Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 21, 2025

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

RE: CCN: 245451
Cycle Start Date: May 14, 2025

Dear Administrator:

On May 14, 2025, a 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 August 14, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by November 14, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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May 21, 2025

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

Re: State Nursing Home Licensing Orders
Event ID: OHB611

Dear Administrator:

The above facility was surveyed on May 12, 2025 through May 14, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 _____	C 05/14/2025

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

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E 000	Initial Comments On 5/12/25-5/14/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. 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.	E 000		
F 000	INITIAL COMMENTS On 5/12/25 to 5/14/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited : H54513210C (MN00109583) H54513209C (MN00109792) H54513211C (MN00110581) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to	F 000		

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

Electronically Signed | 05/28/2025

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 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an insulin SoloStar Insulin pen was appropriately primed prior to insulin administration for 1 of 2 residents (R30) who received 25 units of Lantus insulin daily. Findings include: During an observation and interview on 5/12/25 at 5:50 p.m., licensed practical nurse (LPN)-A prepared to administer R30's ordered dose of Lantus insulin. The current physician orders for Lantus Solostar insulin identified he was to receive 25 units subcutaneously (subcutaneous injections are used to administer medications between skin and muscle) once per day, with a special note which identified the insulin was to be administered between 4:00 p.m. and 6:00 p.m. daily per resident request. LPN-A checked the pen against the Medication Administration Record (MAR), performed hand hygiene, removed the pen cap, wiped the end of the pen with an alcohol pad, attached the needle, dialed the pen to one unit and depressed the plunger, no insulin was observed exiting the needle. LPN-A then dialed the pen to 25 units, retrieved a new alcohol pad and proceeded to R30's room to administer the	F 760	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. R30 did not receive Lantus insulin prior to the pen being primed as the LPN administering the medication was provided with education prior to the error occurring. All residents who receive insulin via insulin pens are at risk due of this deficient practice. Individual nurse was re-educated by DON	5/31/25

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F 760	Continued From page 2 dose of insulin. LPN-A was interrupted, and she and the surveyor exited the room, where LPN-A was asked about her procedure for priming (removes the air from the needle and cartridge that may collect during normal use. This ensures ensures receiving the full dose) the insulin pen. She replied her normal procedure was to prime the pen with one or two units, and then dial to the ordered dose of insulin. LPN-A stated she was not aware of what the manufacturer's directions instructed for priming the pen by dialing to two units after attaching the needle. LPN-A wasted the dose of insulin, dialed the pen to two units, demonstrating the insulin coming through the needle, performed hand hygiene, applied gloves, and proceeded to administer R30's insulin in his left lower abdomen. LPN-A stated she had always primed insulin pens in that manner and was not aware she needed to prime with two units to remove air from the needle. During an interview on 5/13/25 at 8:30 a.m., the director of nursing (DON) stated her expectation for licensed nursing staff administering insulin was to follow the manufacturer's instructions and the facility policy for priming pens with two units prior to administration of the ordered insulin dose. Review of the manufacture's instruction sheet: How to use your Lantus SoloStar pen: - a short version of the instruction leaflet included in the Lantus SoloStar pen box. The pamphlet detailed the importance of following the listed steps to help ensure an accurate dose of insulin was received. 1.) Remove the pen cap with clean hands. Check the reservoir to ensure it is clear and colorless and has no particles. 2.) Wipe the pen tip (rubber seal) with an alcohol	F 760	on 5/12/25. To ensure systemic changes are sustained, all nurses will complete Sanford Learn ED-4916 Insulin Preparation by 5/31/25. 2025 Annual Training does include training and competency testing for insulin preparation. To ensure compliance is maintained, the DON or designee will audit insulin pen administration, including priming the pen, weekly x 4 and monthly x 3 beginning the week of 5/26. Audit results will be brought to the QAPI committee for further recommendations.	

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F 760	Continued From page 3 swab. 3.) Remove the protective seal from the new needle, line the needle up straight with the pen and screw the needle onto the pen. 4.) After attaching the needle, remove the outer needle cap and save to remove the needle after the injection. 5.) Remove the inner needle cap and discard. 6.) Dial the pen to 2, hold the pen upright, tap the reservoir to bring any bubbles to the top, depress the plunger and ensure insulin exits the needle. The dial will automatically return to zero. 7.) Check to ensure the dial returned to zero, and then dial to the ordered dose of insulin. 8.) Clean the injection site with an alcohol pad, Hold the pen straight, insert the needle into the skin, depress the plunger and wait 10 seconds before releasing the plunger and removing. 9.) Replace the outer needle cap over the needle and remove the needle from the pen and dispose in a sharps container. Review of the Revised September 2014 Med-Pass, Inc policy Insulin Administration identified nursing staff were to have access to manufacturer's instructions for all types of insulin administration devices prior to use. The policy identified steps for use of an insulin pen: Verify the physician orders for the type and dose of insulin to be administered; Prime the pen with 2 units of insulin; dial the pen to the ordered dose; administer the insulin in the identified body location; and wash hands following administration of the medication.	F 760		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		5/31/25

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F 812	Continued From page 4 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fire suppression pipes located directly above the deep fat fryer, and stove top grill surface were free from accumulation of dirt and grease. This buildup had the potential to contaminate food being prepared and served. In addition, the facility failed to ensure 1 of 1 meat slicer was appropriately cleaned and sanitized following use. These deficient practices had the potential to affect all 51 residents who received food prepared in the facility kitchen. Findings include: During an observation and interview on 5/12/25 at 12:33 p.m., with the certified dietary manager (CDM) identified the vent hood located above the stove top grill and deep fat fryer, contained metal	F 812	The meat slicer and fire suppression pipes above the deep fat fryer and stove top grill were cleaned immediately upon finding on 5/12/25. The light fixtures were also cleaned immediately upon finding on 5/14/25. The hood and filter cleaning policy was reviewed and updated on 5/22/25 to specifically address the cleaning of suppression system pipes and light covers in the procedure. The weekly cleaning schedule was revised on 5/22/25 to specifically address the suppression pipes and light covers under the hood cleaning assignment. Midwest Fire & Safety was contacted	

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F 812	Continued From page 5 pipes identified as the fire suppression system, which were coated with a black fuzzy substance the CDM identified as dirt and grease buildup. Both the pipes and light fixtures in the hood had multiple areas identified as rust. The CDM stated she had only been in her position for two weeks and had not noticed the buildup on the ends of the fire suppression pipes. CDM indicated she would have the area cleaned immediately due to the potential for contamination of food being prepared. Observation of a meat slicer identified as last used on 5/11/25, to slice ham was on a counter and covered with plastic. When the plastic was removed, food particles were observed on the shield behind the blade, on the platform, and there was buildup of food particles on the sides and grooved surface of the unit. The CDM confirmed the meat slicer had not been cleaned and sanitized appropriately following use and would need to be cleaned prior to being used again. During an interview on 5/12/25 at 12:45 p.m. , the CDM identified her expectation was for cleaning schedules to be followed and identified the need for improvement and monitoring of cleaning and sanitation of food preparation equipment located in the facility kitchen. CDM stated the vented hood was due for an annual cleaning however, confirmed she had not noticed the buildup on the pipes located above the food preparation surfaces. A policy for scheduled kitchen maintenance/cleaning was requested, but not provided by the end of the survey period. Review of the 2008 policy for cleaning slicers	F 812	regarding the kitchen suppression system and inspected the unit on 5/15/25. Midwest Fire & Safety recommended replacement of the suppression pipes. Maintenance Director will replace by 5/31/25. The meat slicer policy was reviewed and updated on 5/22/25 with a more specific procedure of cleaning and sanitizing the machine. The updated policies was reviewed and approved at the 5/27/25 QAPI meeting. The Director of Food and Nutrition Services held a cook's in-service on 5/27/25 to include the following topics: reviewing the updated hood and meat slicer policies, reviewing the updated cleaning schedule and a demonstration by presenter on how to properly clean the hood, fire suppression system and removal and cleaning of the light covers along with a demonstration on how to clean and sanitize the meat slicer. The hood system and meat slicer will be cleaned according to policy and the completed tasks will be recorded on the cleaning schedule. The cleaning and documenting of the hood and meat slicer will be audited for compliance by the Director of Food and Nutrition Services weekly x 4 weeks, bi-monthly x 1 month, and monthly thereafter until the compliance rate is 100% for 3 consecutive months. The corrective action plan will be added to the	

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F 812	Continued From page 6 identified the slicer was to be cleaned and sanitized after each use. All parts of the slicer were to be disassembled and washed in the pots and pans sink or dish machine. All parts were to be sanitized in a chemical sanitizer, or in the dishwasher. The remaining parts of the slicer that could not be placed in the dishwasher were to be washed with hot water and soap, rinsed and allowed to dry. Special attention was to be paid to any moveable parts, especially the blade. The parts were to be sanitized and allowed to dry, the slicer was to be reassembled and covered. The counter where the slicer was located was also to be washed and sanitized with each use of the slicer.	F 812	dietary QAPI plan and audit results/further action will be reviewed and reported on at QAPI meetings until goal is met.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		5/31/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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	245451	A. BUILDING _____ B. WING _____	C 05/14/2025

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F 880	Continued From page 8 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the common use blood glucometer machines were disinfected according to current manufacturer's guidelines between resident use for 2 of 3 residents (R44 and R1) reviewed who received blood glucose testing in the facility. Findings include: Observation on 5/12/25 at 5:27 p.m. with trained medication aide (TMA)-A as she prepared to check a blood glucose for R44. TMA-A took the glucometer from the charging station located at the nursing station, collected her necessary supplies, and proceeded to R 44's room where she donned personal protective equipment (PPE) of gown and gloves. TMA-A obtained a clean towel which she placed on the bedside table and placed the glucometer and supplies on the towel. She then washed her hands, put on new gloves, scanned the bottle of test strips and placed a strip into the glucometer. TMA-A wiped R44's finger with an alcohol pad, allowed to dry and utilized a lancet (A lancet is a small, sharp surgical instrument used to make small incisions, typically for drawing blood samples. It is commonly used in diabetes management) to obtain a blood sample which she collected with the test strip. TMA-A placed a cotton ball on R44's finger and after obtaining a reading disposed of the used items in the sharp's container in R44's bathroom.	F 880	Staff member involved was immediately educated on the appropriate procedures of disinfection of a glucometer between uses. All other residents who have their blood glucose checked using a glucometer have the risk to be affected by this deficient practice. To ensure systemic changes are sustained, the policy titled “NOVA Statstrip Meter Procedure” was updated to include verbiage on cleaning the meter including, “Per Infection Prevention and Control Administrative SOP Shared Medical Equipment, the meters exterior will be cleaned between each patient. Commercial surface decontamination approved by OAHS may be used (i.e.Sani-Cloth AF3 - Grey Lid). Refer to User's Manual for specific instructions for each meter. Allow meter to remain wet for appropriate contact time depending on germicidal wipe in use.” The updated policy was reviewed and approved at the 5/27/25 QAPI meeting. A video on the proper use of Sani-Cloth AF3 was sent to all nursing staff who use glucometer of 5/16/25. Infection Preventionist will develop a tool for staff to include the type of sani-cloth, what the sani-cloth is used for, and proper	

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F 880	Continued From page 9 She removed her PPE and performed hand hygiene. TMA-A went out of the room to her cart positioned outside the room and proceeded to wipe off the glucometer, and bottle of strips with alcohol pads. She stated she would need to clean the glucometer and bottle of strips again as she had contaminated them when she was removing her PPE. TMA-A returned to the nursing station, retrieved alcohol pads, and wiped off the glucometer and bottle of strips with the alcohol pads and returned to the docking station. When asked, she confirmed the glucometer was disinfected and ready to use for the next test. During an observation and interview on 5/12/25 at 5:50 p.m., with registered nurse (RN)-A as she retrieved the common use glucometer and identified she was going to check a blood sugar and administer R44's insulin. RN-A obtained her supplies, used hand sanitizer and proceeded to the area outside R44's room where she donned PPE of gown and gloves. RN-A took a gray labeled Sani Cloth, wiped over the surface of the common use glucometer and set aside to dry. RN-A stated the glucometer needed to remain wet for three minutes however, did not leave the meter in contact with the cloth and confirmed the meter was dry within a little more than a minute. RN-A reported she had not ensured the meter remained wet for the three minute time period and had never checked to determine how long it took for the solution to dry after wiping the surface. During an interview on 5/12/25 at 5:55 p.m., TMA-A stated she was not aware that alcohol was not the correct product to use for disinfecting the common use glucometers, and that she was not aware of how the manufacturer and/or policy	F 880	wet time to disinfect. All staff will be educated on the proper process for using Sani-Cloths AF3 and all sani-cloths by 5/31/25. All staff using glucometers will complete a competency quiz on the proper use of germicidal wipes when disinfecting glucometers by 5/31/25. During QAPI meeting on 5/27/25, the type of wipe used on glucometers was reviewed. During the meeting, the IDT team made the decision to switch to a different germicidal wipe that has a shorter required time that it need to be visibly wet compared to the 3 minutes the Sani-Cloth AF3 requires. This transition will take place after the Sani-Cloth AF3s are used up. To ensure compliance is maintained, starting the week of 5/26/25, DON or Nurse Lead will audit 2 glucometer disinfection opportunities per household per week on the proper disinfection of glucometers weekly for 4 weeks, and monthly for 3 months. This plan of correction will be monitored and brought to our monthly QAPI meeting.	

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F 880	Continued From page 10 directed the meter to be cleaned and disinfected following use. RN-A who was also in attendance, confirmed to TMA-A the glucometer was supposed to be disinfected using the gray labeled Sani cloth wipes and reported she had just realized the solution needed to remain wet on the surface for three minutes to disinfect the surface.	F 880		

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F 880	Continued From page 11 During an observation and interview on 5/12/25 at 12:03 p.m., TMA-B cleansed hands and applied gloves prior to checking resident blood sugars. TMA-B placed a test strip into the common use glucometer, cleansed R1's middle right finger with an alcohol wipe, used a lancet to prick her finger and dropped the sample of blood onto the test strip. At 12:08 p.m., TMA-B sanitized the common use glucometer with a single use Sani wipe by wiping the front and back briefly and placed the glucometer on her cart. When interviewed, TMA-B stated she believed the glucometer was sanitized after wiping it as she had. TMA-B removed gloves and sanitized her hands. TMA-B entered the results into R1's electronic medical record and moved her cart down the hallway to the hallway located to the right of the dining room. At 12:12 p.m., TMA-B was bringing R9 to a private area to check her blood sugar when surveyor stopped her and asked her to review the manufacturer's guidelines	F 880		

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F 880	Continued From page 12 for the Sani wipe she used for sanitizing the glucometer. TMA-B reviewed the instructions and did confirm the instructions identified the glucometer was to remain wet for three minutes to ensure proper sanitization. TMA-B confirmed she had not done that as instructed. TMA-B removed a new Sani wipe, wiped the glucometer down on each side and wrapped the wipe around the glucometer as instructed before she continued on with further blood sugar checks. During a telephone interview on 5/14/25 at 10:08 a.m., infection preventionist (IP) stated the common use glucometers required sanitization between each resident's use. IP identified staff wre expected to use the Sani wipes by wiping three times horizontal and three times vertical and ensure the glucometer remained wet for three minutes. IP stated that may mean staff were to re-wipe the glucometer if needed to ensure it remained wet for three minutes. IP indicated it was the facility's expectation staff would follow the wet time as indicated to prevent the spread of blood-borne pathogens. During an interview on 5/13/25 at 1:15 p.m. the director of nursing (DON) identified her expectation for the common use glucometer was to be cleaned and disinfected after each use according to the policy and manufacturer's instructions. DON identified alcohol wipes were not the appropriate solution for disinfection of the meter and the gray labeled Sani Cloths were available for that purpose. Review of manufacturer's instructions for Sani-Cloth AF3 Germicidal Wipes General Guidelines for Use dated 2019, instructed staff to unfold a clean wipe and thoroughly wet the	F 880		

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F 880	Continued From page 13 surface. Allow treated surface to remain wet for three minutes and let air dry. Review of the January 27, 2025, Nova StatStrip Meter Procedure identified according to Infection Prevention (IC) the meter's exterior was to be cleansed between each patient. The decontamination preparation approved was identified as Sani-Cloth AF3-grey lid. The strip port was to be cleansed by lab staff only. Do not immerse meter or hold the meter under running water. Do not spray with a disinfectant solution.	F 880		

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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: On 5/12/25 to 5/14/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. In addition to the recertification survey, the following complaints were reviewed. The following complaints were reviewed with no licensing orders issued. H54513210C (MN00109583) H54513209C (MN00109792) H54513211C (MN00110581) 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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	2 000		

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2 000	Continued From page 2 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. 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.	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fire suppression pipes located directly above the deep fat fryer, and stove top grill surface were free from accumulation of dirt and grease. This buildup had the potential to contaminate food being prepared and served. In addition, the facility failed to ensure 1 of 1 meat slicer was appropriately cleaned and sanitized following use. These deficient practices had the potential to affect all 51 residents who received food prepared in the facility kitchen. Findings include:	21015	Corrected	5/31/25

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21015	Continued From page 3 During an observation and interview on 5/12/25 at 12:33 p.m., with the certified dietary manager (CDM) identified the vent hood located above the stove top grill and deep fat fryer, contained metal pipes identified as the fire suppression system, which were coated with a black fuzzy substance the CDM identified as dirt and grease buildup. Both the pipes and light fixtures in the hood had multiple areas identified as rust. The CDM stated she had only been in her position for two weeks and had not noticed the buildup on the ends of the fire suppression pipes. CDM indicated she would have the area cleaned immediately due to the potential for contamination of food being prepared. Observation of a meat slicer identified as last used on 5/11/25, to slice ham was on a counter and covered with plastic. When the plastic was removed, food particles were observed on the shield behind the blade, on the platform, and there was buildup of food particles on the sides and grooved surface of the unit. The CDM confirmed the meat slicer had not been cleaned and sanitized appropriately following use and would need to be cleaned prior to being used again. During an interview on 5/12/25 at 12:45 p.m. , the CDM identified her expectation was for cleaning schedules to be followed and identified the need for improvement and monitoring of cleaning and sanitation of food preparation equipment located in the facility kitchen. CDM stated the vented hood was due for an annual cleaning however, confirmed she had not noticed the buildup on the pipes located above the food preparation surfaces. A policy for scheduled kitchen	21015		

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21015	Continued From page 4 maintenance/cleaning was requested, but not provided by the end of the survey period. Review of the 2008 policy for cleaning slicers identified the slicer was to be cleaned and sanitized after each use. All parts of the slicer were to be disassembled and washed in the pots and pans sink or dish machine. All parts were to be sanitized in a chemical sanitizer, or in the dishwasher. The remaining parts of the slicer that could not be placed in the dishwasher were to be washed with hot water and soap, rinsed and allowed to dry. Special attention was to be paid to any moveable parts, especially the blade. The parts were to be sanitized and allowed to dry, the slicer was to be reassembled and covered. The counter where the slicer was located was also to be washed and sanitized with each use of the slicer. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate sanitation of equipment in the kitchen and dining areas. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		5/31/25

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21375	Continued From page 5 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the common use blood glucometer machines were disinfected according to current manufacturer's guidelines between resident use for 2 of 3 residents (R44 and R1) reviewed who received blood glucose testing in the facility. Findings include: Observation on 5/12/25 at 5:27 p.m. with trained medication aide (TMA)-A as she prepared to check a blood glucose for R44. TMA-A took the glucometer from the charging station located at the nursing station, collected her necessary supplies, and proceeded to R 44's room where she donned personal protective equipment (PPE) of gown and gloves. TMA-A obtained a clean towel which she placed on the bedside table and placed the glucometer and supplies on the towel. She then washed her hands, put on new gloves, scanned the bottle of test strips and placed a strip into the glucometer. TMA-A wiped R44's finger with an alcohol pad, allowed to dry and utilized a lancet (A lancet is a small, sharp surgical instrument used to make small incisions, typically for drawing blood samples. It is commonly used in diabetes management) to obtain a blood sample which she collected with the test strip. TMA-A placed a cotton ball on R44's finger and after obtaining a reading disposed of the used items in the sharp's container in R44's bathroom.	21375	Corrected	

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21375	Continued From page 6 She removed her PPE and performed hand hygiene. TMA-A went out of the room to her cart positioned outside the room and proceeded to wipe off the glucometer, and bottle of strips with alcohol pads. She stated she would need to clean the glucometer and bottle of strips again as she had contaminated them when she was removing her PPE. TMA-A returned to the nursing station, retrieved alcohol pads, and wiped off the glucometer and bottle of strips with the alcohol pads and returned to the docking station. When asked, she confirmed the glucometer was disinfected and ready to use for the next test. During an observation and interview on 5/12/25 at 5:50 p.m., with registered nurse (RN)-A as she retrieved the common use glucometer and identified she was going to check a blood sugar and administer R44's insulin. RN-A obtained her supplies, used hand sanitizer and proceeded to the area outside R44's room where she donned PPE of gown and gloves. RN-A took a gray labeled Sani Cloth, wiped over the surface of the common use glucometer and set aside to dry. RN-A stated the glucometer needed to remain wet for three minutes however, did not leave the meter in contact with the cloth and confirmed the meter was dry within a little more than a minute. RN-A reported she had not ensured the meter remained wet for the three minute time period and had never checked to determine how long it took for the solution to dry after wiping the surface. During an interview on 5/12/25 at 5:55 p.m., TMA-A stated she was not aware that alcohol was not the correct product to use for disinfecting the common use glucometers, and that she was not aware of how the manufacturer and/or policy directed the meter to be cleaned and disinfected	21375		

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	00771	A. BUILDING: _____ B. WING _____	C 05/14/2025

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21375	Continued From page 7 following use. RN-A who was also in attendance, confirmed to TMA-A the glucometer was supposed to be disinfected using the gray labeled Sani cloth wipes and reported she had just realized the solution needed to remain wet on the surface for three minutes to disinfect the surface. During an observation and interview on 5/12/25 at 12:03 p.m., TMA-B cleansed hands and applied gloves prior to checking resident blood sugars. TMA-B placed a test strip into the common use glucometer, cleansed R1's middle right finger with an alcohol wipe, used a lancet to prick her finger and dropped the sample of blood onto the test strip. At 12:08 p.m., TMA-B sanitized the common use glucometer with a single use Sani wipe by wiping the front and back briefly and placed the glucometer on her cart. When interviewed, TMA-B stated she believed the glucometer was sanitized after wiping it as she had. TMA-B removed gloves and sanitized her hands. TMA-B entered the results into R1's electronic medical record and moved her cart down the hallway to the hallway located to the right of the dining room. At 12:12 p.m., TMA-B was bringing R9 to a private area to check her blood sugar when surveyor stopped her and asked her to review the manufacturer's guidelines for the Sani wipe she used for sanitizing the glucometer. TMA-B reviewed the instructions and did confirm the instructions identified the glucometer was to remain wet for three minutes to ensure proper sanitization. TMA-B confirmed she had not done that as instructed. TMA-B removed a new Sani wipe, wiped the glucometer down on each side and wrapped the wipe around the glucometer as instructed before she continued on with further blood sugar checks. During a telephone interview on 5/14/25 at 10:08	21375		

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21375	Continued From page 8 a.m., infection preventionist (IP) stated the common use glucometers required sanitization between each resident's use. IP identified staff wre expected to use the Sani wipes by wiping three times horizontal and three times vertical and ensure the glucometer remained wet for three minutes. IP stated that may mean staff were to re-wipe the glucometer if needed to ensure it remained wet for three minutes. IP indicated it was the facility's expectation staff would follow the wet time as indicated to prevent the spread of blood-borne pathogens. During an interview on 5/13/25 at 1:15 p.m. the director of nursing (DON) identified her expectation for the common use glucometer was to be cleaned and disinfected after each use according to the policy and manufacturer's instructions. DON identified alcohol wipes were not the appropriate solution for disinfection of the meter and the gray labeled Sani Cloths were available for that purpose. Review of manufacturer's instructions for Sani-Cloth AF3 Germicidal Wipes General Guidelines for Use dated 2019, instructed staff to unfold a clean wipe and thoroughly wet the surface. Allow treated surface to remain wet for three minutes and let air dry. Review of the January 27, 2025, Nova StatStrip Meter Procedure identified according to Infection Prevention (IC) the meter's exterior was to be cleansed between each patient. The decontamination preparation approved was identified as Sani-Cloth AF3-grey lid. The strip port was to be cleansed by lab staff only. Do not immerse meter or hold the meter under running water. Do not spray with a disinfectant solution.	21375		

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21375	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could assure the appropriate processes are in place of for sanitizing of equipment according to best practices, and manufacturers recommendations. The director of nursing, or designee, could perform random audits to assure practices were being implemented appropriately. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as	21545		5/31/25

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21545	Continued From page 10 prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an insulin SoloStar Insulin pen was appropriately primed prior to insulin administration for 1 of 2 residents (R30) who received 25 units of Lantus insulin daily. Findings include: During an observation and interview on 5/12/25 at 5:50 p.m., licensed practical nurse (LPN)-A prepared to administer R30's ordered dose of Lantus insulin. The current physician orders for Lantus Solostar insulin identified he was to receive 25 units subcutaneously (subcutaneous injections are used to administer medications between skin and muscle) once per day, with a special note which identified the insulin was to be	21545	Corrected	

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21545	Continued From page 11 administered between 4:00 p.m. and 6:00 p.m. daily per resident request. LPN-A checked the pen against the Medication Administration Record (MAR), performed hand hygiene, removed the pen cap, wiped the end of the pen with an alcohol pad, attached the needle, dialed the pen to one unit and depressed the plunger, no insulin was observed exiting the needle. LPN-A then dialed the pen to 25 units, retrieved a new alcohol pad and proceeded to R30's room to administer the dose of insulin. LPN-A was interrupted, and she and the surveyor exited the room, where LPN-A was asked about her procedure for priming (removes the air from the needle and cartridge that may collect during normal use. This ensures ensures receiving the full dose) the insulin pen. She replied her normal procedure was to prime the pen with one or two units, and then dial to the ordered dose of insulin. LPN-A stated she was not aware of what the manufacturer's directions instructed for priming the pen by dialing to two units after attaching the needle. LPN-A wasted the dose of insulin, dialed the pen to two units, demonstrating the insulin coming through the needle, performed hand hygiene, applied gloves, and proceeded to administer R30's insulin in his left lower abdomen. LPN-A stated she had always primed insulin pens in that manner and was not aware she needed to prime with two units to remove air from the needle. During an interview on 5/13/25 at 8:30 a.m., the director of nursing (DON) stated her expectation for licensed nursing staff administering insulin was to follow the manufacturer's instructions and the facility policy for priming pens with two units prior to administration of the ordered insulin dose. Review of the manufacture's instruction sheet: How to use your Lantus SoloStar pen: - a short	21545		

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21545	Continued From page 12 version of the instruction leaflet included in the Lantus SoloStar pen box. The pamphlet detailed the importance of following the listed steps to help ensure an accurate dose of insulin was received. 1.) Remove the pen cap with clean hands. Check the reservoir to ensure it is clear and colorless and has no particles. 2.) Wipe the pen tip (rubber seal) with an alcohol swab. 3.) Remove the protective seal from the new needle, line the needle up straight with the pen and screw the needle onto the pen. 4.) After attaching the needle, remove the outer needle cap and save to remove the needle after the injection. 5.) Remove the inner needle cap and discard. 6.) Dial the pen to 2, hold the pen upright, tap the reservoir to bring any bubbles to the top, depress the plunger and ensure insulin exits the needle. The dial will automatically return to zero. 7.) Check to ensure the dial returned to zero, and then dial to the ordered dose of insulin. 8.) Clean the injection site with an alcohol pad, Hold the pen straight, insert the needle into the skin, depress the plunger and wait 10 seconds before releasing the plunger and removing. 9.) Replace the outer needle cap over the needle and remove the needle from the pen and dispose in a sharps container. Review of the Revised September 2014 Med-Pass, Inc policy Insulin Administration identified nursing staff were to have access to manufacturer's instructions for all types of insulin administration devices prior to use. The policy identified steps for use of an insulin pen: Verify the physician orders for the type and dose of insulin to be administered; Prime the pen with 2 units of insulin; dial the pen to the ordered dose;	21545		

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21545	Continued From page 13 administer the insulin in the identified body location; and wash hands following administration of the medication. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/14/2025. At the time of this survey, Fairway View Neighborhoods was found not 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/29/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Fairway View Neighborhoods was built in 2016 under the LSC 2000 regulations and is one story in height without a basement. It is fully fire sprinkled 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 is divided into 4 smoke compartments by two-2 hour fire barriers and 2 smoke barriers.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 51 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025 between 09:45 AM and 12:45 PM, it was revealed by a review of available documentation that the emergency lighting in the facility had not had the monthly testing completed since November 2024. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K 291	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. It is the policy of Fairway View Neighborhoods to comply with K291. To assure continued compliance, the following plan of correction has been put into place: The Maintenance Team was educated on the monthly emergency lighting testing	5/28/25

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K 291	Continued From page 3	K 291	and its requirements. Monthly Emergency Lighting testing resumed on 5/28/25. Maintenance Manager or Maintenance Designee will perform monthly emergency lighting testing with Annual Test scheduled for June 2025 as last annual test was conducted June 2024. The Maintenance Manager or designee will perform audits weekly x 4, monthly x 2 and quarterly x 2 to make sure all emergency lighting is tested and in working order. Findings of the audits will be reviewed at QAPI meetings.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		5/15/25

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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain cooking facilities per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. These deficient findings could have a widespread impact on residents within the facility. Findings include: On 05/14/2025 between 9:45 AM and 12:45 PM, it was revealed by a review of available documentation that the suppression systems in the three neighborhood kitchens and in the main kitchen had not been inspected in over 6 months. The last inspection for these systems was completed on October 7, 2024. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 324	Kitchen suppression system in the main kitchen and the three households was inspected immediately on 5/15/25 by Midwest Fire & Safety. Administrator sent the inspection paperwork to the Fire Marshal on 5/27/25. The hood inspection report stated for all the areas that everything was clean and well kept up, and links were changed on all systems. Maintenance Manager and Midwest will schedule future dates accordingly to ensure we are in compliance. Maintenance Manager or designee will visibly audit kitchen suppression systems in the main kitchen and three households monthly x 3 and quarterly x 2. Findings of the audits will be reviewed at QAPI meetings.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		5/15/25

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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
K 353	Continued From page 5 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.3.1, and 5.2.1.1.2(5). These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 05/14/2025 between 9:45 AM and 12:45 PM, it was revealed by a review of available documentation that the facility could not provide a report for the quarterly fire sprinkler inspection that took place on April 7, 2025. 2. On 05/14/2025 between 9:45 AM and 12:45 PM, it was revealed by observation that several sprinkler heads in Orton's Crossing Laundry Room, Harvest Trail Laundry Room, Main Laundry Area, and the Main Kitchen Dishwashing	K 353	Sprinkler heads in Orton's Crossing Laundry, Harvest Trail Laundry, Main Laundry Area, and the Main Kitchen Dishwashing area were cleaned immediately upon finding on 5/14/25. Maintenance Manager added sprinkler head cleaning to the preventative maintenance schedule on a semi-annual basis. We do have the quarterly sprinkler test results conducted by Midwestern Mechanical, but the facility was missing the Semi-Annual inspection documentation. Administrator contacted Midwestern Mechanical on 5/14/25 and determined semi-annual fire sprinkler inspection did take place on 4/7/25. Administrator received semi-annual documentation on 5/15/25 and submitted to Fire Marshal via e-mail. Maintenance Manager has developed a	

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	245451	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2025**

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K 353	Continued From page 6 Area were covered in a layer of lint and debris. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 353	routine schedule of fire sprinkler tests to ensure compliance. The Maintenance Manager or designee will perform audits weekly x 4, monthly x 2 and quarterly x 2 to ensure sprinkler heads are clean. Findings of the audits will be reviewed at QAPI meetings.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/14/2025, between 9:45 AM and 12:45 PM, it was revealed by a review of available documentation that the facility could not provide a current fire damper inspection report for an	K 521	Maintenance Manager contacted G&R Controls on 5/27/25 to determine if the 4-year Fire Damper Inspection took place in 2024 as last documentation showed inspection was done 9/16/2020. It was determined that Fairway View is due for their 4-year inspection. G&R Controls will be contacting our Maintenance Manager with the earliest available date to conduct the 4-year Fire Damper inspection. The Maintenance Manager is currently awaiting confirmation, with the expectation that the inspection will take place within the next 30 days.	6/26/25

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K 521	Continued From page 7 inspection that would have occurred in the last 4 years. Available documentation indicated that the last damper inspection took place on September 16, 2020. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 521	Once the fire dampers are serviced, Maintenance Manager or designee will conduct audits monthly x 3 months and quarterly x 2 month during the monthly fire drills to ensure fire dampers are closing properly. This plan of correction will be monitored and brought to our monthly QAPI meeting.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.	K 761	Administrator contacted Mid Central Door Services on 5/27/25 and it was determined that the annual door inspection occurred in January 2025. Mid Central supplied the appropriate paperwork, and Administrator gave vendor new Maintenance Manager's contact information to schedule future	5/28/25

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K 761	Continued From page 8 Findings include: On 05/14/2025 between 9:45 AM and 12:45 PM, it was revealed by a review of available documentation that the facility could not provide documentation to be reviewed showing that a fire door inspection had been conducted within the last 12 months. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 761	inspections as required. Administrator received annual door inspection documentation on 5/28/25 and sent to Fire Marshal via e-mail. The Maintenance Manager or designee will perform internal fire door audits on all doors semi-annually x 2 to ensure doors are in working order. Findings of the audits will be reviewed at QAPI meetings.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		5/30/25

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K 918	Continued From page 9 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.4.1, and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/14/2025 between 9:45 AM and 12:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that monthly generator operational inspection and testing had occurred in March and April of 2025. 2. On 05/14/2025 between 9:45 AM and 12:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that weekly generator inspections had occurred since July 3, 2024.	K 918	Maintenance Manager educated Maintenance Technicians on weekly and monthly generator check requirements. Weekly generator checks resumed on 5/16/25. Monthly generator checks will resume on 5/30/25. The Maintenance Manager or designee will perform audits weekly x 4, monthly x 2 and quarterly x 2 to make sure all weekly and monthly generator checks are being completed. Findings of the audits will be reviewed at QAPI meetings.	

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K 918	Continued From page 10 An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 918		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 2, 2025

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

RE: CCN: 245451
Cycle Start Date: May 14, 2025

Dear Administrator:

On June 18, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 02, 2025

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

Re: Reinspection Results
Event ID: OHB612

Dear Administrator:

On June 18, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 14, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us