Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 7, 2024

Administrator
Fairview Care Center
702 10th Avenue Northwest
Dodge Center, MN 55927

RE: CCN: 245344
Cycle Start Date: November 2, 2023

Dear Administrator:

On December 19, 2023, we notified you a remedy was imposed. On January 22, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 19, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 2, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 19, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 2, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 19, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Please note that the Health and Life Safety Code (LSC) surveys are being processed in separate enforcement cycles. This letter is for the LSC survey cycle.

Electronically delivered

December 18, 2023

Administrator
Fairview Care Center
702 10th Avenue Northwest
Dodge Center, MN 55927

RE: CCN: 245344
Cycle Start Date: November 2, 2023

Dear Administrator:

On November 20, 2023, we informed you that we may impose enforcement remedies.

On December 15, 2023, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 2, 2024

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 2, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 2, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 2, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Fairview Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 2, 2024. You will receive further information regarding this from the State agency. 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. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 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 May 2, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 15, 2023

Administrator
Fairview Care Center
702 10th Avenue Northwest
Dodge Center, MN 55927

RE: CCN: 245344
Cycle Start Date: October 19, 2023

Dear Administrator:

PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.

On December 7, 2023, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING 01 B. WING ______	R 12/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Based on a review of the facility's plan of correction, the facility is NOT in compliance with the federal requirements identified as deficient at the time of their recertification survey.	{K 000}		
{K 374} SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: On 12/15/2023 at 2:50 PM, it was revealed by telephone conversation with Maint. Dir. that corrections were not yet completed - parts were still to be secured.	{K 374}	Tag-0374 has been corrected on 12/27/23. This has been completed and installed on 12/27/23.	12/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/28/2023

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.

Protecting, Maintaining and Improving the Health of All Minnesotans

PLEASE NOTE: THE HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPARATE ENFORCEMENT CYCLES.

Electronically delivered

November 2, 2023

Administrator
Fairview Care Center
702 10th Avenue Northwest
Dodge Center, MN 55927

RE: CCN: 245344
Cycle Start Date: October 19, 2023

Dear Administrator:

On October 19, 2023, a survey was completed at your facility by the Minnesota Department of Health 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 January 19, 2024, (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 April 19, 2024, (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

PLEASE NOTE: THE HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPARATE ENFORCEMENT CYCLES.

Electronically delivered
November 20, 2023

Administrator
Fairview Care Center
702 10th Avenue Northwest
Dodge Center, MN 55927

RE: CCN: 245344
Cycle Start Date: November 2, 2023

Dear Administrator:

On November 2, 2023, a survey was completed at your facility by the Minnesota Department of 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)).

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

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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 February 2, 2024, (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 May 2, 2024, (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

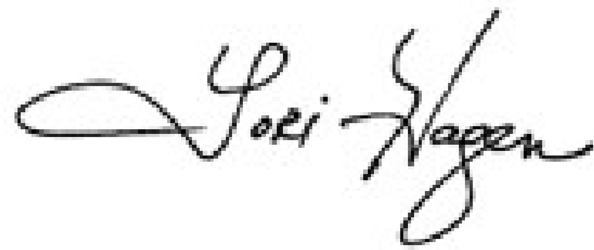
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Please contact me with any questions regarding this letter.

Sincerely,



Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING ______ B. WING ______	C 10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/16/23 through 10/19/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 10/16/23 through 10/19/23, 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. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. H53446501C (MN00097762) H53446419C (MN00096645) H53446421C (MN00096016) H53446420C (MN00094481) H53446395C (MN00088972) H53446394C (MN00084590) H53446393C (MN00084550) H5344069C (MN00082308) H5344070C (MN00081875) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/10/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING ______ B. WING ______	C 10/19/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 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 validate that substantial compliance with the regulations has been attained.	F 000		
F 576 SS=F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing	F 576		10/19/23

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F 576	Continued From page 2 implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents received their mail on Saturdays for 2 of 3 residents (R11, and R25) who attended the resident council meeting. This deficient practice had the potential to affect any resident who received mail. Finding includes: On 10/18/23 at 10:36 a.m., during the Resident Council interview, two residents (R11 and R25) indicated they did not receive their mail on Saturdays. Residents R11 and R25 stated they had to wait until Monday for their Saturday mail, and they no longer received their mail on Saturdays. R11's Annual Minimal Data Set (MDS) dated 8/24/23, indicated intact cognition (able to fully understand). No history of delusions, hallucinations (believing or seeing an untrue reality), or diagnosis of dementia noted (difficulty with memory and brain function) R25's Annual Minimal Data Set (MDS) dated	F 576	F-576 is corrected October 19, 2023. Newly hired Activity Aides will be trained to pick up mail from the post office on Saturdays and distributing received mail to the residents. A signature sheet is available for Activity Aide to sign every time the mail is picked up to monitor compliance. The Activity Director or designee will check this sheet each Monday for compliance.	

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F 576	Continued From page 3 8/25/23, indicated intact cognition. No history of delusions, hallucinations, or dementia noted. During an interview on 10/18/23 at 11:15 a.m., front desk worker (FDW-J) stated she mostly worked the front desk space and worked some Saturday's. FDW-J stated she believed mail was picked up on Saturdays but did not go to get it herself. During an interview on 10/18/23 at 11:19 a.m., business administration manager (BAM-K) stated Monday through Friday she picked up the mail at the post office around 10:30 a.m. BAM-K stated the mail would be reviewed with the administrative assistant as to wear it should be delivered, and there was currently no way for the residents to get mail on Saturdays. During an interview on 10/18/23 at 11:22 a.m., administrative assistant (AA-C) stated she sorted and reviewed the mail but did not get the mail on Saturday. AA-C thought the activities director may get the mail on Saturdays but was unsure how often. During interview on 10/18/23 at 11:26 a.m., activities director (AD-A) stated he worked maybe 10-20 Saturdays within a year, and that he usually got the mail on those Saturdays. AD-A stated the activity assistants got the mail when he was not working. During interview on 10/18/23 at 11:33 a.m., assistant activities director (ADA-B) stated she had never gone to get the mail on Saturdays and had never been trained or made aware of a need to get the mail.	F 576		

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F 576	Continued From page 4 During interview on 10/19/23 at 1:51 p.m., administrator stated she expected the mail be delivered on Saturdays, which was why it had been written into the facility policy and were reviewing the current practice. Facility document, titled, Mail Delivery Policy, dated 10/18/23, indicated on Saturday mail will be picked up by a member of the activities staff and resident mail is sorted and delivered to the resident by activates employee.	F 576		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		10/19/23

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F 726	Continued From page 5 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document, review the facility failed to ensure an agency nurse, on first day at the facility, was oriented to the specifics of the facility to be able to provide safe resident care for residents in one of two wings (Wing One). As a result of this deficient practice the residents had the potential for harm for staff not understanding the facility processes for safe resident care. Findings include: On 10/18/23 at 7:11 a.m., during the medication administration observation, Registered Nurse (RN)-C prepared R5's medications to be administered and was unable to identify the resident to administer the medications. RN-C asked another staff member to identify R5 in the dining area. RN-C was assigned to care for residents located on Wing One. Observation on 10/18/23 at 1:30 p.m., 2:00 p.m., and 2:35 p.m., the medication cart for Wing One was positioned at the end of the wing where it connects to the day room, near the activity table where a puzzle was being put together. The cart was unlocked, and the nurse was not in sight. During an interview on 10/19/23 at 8:37 a.m., the Administrative Assistant explained the process for	F 726	F-726 is corrected effective October 19, 2023. Pictures will be used to identify the residents. These are in the EMAR and have been updated with current photos. Social Services will be in charge of all future residents ensuring these photos are taken and electronically uploaded. Nursing staff has the responsibility to verify resident identity if they are unsure regardless of photo in the EMAR to ensure accuracy. The DON will ensure the agency nurse completed the orientation checklist with the staff nurse. The staff nurse and agency nurse will sign the orientation checklist when completed and the DON will verify and sign the checklist ensuring the training happened. The FVCC Administrative Assistant will ensure the agency nurse's orientation checklists turned in have the agency nurse, Staff nurse and DON's initials showing it was completed.	

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F 726	Continued From page 6 orientation of an agency nurse included a printed orientation sheet and left with the charge nurse to be completed by the new agency nurse and the staff orienting the new person. Log-in access to the electronic medical record was also provided. During an interview on 10/19/23 at 8:15 a.m., RN-B, who worked the night shift the night before, confirmed she had oriented RN-C, when RN C started working for the first time at the facility on 10/18/23, day shift. RN-B provided documentation of the orientation. Not all the areas on the orientation document were completed and the sections to be signed off by the orientee were blank, unsigned by RN-C. During an interview on 10/19/23 at 11:28 a.m., the Director of Nursing (DON) explained as long as the orientation sheet was completed the agency nurse would be ready to perform safe resident care. Review of the facility policy "Pool/Agency Expectations" with an effective date 10/18/23, revealed "The trainer on duty when the agency/pool person starts, will go through the appropriate orientation checklist for their function in the building that day. This will be completed and initialed by relevant parties prior to starting a shift on the floor. If, for any reason, items listed cannot be completed, the Director of Nursing and Administrator must be notified, and the exceptions documented and signed by the agency/pool person and a representative of Fairview Care Center."	F 726		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		10/19/23

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F 761	Continued From page 7 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the facility failed to ensure the medication cart was locked and secure for 1 of 2 medication carts (Wing One). As a result of this deficient practice the medications in the cart were unsecured and had the potential for loss or misuse. Findings include: During observation on 10/18/23 at 1:30 p.m., the	F 761	F-761 is corrected effective October 19, 2023. Reminder signs have been placed on both med carts stating "Lock the cart before walking away". A reminder will be added to the orientation checklist on how critical it is to never leave the cart unlocked and unattended. This is referenced in the attached policy.	

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F 761	Continued From page 8 medication cart for Wing One was positioned at the end of the wing where it connected to the day room, near the activity table where a puzzle was being put together. The cart was unlocked, and the nurse was not in sight. During observation on 10/18/23 at 2:00 p.m., the medication cart for Wing One was positioned at the end of the wing where it connected to the day room, near the activity table where a puzzle was being put together. The cart was unlocked, and the nurse was not in sight. During observation on 10/18/23 at 2:35 p.m., the medication cart for Wing One was positioned at the end of the wing where it connected to the day room, near the activity table where a puzzle was being put together. The cart was unlocked, and the nurse was not in sight. During an interview on 10/18/23 at 2:38 PM, Licensed Practical Nurse (LPN)A was preparing to take over the cart for the next shift and verified the cart for Wing One, located near the activity table, was unlocked when LPN A came upon the cart and a nurse was not in sight. During an interview on 10/18/23 at 2:38 PM, the Unit Manager confirmed the cart for Wing One was unlocked and should not have been left without being locked up. During an interview on 10/19/23 at 8:15 AM, Registered Nurse (RN) B, who worked the night shift the night before, confirmed orienting RN C, when RN C started working for the first time at the facility on 10/18/23, day shift. RN C was assigned to care for residents located on Wing One.	F 761	The DON will ensure the agency nurse completed the orientation checklist with the staff nurse. The staff nurse and agency nurse will sign the orientation checklist when completed and the DON will verify and sign the checklist ensuring the training happened. The FVCC Administrative Assistant will ensure the agency nurse's orientation checklists turned in have the agency nurse, Staff nurse and DON's initials showing it was completed.	

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F 761	Continued From page 9 Review of the facility's policy titled "Medication Administration (Specific)" reviewed 01/19/21, revealed "Medication cart is to be kept locked at all times unless in use and within the nurse's sight."	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. 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 food was labeled, dated, and disposed according to the facility's policy for food storage. This failure had the potential to affect all 45 residents who consumed food prepared from the facility's kitchen.	F 812	F-812 was corrected starting October 19, 2023, however, reeducation will take place on November 21, 2023. When truck arrives all items are to be dated with the day they arrived. When item is opened, it will be dated as opened, and when it should be discarded. All	11/21/23

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F 812	Continued From page 10 Findings include: During the initial kitchen inspection on 10/16/23 at 02:56 p.m., the following food items in the dietary refrigerator were not labeled, dated or discarded as required by the facility's policy: leftover puree cereal prepared on 10/08/23 and no date of when to discard. large, opened carton of chocolate milk with no dates when opened prepared bowls of lettuce/tomato salad with no dates for when prepared and discard date large container of leftover cheese sandwiches with no dates when prepared and no discard date. raw pork riblets stored in a zip lock bag with no date when removed from the original container and placed in a zip lock bag and no discard date. three large zip lock bag of boiled, peeled eggs with no dates when the eggs had been removed from the original bag and placed in a leftover bag and the discard date leftover chicken gravy in a large, covered container prepared on 10/08/23 with no discard date. leftover cooked chopped pork in covered container prepared 10/12/23 with no discard date. two large container of ranch dressing opened 01/14/23 and 07/11/23 with no discard date a bottle of mustard condiment opened 09/13/22 with no discard date. large bag of shredded cheese with no open date and an expiration date of 11/08/22. large bag of crispy fried onions opened 03/23/23 and no discard date. pitcher of tomato juice with no open and discard date large package of sliced cheese with no open and	F 812	employees who pull stock have been verbally informed of the food dating policy. This will be reinforced at the meeting with the kitchen staff taking place on November 21, 2023. The cooks will be assigned to monitor the dates on the food on a daily basis and sign off that everything opened in the refrigerators and shelves is dated. If it is not dated and cannot be identified as just being opened by someone working the shift, it will be thrown away. The culinary director will inventory once per week and ensure these dates are on all closed and opened packages. If finding anything out of date or not dated and unable to identify when it was opened, the food will be thrown away. The Administrator will perform at a minimum, one spot check per month to ensure all items are dated according to the attached policy.	

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F 812	Continued From page 11 discard date. large tray of leftover brownies in plastic wrap with no prepared or discard date During an interview on 10/16/23 at 3:15p.m., Director of Food Services (DFS) confirmed the foods identified in the refrigerator lacked either a preparation date, open date and that all of the food identified lacked a discard date. Review of the facility's policy titled, "Food Storage" reviewed 05/04/23 revealed, " ....a date marking should indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed ... or discarded to be visible on all high-risk food, and leftover food ...being clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded. All foods should be ...labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed for their safe useable dates ...or discarded."	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883		11/22/23

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F 883	Continued From page 12 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 883		

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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 883	Continued From page 13 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review the facility failed to ensure the influenza vaccine was given and/or documented refusal for the 2022 influenza season for 2 of 5 residents (R2, R7). As a result of this deficient practice, the resident who did not received the requested influenza vaccine were at higher risk for contracting influenza and the resident without education was not making an informed decisions about choice to receive the influenza vaccine or not. Findings include: R2's Admission Record indicated admission date of 04/04/17, readmission on 09/05/19 and medical diagnoses included Hemiplegia and hemiparesis following cerebral infarction. Further, a consent form for the 2022 season influenza vaccination documenting the choice YES, to receive the 2022 influenza vaccination. The form lacked documentation the 2022 influenza vaccination was given. During an interview on 10/17/23 at 4:58 p.m., the Infection Preventionist stated the influenza vaccination process at the facility was to have the local pharmacy administer the vaccinations. After the consent was signed, desire for the vaccination confirmed, education completed, the pharmacy administered the vaccination and documented on the consent form location, lot number of vaccination and initials of person administering the injection. The Infection Preventionist confirmed the consent form for R2 lacked documentation the 2022 influenza vaccine	F 883	F-883 is corrected effective October 24, 2023. Ensure that the residents have documentation in the progress notes in PointClickCare moving forward. Checking with PointClickCare as to whether we can have a declination tab entered into the form on PCC. This will be done by November 22, 2023. With all vaccinations and immunizations that occur after October 19, 2023, a signed declination or a signed acceptance form must be on file for all residents. The ADON will be responsible for ensuring his happens. The DON will verify by auditing after every one has taken place and initialing the form. Those who have had vaccinations/immunizations, names will be reviewed at the quarterly QAPI and verified by DON that the paperwork is in order.	

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	245344	A. BUILDING ______ B. WING ______	C 10/19/2023

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F 883	Continued From page 14	F 883		

was administered, noting a comment on the top of the form that indicated, "will wait." The Infection Preventionist confirmed the injection should have been administered and was not.

R7's Admission Record indicated admission date of 11/12/15, readmission on 09/19/18, and medical diagnoses of diabetes mellites and chronic kidney disease. However, lacked documentation of a consent to accept or refuse the 2022 influenza vaccination.

During an interview on 10/17/23 at 4:58 p.m., Infection Preventionist remembered R7 refused the influenza vaccination and confirmed there was no documentation about the refusal or information about the risks or benefits of receiving or refusing the influenza were provided to R7.

During an interview on 10/18/23 at 10:44 p.m., Director of Nursing (DON) confirmed R2 did not received the requested influenza vaccine for 2022 and R7, who may or may not have refused, had no documentation of being provided education about risks and benefits of the influenza vaccine for 2022.

Review of the facility policy titled "Influenza and Pneumococcal Disease Prevention" revised 01/05/23, revealed, " Influenza immunizations are offered to all resident and facility personnel from October 1 through March 31 annually. Documentation that the resident either received the influenza ... immunization or did not due to medical contraindications or refusal."

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	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/02/2023**

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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 11/02/2022. At the time of this survey, FAIRVIEW CARE CENTER 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		11/30/2023

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

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K 000	Continued From page 1	K 000		

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.

FAIRVIEW CARE CENTER is a 1-story building with no basement.

The building was constructed at 2 different times. The original building was constructed in 1975 and was determined to be of Type II(000) construction. In 1997, addition was constructed to the North Wing that was determined to be of Type II(000) construction.

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K 000	Continued From page 2 Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=D	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	K 324		12/8/23

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K 324	Continued From page 3 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement protective measures per NFPA 101 (2012 edition), Life Safety Code section 19.3.2.5.3(9). This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation in the Activities Area that the cooking stove was not fully equipped with the protective safety measures. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	Tag-0324 will be corrected by 12/8/2023. Stove has keyed switch and indicator light. Electrician has been contacted and has ordered a 120 minute timer. It will be installed by 12/8/2023.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		11/3/23

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K 345	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain unobstructed access to components of the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 19.3.4.2.2, NFPA 72 (2010 edition), National Fire Alarm and Signal Code, section 17.14.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation that adjacent to RM 321, the manual fire alarm box / pull station was access obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	Tag-0345 has been corrected 11/3/2023. At south entrance by door 321 a cabinet was under pull station. It was removed 11/3/23. All pull stations and fire extinguishers were inspected for access on 11/3/23. Daily and intermittent inspection by the maintenance department will be done to maintain unobstructed access to the fire alarm system. A daily log will be signed off and Maintenance Director will monitor compliance.	
K 353 SS=D	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, 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	K 353		11/22/23

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K 353	Continued From page 5 ______ 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 maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.4, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation that sprinkler heads located in the main Kitchen exhibited signs of debris loading and oxidation. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	TAg-0353 has been corrected 11/22/2023. All sprinkler heads in kitchen were inspected and cleaned of debris on November 3rd 2023. Heads were inspected by Fire Sprinkler service to asses condition. None were needing replacing at the time on 11/22/23. Date sprinkler system was last annual inspection on 08/29/2023 by Olympic Fire Protection and the water supply source is the City of Dodge Center.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced	K 355		11/21/23

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K 355	Continued From page 6 by: Based on observation and staff interview, the facility failed to maintain accessibility to fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.1, 6.1.3.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation, that the K-type fire extinguisher located in Kitchen was accessible obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	Tag-0355 has been corrected 11/21/2023. K extinguisher was moved to new location on November 21, 2023 in kitchen where it will not be blocked. All fire extinguishers in facility were inspected so nothing blocking them 11/21/23. Kitchen staff was trained on 11/21/2023 to not block fire extinguishers. Maintenance Department will continue inspection for compliance.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	K 374		12/14/23

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K 374	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation that the fire / smoke barrier door assemblies in the Admin Wing exhibited and air-gap greater that 1/8 inch, allowing the movement and passage of smoke. 2. On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation that the fire / smoke barrier door assemblies in Wing #2, upon testing, did not self-close and seal the opening. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	Tag-0374 will be corrected by 12/14/2023. Contract was signed with REMEDI8 (formerly Fire Door Solutions and Barrier compliance) on November 6th 2023, to do full inspection, documentation, parts order and repair. Scheduled date for onsite inspection, minor repairs and ordering parts not on hand is 12/14/23. Rated doors will be inspected annually. Maintenance Department will perform a Quarterly Rated Door inspection and resuls reported to QAPI. Maintenance Department will maintain a log of inspection for compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible	K 712		11/30/23

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K 712	Continued From page 8 alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that a fire drill was conducted in 3rd quarter for 3rd shift staff, and during 4th quarter for 1st shift. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 712	Tag-0712 will be corrected. Fire drill schedule will be made out annually. Schedule will be submitted to Safety and QAPI committee. Actual monthly drills will be reported to Safety and QAPI meeting. Administrator will monitor compliance.	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4).	K 753		11/3/23

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K 753	Continued From page 9 o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage proper percentages of combustible material(s) per NFPA 101 (2012 edition), Life Safety Code, section 19.7.5.6. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation, that resident room door (RM 205) was 100% covered with seasonal combustible decorative material An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 753	Tag-0753 has been corrected on 11/03/2023. Decoration was removed November 3rd, 2023. Activity director was educated. All staff were educated at annual all staff training November 8th & 9th. Maintenance Department will monitor for compliance.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		11/6/23

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

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K 920	Continued From page 10 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.4, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1), (2) and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation in the Dry Goods Storage Area that a commercial freezer was connected to an extension cord - not directly to the wall. 2. On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation in the Sprinkler System Riser Room an extension cord was connected to an appliance, ascended up the wall and above the ceiling tile, and was found descending from the ceiling tile in the Maint Director Office, and connected to an outlet.	K 920	Tag-0920 has been corrected. 1) Electrician wired in permanent receptacle behind freezer. Freezer is now plugged into receptacle on November 6th, 2023. 2) Extension cord was removed in sprinkler room. Electrician installed a new receptacle to use on November 6th, 2023. 3) Daisy chained power taps were removed. PT personnnel were educated. All staff were educated at All Staff Training on November 8th & 9th 2023. Maintenance director inspected facility and found no others on November 6th. Maintenance Director inspected again on November 28 and found power taps were compliant. Power tap inspection & extension cord use will be inspected quarterly by maintenance department. Results reported to QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 920	Continued From page 11 3. On 11/02/2023 between 1:00 PM and 4:00 PM, it was revealed by observation in the Physical Therapy / Occupational Therapy Area, relocatable power taps were daisy-chained together. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920		