Continued From page 7 -11/3/16, R52's lower legs have three plus pitting edema, and legs about to start weeping. Physician had adjusted dose of Lasix and ordered daily weights at that time. -11/4/16, R52 stated she was short of breath and had been worsening for the past two days. R52 had fine crackles in left lung, and oxygen applied and an intramuscular injection of Lasix was given per physician order at that time. -11/4/16, later in the day, family discussion held and discussion made not to hospitalize R52. In addition, the physician again adjusted the Lasix dose for R52. -11/5/16, R52 expired with family present. During interview on 3/29/17, at 2:00 p.m. clinical manager (CM)-A stated she reviewed R52's medical record and R52's weights had not been obtained and monitored in accordance with the physician orders adding, "[It] wasn't done." CM-A stated weight monitoring on a heart failure patient was a, "Nursing standard of practice," and staff, "Didn't follow the order." A facility Intake and Output policy dated 10/15, identified a purpose including, "To help maintain fluid balance," and listed several instructions for staff to follow which included to follow the physician orders. The policy lacked any information or direction on collecting weights for a heart failure patient. No further policies or procedures for weight and/or fluid monitoring were provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure individual resident needs are met based on comprehensive assessment. The director of nursing or her	2 830		

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2 830	Continued From page 8 designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications administered through a gastroenteral tube were administered separately in accordance with facility policy to decrease the risk of adverse effects for 1 of 1 residents (R59) reviewed for feeding tube care. Findings include:	2 930	This has been corrected.	4/27/17

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2 930	Continued From page 9 R59's admission Minimum Data Set (MDS) dated 2/8/17, identified R59 had moderate cognitive impairment and totally dependent on staff for eating, and utilized a feeding tube for nutrition. R59's Physician Order Report signed 3/6/17, identified R59 was to have, "Nothing by mouth," and listed several medication orders including: - Lasix (medication used to reduce fluid in the body) 20 milligrams (mg) orally every day; - Metoprolol (medication used for high blood pressure and chest pain) 2.5 ml by gastric tube twice a day; - Omeprazole oral suspension (medication used for stomach acid) 20 ml (40 mg) by gastric tube twice a day; - Ferrous sulfate (iron supplement) 66 mg (4.4 ml) by gastric tube once a day, and; - Guaifenesin (medication used to thin mucous in the lungs and throat) 400 mg by gastric tube three times a day. The signed Physician Order Report dated 3/6/17, lacked any direction or instruction on the administration of R59's medications, including if the medications were able to be mixed together for administration in the feeding tube. During observation of medication administration on 3/28/17, at 8:36 a.m. registered nurse (RN)-A prepared R59's medications in the hallway outside his room with an orientating nurse (RN-B). RN-A measured and poured the liquid metoprolol, ferrous sulfate and omeprazole into	2 930		

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2 930	Continued From page 10	2 930		

separate medication administration cups and then combined each of them into a small drinking cup. RN-A removed guaifenesin and furosemide tablets from their packaging, crushed the tablets and proceeded to pour the crushed tablets into the same cup as the prepared liquid medications were in and mixed the medication together using a plastic spoon. RN-A then entered R59's room to administer the medications. RN-A disconnected R59's suspended formula container and auscultated placement of a visible feeding tube going into R59's abdomen, then attached a empty clear plastic syringe to the tube port. RN-A filled the syringe with plain water, allowed it to empty per gravity, then poured the cup of prepared medications into the syringe mixed with water. The medications drained per gravity and RN-A flushed the syringe with additional water before securing the cap on the feeding tube port.

On 3/28/17, at 8:58 a.m. RN-A indicated R59 used a gastroenteral tube (inserted through the abdomen directly into the stomach) for all his nutrition and medication administration since his admission to the facility. RN-A also indicated R59 should not have anything by mouth except, "only with speech therapy." RN-A indicated she mixed the medications together for administration through the tube for, "ease of administration." RN-A reviewed R59's signed physician orders and identified there was no order from the physician directing the medications to be mixed together for administration and stated "not that I see." Further, RN-A indicated she would contact R59's physician and make sure it was acceptable to mix the medications together for administration.

On 3/29/17, at 11:30 a.m. consulting pharmacist (CP) indicated it would be best practice to

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2 930	Continued From page 11 administer medications separately with water flushes in between and stated "just so that if there is any interaction, you take that out of play." CP indicated R59's five administered medications did not have any known interactions if given together, however verified this was not best practice. CP indicated some residents could have difficulty having too much fluid or mixed medications given at once could have potential to clog the feeding tube if administered together. CP indicated although the five administered medications didn't have an increased risk of clogging the tube, didn't mean something could not be added which could have risk in the future. Further, CP indicated an in-service on medication administration through a feeding tube might be of benefit to the facility. On 3/29/17, at 1:38 p.m. the director of nursing (DON) confirmed tube feeding medications should not be mixed together for administration unless a physician has ordered it, in case the medication administration had to be stopped for any reason, the staff would not know what medications had or had not been administered. Further, the DON stated staff "Should of followed the policy," and administered R59's medications separately through the feeding tube. Review of the facility policy titled, Tube Feeding Administration policy dated 12/16, identified a purpose for, safe administration of tube feeding and medications, along with ensuring medications will be administered according to standard of practice. The policy identified steps to follow for medication administration by feeding tube including, "do not mix medications together." Administer each medication separately with 30 milliliters (ml) of warm water unless physician order state differently. Further, the policy directed	2 930		

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2 930	Continued From page 12 staff to flush the feeding tube with water before administering medications, in-between each medication and after the final medication is provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could review the policies and procedures for the administration of medications through the Gastrostomy Tube and could provide ongoing staff training regarding the administration of medications through the tube. Ongoing audits of the procedure for all licensed staff could be performed to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 930		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement nutritional interventions related to the provision of calorie dense foods which included super potatoes at noon meal and monitoring and recording	2 965	This has been corrected.	4/27/17

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2 965	Continued From page 13	2 965		

meal/supplement intake in order to prevent further weight loss for 1 of 2 (R39) residents reviewed for significant weight loss.

Findings include:

Review of R39's Diagnoses Report dated 3/1/17, identified R39 had dementia, chronic lymphocytic leukemia, myalgia (muscle pain), intestinal carbohydrate absorption disorder and constipation.

R39's annual Minimum Data Set (MDS) dated 11/7/16, identified R39 had severe cognitive impairment. The MDS further indicated R39 was 73 inches (in) and weighed 152#, had no weight loss, was independent with eating, had no eating problems and had no alterations to his diet.

R39's significant change MDS dated 1/30/17, identified R39 had severe cognitive impairment. The MDS further indicated R39 was 73 inches (in) and weighed 141#, had significant weight loss, required supervision with eating, had no eating problems and had no alterations to his diet.

R39's Care Area Assessment (CAA) dated 1/30/17, identified R39 had an increased dependence with activities of daily living (ADLs) related to weakness, limited range of motion, poor coordination, visual impairment and pain. The CAA further indicated R39 required set-up assistance, supervision, cueing and encouragement with eating and had an unplanned significant weight loss. The CAA failed to identify R39's current eating pattern, functional limitations, mental problems, communication problems, dental problems, diseases, labs or medications which could affect R39's appetite

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2 965	Continued From page 14	2 965		

and nutritional needs. The CAA indicated R39 had no appetite, consumed small portions of foods, sometimes refused his favorite foods and staff were to offer foods 1-2 hours after he refused to eat.

R39's care plan dated 3/22/17, identified R39 had the potential for nutritional problems related to dementia and advanced age, would maintain nutritional diet/intake along with maintain/improve weight and consume at least 75% of all solids and liquids and would be free of stomach discomfort after drinking supplement . The care plan listed various interventions which included milk base Ensure was to replace the fruit based supplement, staff were to assist R39 and use spoken menu for choices at meals, assist R39 with tray set-up and food placement, encourage eating, monitor weight and food intake and report to dietary if R39's meal intake fell below 50%. The care plan indicated R39 was to receive a regular diet with calorie dense foods which included super cereal breakfast and super potatoes at noon, whole milk at meals, afternoon and evening snacks and 6 ounces (oz) of fruit drink nutritional supplement morning, afternoon and evening.

During observations on 3/29/17, at 11:32 a.m. homemaker (HM)-A was present in the kitchen setting up for the noon meal. She stated it was the HM's responsibility to ask residents what they wanted to eat and take their meal and drink orders. HM-A stated all residents had a Resident Dining Preferences sheet which was kept in the binder next to the serving area for staff to use. She stated R39 received fruit based nutritional supplements TID from nursing in his room and nursing recorded his intake of the supplements. She stated they didn't have anyone on hi-calorie, hi- protein nutrition interventions. HM-B was also

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2 965	Continued From page 15	2 965		

present in the kitchen at that time and confirmed currently there were no residents that received hi-calorie, hi-protein nutrition interventions.

-12:11 p.m. nursing assistant (NA)-B walked up to the serving station in the kitchen and stated out loud to HM-A, "R39 is going to eat in his room." NA-B told HM-A to only give him a little bit of meat. HM-A asked NA-B, "Do you think he would like a little hashbrowns, something a little different than mashed potatoes." HM-A put a couple bites of rib meat, hashbrowns and sweet potatoes on R39's plate. HM-A confirmed the serving sizes on R39's plate were the usual serving sizes for R39. NA-B took the plate from HM-A, left the kitchen area and delivered meal to R39's room. Staff failed to provide super potatoes and did not offer him choices of food and fluids.

-12:14 p.m. R39 was reclined back in his recliner in his room, covered up to his neck with a plaid quilt. NA-B entered R39's room with meal on tray and set it on R39's tray table in front of the recliner. NA-B removed the white lids from R39's water and milk and applied a clothing protector to cover R39's shirt. NA-B left the tray table out of R39's reach, on the tray table in front of R39's recliner. NA-B left R39's room. NA-B did not inform R39 what foods or beverages he received or describe food placement.

-12:16 p.m. R39 pointed to his food and said, "Look at it." R39 recognized he had meat of some kind, R39 wasn't sure what the other food items were on the plate. R39 stated, "Eeeeeew you can have it, " regarding his foods. R39 did not attempt to eat his meal or beverages.

-12:27 p.m. unit manager (UM-B) entered R39's room and asked him if he was going to eat lunch.

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2 965	Continued From page 16 R39 replied, "Not today." She told him what was on his plate and R39 stated he didn't want the food items. UM-B offered R39 ice cream and if she could get him anything, R39 replied, "No." She offered R39 his milk in his hand and R39 stated,"No, just leave it there." She stated R39 does this and she would check back later and left his room. -12:30 p.m. R39 leaned forward and picked up his glass of milk. He consumed all of his milk. After he drank his milk, he started spitting large thick blobs of white phlegm into a trashcan next to his recliner. R39 sat back in the recliner, and dozed off in his recliner. R39 had not drank any of his water or ate any of his food. R39 did not have adequate supervision or encouragement during his meal. R39"s current Physician Order Report dated 3/1/17, identified R39 was on a regular diet. The Report failed to include any other nutritional orders. R39's Nutritional Evaluation History and Data Collection form dated 11/8/16 identified R39's weight was relatively stable overall but a weight gain of 10-15# would be beneficial as R39 was underweight based on his body mass index (BMI) and R39 had a fair meal intake in the main dining room. Review of R39's weight records from 10/1/17, to 3/28/17, identified R39 had a significant weight loss over 30 days from 12/15/16 to 1/12/17 or 5.9% of his body weight. R39's weekly weight record revealed the following weight loss trend, which included R39 sustained further weight loss of 2.9% over the last 12 days:	2 965		

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2 965	Continued From page 17 -3/28/17 weight 136 lbs -3/16/17 weight 140 lbs -3/2/17 weight 136.9 lbs -3/16/17 weight 140 lbs -2/23/17 weight 142.6 lbs -1/26/17 weight 141.3 lbs -1/12/17 weight 143 lbs -12/22/16 weight 144.2 lbs -12/15/16 weight 150.8 lbs Review of R39's meal intake records from 10/1/16, to 3/19/17, revealed the following: -10/1/16 to 10/31/16, R39 refused or consumed 0% of his breakfast meals or lunch and supper entrees and meats. The record further indicated R39 did not receive nutritional supplement and consumed all of his super mashed potatoes. -11/1/16 to 11/30/16, R39 refused or consumed 0% of his breakfast meals or lunch and supper entrees and meats. The record further indicated R39 did not receive nutritional supplement and consumed at least 50% super mashed potatoes 14/31 noon meals. The record failed to identify R39's intake of super mashed potatoes for 4 days. -12/1/16 to 12/31/16, R39 refused or consumed 0% of his breakfast, meats at lunch and minimal to none of entrees at supper. The record further	2 965		

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2 965	Continued From page 18 indicated R39 did not receive nutritional supplement and consumed all of his super mashed potatoes. -1/1/17 to 1/31/17, R39 had incomplete meal intake records and identified R39 consumed all of his desserts, milk, water and super mashed potatoes. The record did not identify if R39 received a nutritional supplement. -2/1/17 to 2/28/17, R39 had incomplete meal intake records and identified R39 consumed all of his desserts, milk, water and super mashed potatoes. The record did not identify if R39 received a nutritional supplement. -3/1/17 to 3/19/17, R39 had incomplete meal intake records and identified R39 consumed all of his desserts, milk, water and super mashed potatoes. The facility failed to record R39's meal intake after 3/19/17, and did not identify if R39 received a nutritional supplement. Review of R39's Medication Administration History (MAR) from 1/1/17 to 3/30/17 revealed R39 had received Prostat (protein powder supplement) twice a day on 2/3/17 , 2/4/17, 2/5/17 and 2/6/17 and consumed varying percentages(%) from 1- 25 % to 75-100%. No further documentation of the Prostat was found on the MARs. Review of 31's Treatment Adminsitration History forms from 1/1/17, to 3/30/17, revealed the following nutritional supplement intake. 1/1/17 to 1/31/17, the form did not identify any nutritional supplements had been offered or given to R39 for the month.	2 965		

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2 965	Continued From page 19 2/1/17 to 1/28/17, the form did not identify any nutritional supplements had been offered or given to R39 for the month. 3/1/17 to 3/30/17, the form did not identify R39 received or been offered any nutritional supplements until 3/29/17, when an order for a supplement was started for three times a day. Documentation indicated R39 had received the supplement three times on 3/29/17 and once on 3/30/17, and had consumed 75-100% each time. Review of R39's progress notes from 11/7/16 to 3/29/17 revealed: -11/7/16, indicated R39's annual review was completed this date by the certified dietary manager (CDM) and identified R39 was on a regular diet and received super cereal and super potatoes, and 6 oz's of fruit drink supplement TID. The note further indicated R39 would make his own choices using the spoken menu and R39's current weight was 152 lbs and R39 had lost 9 lbs over the last year. The note identified R39 would have his meals in the main dining room for noon and evening and indicated R39 usually ate breakfast in his room or activities room. -1/25/17, indicated R39 was assessed this date for nutritional risk. The note further indicated R39 was gradually losing weight, his current weight was 144 lbs, which was down from 151 lbs last month and R39 had lost 11 lbs over the last 90 days. The note identified R39 was to receive a regular diet with high calorie interventions of super cereal, double portion of toast with jelly at breakfast, super mashed potatoes at noon and fruit based nutritional supplement 3 times per day between meals and was to provided by nursing.	2 965		

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2 965	Continued From page 20 The note further indicated family brought in goodies, they would encourage family to eat with resident in hope of increasing his intake and continue to assess. -1/30/17, indicated registered dietitian (RD) spoke with R39's daughter and staff would offer R39 a small snack 1-2 hours after meals if he refused and dietary could hold a small sampling of the regular meal and take it to his room after a meal refusal. The note further indicated R39's identified R39's favorite foods which included peanut butter and jelly toast, ice cream, fruit sauce, and apple flavored nutritional supplement. -2/9/17, indicated R39 refused protein supplement and they would continue with other high calorie interventions. The note further indicated R39's last weight was 141# and gradual weight gain was desired for R39 and new interventions were put in place to promote increased intake. Review of the current Resident Dining Preferences form provided by the facility, utilized as homemaker reference for resident diets and interventions, identified R39's food preferences included cold breakfast cereal and white toast with peanut butter and jelly, his favorite meal was dinner, he had no food dislikes, received orange juice, milk and water for breakfast and milk and water for lunch and supper. The form further indicated R39 had high calorie-protein interventions to maintain weight. The facility failed to identify R39 required whole milk and did not identify what high-calorie, high-protein interventions were required for R30 and assistive devices or methods to improve ability to fed himself and other related nutrition information	2 965		

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2 965	Continued From page 21 was left blank. On 3/29/17, at 12:49 p.m. HM-A stated R39 ate in his room about 2/3 of time and came out to the dining room once in a "blue moon." She stated he had not been to the dining room since Sunday. She stated R39 didn't eat much and stated he was a good ice cream eater. She stated R39 generally received supplements if he refused a meal or was offered soup and a sandwich later which R39 generally didn't want that or anything. HM-A stated homemaking staff had never recorded meal intakes for R39 She stated she was not aware of special food or textures for R39's meals. She stated R39 liked peanut butter toast, broth and mashed potatoes with butter. She stated R39 did not like meat or hot dishes and stated she thought he drank his supplements. On 3/29/17, at 1:07 p.m. HM-B stated she did not think R39 had lost any weight and stated R39 liked mashed potatoes, would usually drink milk and broth and would sometimes eat toast with peanut butter and ice cream. She stated staff did not do anything special for R39's meals or give him any special foods. She stated fruit supplements had been offered in the past and stated he never took them. She stated R39 did not like meat or vegetables. She stated she was not aware of any residents who received high-calorie, high-protein interventions. On 3/29/17, at 2:01 p.m. NA-C stated R39 did not eat good but would drink fluids. She stated he received a fruit supplement 6 times a day and drank it. She stated he would usually eat soup and try to give him decent portions of foods at meals. She stated she was not sure if the HM's recorded R39's meal intake and stated nursing	2 965		

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	00771	A. BUILDING: _____ B. WING _____	03/30/2017

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2 965	Continued From page 22 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. A facility policy for weight loss was requested 3/30/17. The facility failed to provide a policy.	2 965		

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2 965	Continued From page 23 SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could develop and implement policies and procedures to ensure residents at nutritonal risk received appropriate interventions to maintain nutrition as determined necessary by their individualized assessment. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident care equipment was kept in a clean and sanitary condition for 1 of 1 residents (R25) observed to have a wheelchair seat in disrepair. Findings include: R25's quarterly Minimum Data Set (MDS) dated 3/13/17, identified R25 had frequent urinary and	21685	This has been corrected.	4/27/17

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21685	Continued From page 24 bowel incontinence and used a wheelchair for a mobility device. R25's care plan dated 7/26/16, indicated R25 had frequent incontinent episodes of bowel and bladder as evidenced by saturation of incontinent products. The care plan indicated R25 required extensive assistance of one staff for toileting needs, and directed staff to offer R25 toileting assistance as often as possible, at least every two hours, to prevent urinate in inappropriate places. The care plan indicated R25 required a wheelchair for locomotion, and was able to propel the wheelchair independently throughout the facility. During observation on 3/27/17, at 5:30 p.m. R25 was seated in his wheelchair in the hallway. The wheelchair seat had a blue vinyl type covering, however, the front edge of the seat was tattered and worn away exposing a light yellow fabric. The tattered area on the seat was approximately 6 inches long and 2 inches wide. On 3/30/17, at 12:40 p.m. R25's wheelchair seat remained tattered with light yellow fabric exposed. On 3/30/17, at 11:19 a.m. nursing assistant (NA)-A reported R25 was incontinent of bowel and bladder and wore an incontinent product at all times. NA-A observed R25's tattered wheelchair seat and stated the wheelchair seat had exposed padding for a couple of months, and stated the therapy department was aware and was trying to get a new chair for R25. NA-A stated R25's wheelchair seat had been saturated with urine before, and stated R25 at times will go to the bathroom in inappropriate places such as the hallway. NA-A stated staff had tried to wipe down the wheelchair seat when it was soiled, and stated the wheelchair seat was hard to clean due	21685		

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21685	Continued From page 25	21685		

to the missing covering. Further, NA-A stated the night shift staff was responsible to clean the resident care equipment every two weeks.

On 3/30/17, at 12:12 p.m. the director of nursing (DON) reported when staff identify damaged resident care equipment, therapy was to be updated so they can get equipment repaired or replaced, especially wheelchairs.

On 3/30/17, at 12:32 p.m. clinical manger (CM)-A confirmed she was not aware of R25's wheelchair seat condition. CM-A confirmed R25 was incontinent of bowel and bladder and wore an incontinent product at all times. CM-A stated R25 could not verbalize his needs to go the bathroom and had been known in the past to urinate in wastebaskets and in corners. CM-A stated if she would have known about the wheelchair seat, it would have been replaced. CM-A confirmed due to R25's incontinence and inappropriate voiding, the wheelchair seat was no longer a cleanable surface.

On 3/30/17, at 1:03 p.m. the director of senior services (DSS) confirmed the therapy department was not aware of R25's wheelchair seat being in disrepair, and confirmed nothing had been ordered to fix or replace the wheelchair seat. The DSS stated staff were expected to communicate with the therapy department when resident equipment issues are identified.

A policy for resident care equipment maintenance was requested, but not provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or her designee could develop and implement policies and procedures and educate appropriate staff to ensure that the

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21685	Continued From page 26 residents's equipment was maintained in a safe, clean, functional, comfortable manner. Ongoing monitoring and record keeping to ensure that the equipment is kept in good repair. Develop a system to audit the equipment on an ongoing basis to ensure compliance and monitor staff for adherence to these policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21685		