DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2023

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

RE: CCN: 245451
Cycle Start Date: June 7, 2023

Dear Administrator:

On June 7, 2023, 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, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
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 September 7, 2023 (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 December 7, 2023 (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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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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Electronically delivered
June 29, 2023

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

Re: State Nursing Home Licensing Orders
Event ID: S7UU11

Dear Administrator:

The above facility was surveyed on June 5, 2023 through June 7, 2023 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, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
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 06/07/2023

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
E 000	Initial Comments On 6/5/23, to 6/7/23, 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 6/5/23, to 6/7/23, 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: The following complaints were reviewed with no deficiency issued. H54512584C (MN00089555), H54512582C (MN00090691), H54512583C (MN00092487). 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.	F 000		

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

Electronically Signed | 07/08/2023

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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F 000	Continued From page 1 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 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		7/5/23

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F 578	Continued From page 2 individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented in the medical record for 1 of 51 residents (R11) reviewed for advanced directives. Findings include: R11's quarterly Minimum Data Set (MDS) dated 4/18/23, indicated R11 had severe cognitive impairment and had diagnoses which included: Parkinson's, diabetes mellitus, (DM), and dementia. Identified R11 required extensive assistance with activities of daily living (ADL's) which included: bed mobility, transfers, and toileting. R11's current care plan dated 4/19/23, identified R11's advance directives were (do not resuscitate) DNR. Review of R11's electronic health record (EHR) identified the following: -R11's physician orders dated 4/29/23, identified R11 had an order for DNR. -R11's dashboard profile on the computer screen identified R11's status was DNR. -R11's Advance Directive dated 12/9/06, identified R11's status was a DNR.	F 578	On 6/6/23 upon the realization that the Choices of Limited Treatment did not contain the same code status as the face sheet, the Choices of Limited Treatment form was verified to be correct and remained in the paper chart. The face sheet which was incorrect was then removed from the paper chart. On 6/6/23 All Choices of Limited Treatment forms were audited on all residents for accuracy. Face sheets were removed from all resident paper charts and the paper face sheet will no longer be placed in the binder. On 6/8/23 paper charts on all resident were retired and replaced with a single binder which contains current Choices of Limited Treatment. The binder is red and clearly marked "Choices of Limited Treatment" to allow quick access for staff. On 6/14/23 staff were educated at the All Staff meeting on the new process for immediate identification of a resident□s CPR status and other choices of limited treatment for all current residents.	

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F 578	Continued From page 3 Review of R11's paper health record identified the following: -R11's choices sheet dated 5/17/21, identified R11's status was a DNR. -R11's face sheet undated identified R11 was a full code status. The paper health record identified a discrepancy of R11's wishes for resuscitation. During an interview on 6/6/23, at 8:18 a.m. registered nurse (RN)-A stated her usual practice in verifying a resident's code status was to first review the choices sheet which was located in the front of each resident's paper chart. In addition, RN-A stated there was a face sheet which identified the resident's code status located behind the choices sheet in each resident's paper chart. RN-A stated she would review the face sheet after the choices sheet. During a telephone interview on 6/6/23, at 2:05 p.m. nurse manager (NM) stated her usual practice in verifying a resident's code status was to review the choices sheet of the paper chart first. Secondly, she would review the face sheet of the paper chart. During an interview on 6/6/23, at 2:10 p.m. RN-B stated her usual practice in verifying a resident's code status was to review the resident's choices sheet which was located in front of the paper chart and then the face sheet which was located directly behind the choices sheet. RN-B confirmed R11's choices sheet in the paper chart identified R11 was a DNR. In addition, RN-B confirmed R11's face sheet in the paper chart identified R11 was a full code verifying a	F 578	On 7/5/23 The policy on Advance Directives and Choices of Limited Treatment was updated to reflect the new procedure. On 7/5/23 the deficiencies that were a result of Survey 6/5/23-6/7/23 were discussed at All Staff along with POC. Education was provided to all staff on the location of the binders and the new process per our updated Advance Directives and Choices of Limited Treatment Policy. All new nursing staff will be educated on this policy and procedure during their orientation. A Quality Assurance/Performance Improvement audit has been developed to ensure current and updated Choices of Limited Treatment sheets are placed into the red binder within each household. Beginning the week of 7/10/23, weekly auditing of the Choices of Limited Treatment binder will be completed by nurse leads or designee, for 3 months or until 100% compliant. The Quality Assurance/Performance Improvement audit results will be reported to the Quality Assurance/Performance Improvement meeting to monitor progress and ensure 100% compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 4 discrepancy. RN-B stated she was uncertain why the face sheet in the paper chart had not been updated to reflect the accurate status of DNR. During an interview on 6/6/23, at 2:15 p.m. director of nursing (DON) confirmed there was a discrepancy in R11's paper chart in which the choices sheet identified R11 was a DNR code status and the face sheet in the paper chart indicated R11 was a full code status. DON stated the facility's process in determining a resident's code status was to review the choices sheet in the paper chart. DON indicated the face sheet in the hard chart would have been a secondary place to look. DON stated her expectation would have been the choices sheet and the face sheet in R11's chart would have matched since the discrepancy had the potential to misdirect staff on whether or not cardiopulmonary resuscitation (CPR) should have been provided or not when an emergency situation occurred. A facility policy titled Advance Directives revised 2/4/21, indicated Advance Directives and choices of Limited Treatment form would be respected in accordance with state law and facility policy. Policy stated a copy of Advance Directive and choices of Limited Treatment would have been kept in paper form in the chart as well as scanned into the resident's chart.	F 578		

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F 578	Continued From page 5	F 578		

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	245451	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2023**

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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. 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		07/08/2023

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

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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 345 SS=E	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 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5, and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.4.2.2 This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/06/2023 at 11:00 AM, it was revealed by a review of available documentation that the last annual fire alarm inspection report dated 10/18/2022 reported smoke detectors in rooms 400- 401, 404, 404-407, 409, 411-412 were not tested.	K 345	On 6/15/23 Midwest Alarm Fire & Security Systems returned to Fairway View Neighborhoods to test smoke detectors in rooms 400, 401, 404, 407, 408, 409, 411, and 412. Midwest Alarm was did not test these rooms at their previous visit in October 2022 due to these being COVID-19 positive resident rooms. All sensitivities on detectors tested ok and system normal on departure on 6/15/23, correcting this deficiency. For future inspections, Maintenance Director will audit annual report from Midwest Alarm to ensure all smoke detectors were tested. Fairway View Maintenance staff will assist Midwest Alarm with testing rooms they are unable	6/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 3 An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 345	to due to health reasons by properly donning/doffing and following Infection Control guidelines as required for each resident at the time of inspection.	
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 maintain the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6, 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. Findings include: On 06/06/2023, at 11:30 AM, it was revealed by a review of available fire door test and inspection	K 761	On 7/17/23, Midwest Mechanical is scheduled to replace all identified doors in fire door test and inspection that occurred in December 2022 to bring the facility back into compliance.	7/17/23

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	245451	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2023**

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K 761	Continued From page 4 documentation and an interview with the Administrator that the facility provided documentation verifying that the fire door inspection had been completed on 12//2022, as of the time of the survey have failed to have the repairs completed. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 761		

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	00771	A. BUILDING: _____ B. WING _____	C 06/07/2023

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FAIRWAY VIEW NEIGHBORHOODS	201 MARK DRIVE ORTONVILLE, MN 56278

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/5/23, to 6/7/23, 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. 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 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum: A. the resident's legal name and preferred name; B. previous address; C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if any; I. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and clergy member; M. hospital preference; and N. name of attending physician. This MN Requirement is not met as evidenced	2 620		7/5/23

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2 620	Continued From page 3 by: Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented in the medical record for 1 of 51 residents (R11) reviewed for advanced directives. Findings include: R11's quarterly Minimum Data Set (MDS) dated 4/18/23, indicated R11 had severe cognitive impairment and had diagnoses which included: Parkinson's, diabetes mellitus, (DM), and dementia. Identified R11 required extensive assistance with activities of daily living (ADL's) which included: bed mobility, transfers, and toileting. R11's current care plan dated 4/19/23, identified R11's advance directives were (do not resuscitate) DNR. Review of R11's electronic health record (EHR) identified the following: -R11's physician orders dated 4/29/23, identified R11 had an order for DNR. -R11's dashboard profile on the computer screen identified R11's status was DNR. -R11's Advance Directive dated 12/9/06, identified R11's status was a DNR. Review of R11's paper health record identified the following: -R11's choices sheet dated 5/17/21, identified R11's status was a DNR. -R11's face sheet undated identified R11 was a full code status. The paper health record identified a discrepancy of R11's wishes for resuscitation.	2 620	Corrected	

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2 620	Continued From page 4 During an interview on 6/6/23, at 8:18 a.m. registered nurse (RN)-A stated her usual practice in verifying a resident's code status was to first review the choices sheet which was located in the front of each resident's paper chart. In addition, RN-A stated there was a face sheet which identified the resident's code status located behind the choices sheet in each resident's paper chart. RN-A stated she would review the face sheet after the choices sheet. During a telephone interview on 6/6/23, at 2:05 p.m. nurse manager (NM) stated her usual practice in verifying a resident's code status was to review the choices sheet of the paper chart first. Secondly, she would review the face sheet of the paper chart. During an interview on 6/6/23, at 2:10 p.m. RN-B stated her usual practice in verifying a resident's code status was to review the resident's choices sheet which was located in front of the paper chart and then the face sheet which was located directly behind the choices sheet. RN-B confirmed R11's choices sheet in the paper chart identified R11 was a DNR. In addition, RN-B confirmed R11's face sheet in the paper chart identified R11 was a full code verifying a discrepancy. RN-B stated she was uncertain why the face sheet in the paper chart had not been updated to reflect the accurate status of DNR. During an interview on 6/6/23, at 2:15 p.m. director of nursing (DON) confirmed there was a discrepancy in R11's paper chart in which the choices sheet identified R11 was a DNR code status and the face sheet in the paper chart indicated R11 was a full code status. DON stated the facility's process in determining a resident's	2 620		

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2 620	Continued From page 5 code status was to review the choices sheet in the paper chart. DON indicated the face sheet in the hard chart would have been a secondary place to look. DON stated her expectation would have been the choices sheet and the face sheet in R11's chart would have matched since the discrepancy had the potential to misdirect staff on whether or not cardiopulmonary resuscitation (CPR) should have been provided or not when an emergency situation occurred. A facility policy titled Advance Directives revised 2/4/21, indicated Advance Directives and choices of Limited Treatment form would be respected in accordance with state law and facility policy. Policy stated a copy of Advance Directive and choices of Limited Treatment would have been kept in paper form in the chart as well as scanned into the resident's chart. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review policies and procedures for advanced directives and/or physician orders to ensure records are consistent and maintained accurate throughout the medical record upon admission, quarterly, and with any significant change. Staff should be educated on the need to clarify discrepancies in advanced directives, and/or physician orders. The DON or designee should review the resident affected, and all other current residents to ensure accuracy of code status and audit any newly admitted resident health records. The results of those audits should go to the Quality Assurance Performance Improvement (QAPI) committee for a specific time until compliance is achieved and maintained to determine compliance or the need for further monitoring.	2 620		

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2 620	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 620		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 31, 2023

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

RE: CCN: 245451
Cycle Start Date: June 7, 2023

Dear Administrator:

On June 29, 2023, we notified you a remedy was imposed. On August 28, 2023 the Minnesota Department(s) 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 August 11, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 7, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 29, 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 September 7, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 11, 2023, 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,

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

August 31, 2023

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

Re: Reinspection Results
Event ID: S7UU12

Dear Administrator:

On July 17, 2023 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 June 7, 2023. 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