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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TMET

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00259

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245170**
2.STATE VENDOR OR MEDICAID NO.
(L2) **616845105**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRVIEW UNIVERSITY TRANS SERV**
(L4) **2450 RIVERSIDE AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55454**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/032014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:
ompliance With
Program Requirements
Compliance Based On:
1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 05/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/13/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/11/1969** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5170

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 11/14/13. On 01/03/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 01/23/14, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 11/14/13, effective 12/27/13. Refer to the CMS-2567B for both health and life safety code.

Effective 12/27/13, the facility is certified for 36 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5170

March 11, 2014

Ms. Sharon Johnson, Administrator
Fairview University Transitional Services
2450 Riverside Avenue South
Minneapolis, Minnesota 55454

Dear Ms. Johnson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 27, 2013, the above facility is certified for:

36 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 27, 2014

Ms. Sharon Johnson, Administrator
Fairview University Trans Serv
2450 Riverside Avenue South
Minneapolis, MN 55454

RE: Project Number S5170023

Dear Ms. Johnson:

On December 3, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 14, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 23, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 14, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 18, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 14, 2013, effective December 27, 2013 and therefore remedies outlined in our letter to you dated December 3, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Telephone: 651-201-3792 Fax: 651-201-3790

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245170	A. Building B. Wing	1/3/2014

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0329 Reg. # 483.25(l) LSC	12/27/2013	ID Prefix F0428 Reg. # 483.60(c) LSC	12/27/2013	ID Prefix F0465 Reg. # 483.70(h) LSC	12/27/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	05/12/2014	18623	01/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/14/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245170	A. Building B. Wing	1/3/2014

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0329 Reg. # 483.25(l) LSC	12/27/2013	ID Prefix F0428 Reg. # 483.60(c) LSC	12/27/2013	ID Prefix F0465 Reg. # 483.70(h) LSC	12/27/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By 16022	Date: 1/27/14	Signature of Surveyor: 18623	Date: 1/3/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/14/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245170	01 - MAIN BUILDING 01	1/23/2014

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0020	Correction Completed 11/14/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	16022	1/27/14	28120	1/23/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/14/2013				

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245170	**FAIRVIEW UNIVERSITY TRANS SERV**	*K4 **11/14/2013**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1 [X]	A2 [ ]	A3 [ ]	A4 [X]	A5 [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A. [X]	B. [ ]	C. [ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TMET

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00259

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245170**
2.STATE VENDOR OR MEDICAID NO.
(L2) **616845105**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRVIEW UNIVERSITY TRANS SERV**
(L4) **2450 RIVERSIDE AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55454**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/14/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **36** (L18)

13.Total Certified Beds **36** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 12/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/12/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/11/1969** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN = 24-5170

At the time of the standard survey completed November 14, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Also, see attached Fire Safety Evaluation System (FSES) for life safety code results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7661

December 3, 2013

Ms. Sharon Johnson, Administrator
Fairview University Transitional Services
2450 Riverside Avenue South
Minneapolis, Minnesota 55454

RE: Project Number S5170023 and Complaint Number H5170020

Dear Ms. Johnson:

On November 14, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 14, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5170020.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the November 14, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5170020 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 24, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 24, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by February 14, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 14, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BUILDING _____ B. WING _____	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

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F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A concurrent complaint investigation was conducted and H5170020 was not substantiated based on the evidence at the time of the survey.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	F-329 - **Based on observation, interview and document review, the facility failed to monitor for drug-induced side effects and efficacy for 1 of 5 residents in the sample reviewed for the use of anti-psychotic and anti-anxiety medications.** All patients who are admitted to the Transitional Care Unit will have orthostatic blood pressures taken and recorded upon admission. Additionally, any patient on psychotropic medications upon admission will be administered the DISCUS assessment within a week of admission. The care plan has been updated to include goals of care for patients on sleep aids, hypnotics, psychotropic and anti-anxiety medications. The TCU nurses have been advised to chart on a flow sheet for patients on medications for mood stabilization, antidepressants, hypnotics and anti-anxiety medications. The flow sheet prompts for notations on targeted	12-18 12-18 12-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon A Johnson | TITLE: Administrator | (X6) DATE: 12-18-13

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 329	Continued From page 1 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor for drug-induced side effects and efficacy for 1 of 5 residents (R80) in the sample reviewed for the use of anti-psychotic and anti-anxiety medications. Findings include: R80 was re-admitted on 10/23/13, with diagnoses of lymphoma, multiple Myeloma (with ongoing chemotherapy) and metastatic cancer to the spine, esophagus, and gallbladder. R80 was re-admitted to the facility after a fall at home in which R80 sustained a left femoral neck fracture. R80 received Zyprexa (an antipsychotic medication) - which potentially can be a risk factor for tardive dyskinesia often called extrapyramidal side effects (EPSE) (involuntary movements of the tongue, lips, face, trunk, and extremities and severe orthostatic hypotension (when a person's blood pressure drops significantly when changing positions from lying down or sitting to standing up). Compazine (a medication used for nausea/vomiting) which can potentially cause side effects of tardive dyskinesia and/or hypotension. Ativan (an anti-anxiety medication) which can potentially cause a side effect of hypotension. R80 was not monitored for the potential side effects and indications for use	F 329	behaviors; emotional state; and sleep. Bi-monthly, either the Director of Nursing or the MDS Nurse will audit the patients identified through MDS as on psychotropic medications for completion of the DISCUS. The Director of Nursing or her designee will also randomly audit charts of 10% of patients to review charting for mood; emotional state; and sleep. The audit will continue for 3 months. Acceptable deviation will be <10%. Any incomplete charting will result in coaching of staff.	3-19-14 12-9-13

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F 329	Continued From page 2 of the medications. R80 was observed to be lying down in bed on 11/12/13, at 3:10 p.m. R80 stated they were not feeling well. On 11/13/13, at 7:30 a.m. R80 was observed lying on a gurney waiting for tests to be performed. The care plan dated 10/23/13, indicated: fall precautions, monitor for fall risk and follow safety measures, using a rolling walker provided from home. On Zyprexa, Compazine watch for EPSE. The care plan failed to identify target behaviors and what to monitor for the falls risk. A Pharmacy Medication Review Regimen dated 11/1/13, at 3:41 p.m., indicated a pharmacist had reviewed all medications, all medications had clear indications and recommended limiting Tylenol to 3 grams per day related to an elevated liver test, no hemoglobin (HGB) parameters for Aranesp, to monitor platelets weekly related to blood thinning medications. Magnesium to be rechecked on an office visit and to monitor for excessive sedation and falls related to gabapentin and hydromorphone (a pain control medication) ordered as needed. No additional pharmacy review notes were available. The recommendations lacked evidence of review of anti-psychotic medications, and lacked a warning for orthostatic blood pressure monitoring (even though it was listed in the detailed medication order), and lacked direction for a baseline Abnormal Involuntary Movement Scale (AIMS), or Dyskinesia Identification System: Condensed User Scales (DISCUS). The Care Area Assessment (CAA) dated 11/5/13, included: functional rehabilitation, falls,	F 329		

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F 329	Continued From page 3 psychotropic drug use, and indicated care plan initiated. Physicians orders: indicated Zyprexa (an antipsychotic medication) 2.5 milligrams (mg) was ordered on 11/5/13, Compazine 5-10 mg tablets every six hours as needed was ordered 11/8/13, and Ativan 0.5 mg for anxiety or nausea and vomiting was ordered 11/8/13. Nursing progress notes dated 11/8/13, indicated Behavioral assessment "not exhibited", mobility in bed, transfers, and ambulation "Independent, no help or oversight at anytime." The medical record lacked evidence of the monitoring of the side effects and target behvaior/mood monitoring. On 10/14/13, at 10:50 a.m. registered nurse (RN)-A charge nurse stated EPSE would be documented on the flow sheet, when the flow sheet was reviewed RN-A stated, there were areas for cognition, mood, behaviors, and speech, but no area to document side effects. RN-A stated EPSE monitoring may be put into nursing notes. On 11/14/13, at 10:55 a.m. the consultant pharmacist stated nursing staff recorded side effects of medications and would fill out any forms for DISCUS or AIMS assessments. On 11/1/4/13, at 10:58 a.m. the director of nursing (DON) stated antipsychotic charting would be under behavioral in the electronic medical record (e-MR) and would be exception charting. A review of the e-MR charting did not include any behavioral notes on behaviors or EPSE. The DON verified there was no orthostatic blood pressure (BP) assessment documented, but did	F 329		

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F 329	Continued From page 4 note the order (in Epic e-mar). The DON was not aware orthostatic BP's were needed for Zyprexa, or that the DISCUS, AIMS or other method of assessing and monitoring EPSE is needed as baseline for anti-psychotic medications. The DON did verify that R80 was considered a high fall risk on assessment due to the fall at home, and Zyprexa and Compazine medications. On 11/14/13, at 10:45 a.m. MDS coordinator (MDS-J) reviewed the Epic e-MR and did not see any side effects or behavioral documentation, but stated she was not the expert on EPIC charting. MDS-J stated usually the resource nurse, does the admission, and sets up the initial care plan. The facility lacked baseline DISCUS/AIMS assessment, did not identify target behaviors and lacked side effect monitoring for Zyprexa and Compazine. The Policy Medication Management: TCU, dated as reviewed 1/24/11, indicated: I. "The interdisciplinary team reviews the resident's medication regiment [sic] for efficacy and actual or potential medication-related problems on an ongoing basis... B. The resident is evaluated before initiating, withdrawing or withholding medications, or using nonpharmacologic approaches. 1. The extent of the evaluation will vary according to the resident's current condition, but may include: a. An appropriately detailed evaluation of mental, physical, psychosocial, and functional status, including co-morbid conditions and pertinent psychiatric symptoms and diagnoses... C. Information gathered during the initial and ongoing evaluations are incorporated into a	F 329		

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F 329	Continued From page 5 comprehensive care plan that reflects appropriate medication related goals and parameters for monitoring the resident's condition and ongoing need for the medications, including, but not limited to what is monitored, who will be responsible for monitoring, and how often and when a re-evaluation is necessary. 1. The care planning team defines quantitative and qualitative monitoring parameters using a variety of resources...Monitoring Medication in Long Term Care Residents, manufacturers' package inserts and black box warnings; facility policies and procedures; pharmacists; clinical practice guidelines or clinical standards of practice; medication references; and clinical studies or evidence based review articles that are published in medical and/or pharmacy journals. D. The resident medication regimen is evaluated when one or more of the following occur... 1. Admission or re-admission... I. When a resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and or non-pharmacological interventions, including behavioral interventions have been effective in reducing the symptoms, the resident is evaluated for the appropriateness of a taper or gradual dose reduction (GDR) of the medication 1. Antipsychotic's. If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year. A GDR must be attempted annually, unless clinical	F 329		

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F 329	Continued From page 6 contraindicated.... II. If a medication seems unnecessary or harmful to the resident, the consultant pharmacist requests the prescriber to evaluate the resident for the continued need for the medication and/or to consider tapering the medication. If the prescriber deems the medication necessary, a documented clinical rationale for the benefit of, or necessity for, the medication is documented in the resident's active record. III. When other organizations perform medication therapy management services, e.g., Medicare Prescription Drug Plans (PDPs), the consultant pharmacist evaluates the recommendation for applicability to the long-term care resident. Psychopharmacologic medication is defined by the centers for Medicare and Medicaid Services [42 CFR #483.25(1) Unnecessary Medications (F329)] as any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428		

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F 428	Continued From page 7 Based on observation, interview and document review, the consultant pharmacist failed to identify and report an irregularity regarding antipsychotic medications and/or document clinical indications for continued use and for monitoring of side effects for 1 of 5 residents (R80) whose medications were reviewed. Findings include: R80 was observed to be lying down in bed at 3:10 p.m. on 11/12/13, stated not feeling well. On 11/13/13, at 7:30 a.m. was observed on a gurney (rolling cart to transport patients) to transfer for ventilation perfusion scan (looking for blood clots in the lungs) testing and a biliary (gallbladder) drain change. The Admission Progress Note dated 10/23/13, indicated R80 was admitted with diagnoses of Lymphoma, Multiple Myeloma (with ongoing chemotherapy) and metastatic cancer to the spine, esophagus, and gallbladder and depression. R80 had been hospitalized 9/24/13 through 10/5/13, for bacteremia (an overwhelming immune response to a bacterial infection) secondary to cholangitis (infection in the duct from the gallbladder to the liver). R80 was then in the facility from 10/5/13 through 10/17/13, and discharged home. On 10/18/13, R80 was readmitted to the hospital after a fall at home and was transferred to the facility again on 10/23/13, with acute left femoral neck fracture repair, complicated by acute delirium and acute on chronic anemia, with ongoing chemotherapy. Delirium now resolved, likely multifactorial, secondary to inpatient/post-operative status, chemotherapy, narcotics, infection and benzodiazepines.	F 428	**F428 Based on observation, interview and document review, the consultant pharmacist failed to identify and report an irregularity regarding antipsychotic medications and/or document clinical indications for continued use and for monitoring of side effects for 1 of 5 residents (R80) whose medications were reviewed.** Upon prescribing of any medication, including antipsychotic medications, the pharmacist will review the provider documentation for indications, clarifying with the provider if necessary. During each medication regimen review, dose change, or upon request, the pharmacist will review the medication(s) to ensure they remain appropriate. During the medication regimen review, Pharmacy staff will review the medical record and laboratory data to monitor for side effects of antipsychotic medications. In addition, during each medication regimen review after the initial one, the pharmacist will evaluate if a gradual dose reduction is appropriate. If side effects are present	12-18 12-18

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F 428	Continued From page 8 The care plan dated 10/23/13, indicated: on Zyprexa, Compazine watch for EPSE. The Care plan failed to identify target behaviors, and lacked direction to perform an orthostatic blood pressure check. The Care Area Assessment (CAA) dated 11/5/13, included: functional rehabilitation, falls, psychotropic drug use, and indicated care plan initiated. Physicians orders: indicated Zyprexa (an antipsychotic medication) 2.5 milligrams (mg) was ordered on 11/5/13, Compazine 5-10 mg tablets every six hours as needed was ordered 11/8/13, and Ativan 0.5 mg for anxiety or nausea and vomiting was ordered 11/8/13. Nursing progress notes dated 11/8/13, indicated Behavioral assessment "not exhibited", mobility in bed, transfers, and ambulation "Independent, no help or oversight at anytime." The medical record lacked evidence of the monitoring of the side effects and target behavior/mood monitoring for the medications ordered for R80. On 10/14/13, at 10:50 a.m. registered nurse (RN)-A charge nurse stated EPSE would be documented on the flowsheet, when the flowsheet was reviewed RN-A stated, there were areas for cognition, mood, behaviors, and speech, but no area to document side effects. RN-A stated EPSE monitoring may be put into nursing notes. On 11/14/13, at 10:55 a.m. the consultant pharmacist stated nursing records side effects of medications and would fill out any forms for	F 428	or gradual dose reduction is appropriate, the pharmacist will contact the provider directly. The pharmacy manager will audit patients receiving antipsychotic medications bi-monthly x6 to ensure compliance. Acceptable deviation will be <10%. Any irregularities will immediately be corrected and reported to the Director of Nursing.	3-19-14 D-3-13

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F 428	Continued From page 9 DISCUS or AIMS assessments. The consultant pharmacist verified pharmacy was decentralized (on the unit every day reviewing medication orders). On 11/1/4/13, at 10:58 a.m. the director of nursing (DON) stated antipsychotic charting would be under behavioral in the electronic medical record (e-MR) and would be exception charting. A review of the e-MR charting did not reveal any behavioral notes on behaviors or EPSE. The DON verified there was no orthostatic blood pressure (BP) assessment documented, but did note the order did exist in Epic e-mar. The DON was not aware orthostatic BP's were needed for Zyprexa and Compazine, or that the DISCUS, AIMS or other method of assessing and monitoring EPSE was needed as baseline for anti-psychotic medications. The DON did verify that R80 was considered a high fall risk on assessment due to the fall at home, and Zyprexa and Compazine medications. The nursing notes lacked target behavior monitoring for specific identified behaviors for anti-psychotic and anti-anxiety medications. On 11/14/13, at 10:45 a.m. MDS coordinator (MDS-J) reviewed the Epic e-MR and did not see any side effects or behavioral documentation, but stated she was not the expert on EPIC charting. MDS-J stated usually the resource nurse, does the admission, and set up initial care plan. The facility lacked baseline Discus/Aims assessment, did not identify target behaviors and lacked side effect monitoring for Zyprexa and Compazine. The Policy Medication Management: TCU, dated as reviewed 1/24/11, indicated: I. "The interdisciplinary team reviews the	F 428	**Addendum to the Medication Management TCU policy** Upon admission to the TCU, each patient will have an orthostatic blood pressure assessed and documented by nursing staff. The pharmacist will also review this as part of the Medication Regimen Review. Psychotropic medications: any patient admitted on a psychotropic medication will have a DISCUS assessment completed within 1 week of admission. This DISCUS will be repeated quarterly. All psychotropic medication must have a valid indication upon prescribing. All questionable indications will be clarified with the provider. With each Medication Regimen Review, the pharmacist will evaluate the appropriateness of the medication; evaluate side effects and the need for a gradual dose reduction. Any findings will be discussed with the provider and documented in the medical record.	12-18-13

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F 428	Continued From page 10 resident's medication regiment [sic] for efficacy and actual or potential medication-related problems on an ongoing basis... B. The resident is evaluated before initiating, withdrawing or withholding medications, or using nonpharmacologic approaches. 1. The extent of the evaluation will vary according to the resident's current condition, but may include: a. An appropriately detailed evaluation of mental, physical, psychosocial, and functional status, including co-morbid conditions and pertinent psychiatric symptoms and diagnoses... C. Information gathered during the initial and ongoing evaluations are incorporated into a comprehensive care plan that reflects appropriate medication related goals and parameters for monitoring the resident's condition and ongoing need for the medications, including, but not limited to what is monitored, who will be responsible for monitoring, and how often and when a re-evaluation is necessary. 1. The care planning team defines quantitative and qualitative monitoring parameters using a variety of resources...Monitoring Medication in Long Term Care Residents, manufacturers' package inserts and black box warnings; facility policies and procedures; pharmacists; clinical practice guidelines or clinical standards of practice; medication references; and clinical studies or evidence based review articles that are published in medical and/or pharmacy journals. D. The resident medication regimen is evaluated when one or more of the following occur... 1. Admission or re-admission...	F 428		

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	245170	A. BUILDING _____ B. WING _____	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 11 I. When a resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and or non-pharmacological interventions, including behavioral interventions have been effective in reducing the symptoms, the resident is evaluated for the appropriateness of a taper or gradual dose reduction (GDR) of the medication 1. Antipsychotic's. If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts) within the first year, unless clinically contraindicated. After the first year. A GDR must be attempted annually, unless clinical contraindicated.... II. If a medication seems unnecessary or harmful to the resident, the consultant pharmacist requests the prescriber to evaluate the resident for the continued need for the medication and/or to consider tapering the medication. If the prescriber deems the medication necessary, a documented clinical rationale for the benefit of, or necessity for, the medication is documented in the resident's active record. III. When other organizations perform medication therapy management services, e.g., Medicare Prescription Drug Plans (PDPs), the consultant pharmacist evaluates the recommendation for applicability to the long-term care resident. Psychopharmacologic medication is defined by the centers for Medicare and Medicaid Services [42 CFR #483.25(1) Unnecessary Medications (F329)] as any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders."	F 428		
F 465	483.70(h)	F 465		

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F 465 SS=E	Continued From page 12 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure comfortable temperatures were maintained in resident's rooms for 2 of 3 residents (R214, R218). In addition, 2 refrigerators in the occupational therapy (OT) kitchen/Leisure room were not maintained in a clean manner when reviewed for environment which had the potential to affect up to 14 residents per week who participated in occupational therapy learning skills. Findings include: Comfortable Temperatures: On 11/12/13, 03:01 p.m. during interview R218 stated It gets cold and hot in here and has been hard to regulate the temperature." She was not sure if she had reported it but thought she had to one of the staff. On 11/12/13, 03:48 p.m. during interview R214 stated "It is hard to regulate temperature in this room it is either too hot or too cold." On 11/14/13, at 9:00 a.m. the environmental tour was conducted with the facility administrator (O)-A, the director of environmental services (O)-B, the director of facility services (O)-C, the regulatory compliance specialist (O)-E and the	F 465	The Facilities team has completed a room-to-room check of thermostatic controls, to assure that controls are working in patient rooms. The Administrator has reminded all TCU staff, through email and other communication, to check with patients on room comfort as well as other needs.	12-16

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F 465	Continued From page 13 principle engineer. The following issues were noted: -At 9:06 a.m. R218 was observed lying in her bed with covers up to her neck and the induction unit vent area was covered with cloth tote bags and a pillow on top. R218 reported to surveyor and O-C the temperature was hard to regulate. O-C was observed reaching over the induction unit on the wall and stated "Feels a little cool here." R218 stated she used the tote bags and pillow to keep the cold air from blowing in the room. O-C assured R218 that the engineering staff would look into the issue as soon as possible. The temperature was reading 70 degrees Fahrenheit. -At 9:10 a.m. R214 reported to O-C the temperature in the room was hard to regulate and stated was a little cold right then and was shortly going to get a sweater. R214 further stated "When the sun comes up it gets hot and I am going home tomorrow but want the problem to be fixed for the next patient." O-C assured the R214 the issue would be resolved and temperature at the time was reading 75.9 degrees Fahrenheit. The Plant Operations and Maintenance Program policy revised 12/10, directed "The maintenance and operation of all hospital buildings, plant components, utilities (including electric, water systems, steam, air, gas, fuel, oil), sanitary systems, refrigerator units, ventilation and air conditioning systems, fire alarm systems, and internal lighting are the primary responsibilities essential in the Plant Operations and Maintenance Program." OT Kitchen/leisure room: On 11/12/13, at 4:05 p.m. R224 reported "The kitchen area to the right of the nursing station is	F 465	The Administrator will, once a week, randomly check w/patients on room comfort and will randomly survey the kitchen for cleanliness. She will log results for 3 months, and note correction taken, if needed.	3-19-14 188743

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F 465	Continued From page 14 dirty and there was mold in the coffee maker when I was in that kitchen and I had to clean it. The occupational therapist staff came and got me to fix a bag of popcorn but I told the staff I was not going to do so as the microwave was dirty and looking inside the drawers and fridges it was disgusting. I can clean the area even better than them here. And I can make a bag of popcorn myself." On 11/14/13, at 9:00 a.m. the environmental tour was conducted with the facility administrator (O)-A, the director of environmental services (O)-B, the director of facility services (O)-C, the regulatory compliance specialist (O)-E and the principle engineer. The following issues were noted: On 11/14/13, at 9:11 a.m. O-B verified both the refrigerators in the OT kitchen/Leisure room were not clean and stated food service was responsible for cleaning the refrigerators once a month and would check with the food service director (O)-F if the department needed assistance to clean the refrigerators. On 11/14/13, at 9:14 a.m. O-A stated one of the refrigerators used by OT was cleaned by the OT staff and her expectation was to have the area clean as that was resident space. On 11/14/13, at 12:57 p.m. the regulatory specialist provided a copy of "Refrigerators/ Freezers" a cleaning log stated the director of food service (O)-F had provided a blank copy of what the facility actually used to track the cleaning of the refrigerators on the unit and there were no completed cleaning log records which indicated when the refrigerators had been	F 465	The job duties of the Rehab Aid and the Health Unit Coordinator have both been updated to specifically address checking the refrigerators and cleaning the refrigerator. The expectation is that the OT refrigerators receive a deep cleaning once a month. The refrigerators are checked daily to see if there have been any spills or if cleaning is needed because of use. The patient/family refrigerator is supplied as a courtesy to family members who may want to eat here while visiting the patient, or share a home meal with the patient. If the HUC identifies the refrigerator needs to be cleaned, she will either take care of the cleaning (a spill) or notify appropriate staff (more extensive clean).	12-16-13

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F 465	Continued From page 15 cleaned. Additionally, O-E stated the O-F had reported the food service manager was responsible to oversee the cleaning schedule for the refrigerators. On 11/15/13, at 8:18 a.m. via telephone the administrator stated that typically the OT kitchen area would be used by four to six residents or family members and the refrigerators were used as courteously for residents and families to store foods or some residents would use it to store ethnically preferred foods. On 11/15/13, at 8:24 a.m. via telephone the administrator stated per OT typically the OT kitchen area was used by one to two residents per day to practice kitchen skills and normally the residents are not invited to eat the food they are practicing to prepare but rather demonstrating kitchen skills. The facility Refrigerator Safety policy revised 9/7/2012, directed "E. Patient care staff as assigned by the unit is responsible for the: 4. Cleaning of any and all incidental spills." The policy lacked information on where staff was to document after cleaning the refrigerators, how often to clean them, and who was responsible to oversee the refrigerators used to store resident food were maintained clean.	F 465		

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	245170	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/14/2013**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, UMMC Fairview Transitional Services was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to	K 000	Meets by FSES PCok TS 12-23-13	

Dc: 12-24-13

EXIT: 1-14-13

RECEIVED
DEC 23 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12-18-13

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 prevent a reoccurrence of the deficiency. This 5-story building was determined to be of Type II(222) construction. It has a full basement and is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 36 beds and had a census of 20 at the time of the survey. Only the 4th floor is covered in this survey. The requirement at 42 CFR, Subpart 483.70(a) NOT MET as evidenced by:	K 000		
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain vertical openings as required by LSC(00) Section 19.3.1.1. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 12:00 PM on 11/14/2013, observation revealed that the resident room ventilation system is served by a vertical riser duct shaft with horizontal ductwork leading from the penthouse to the resident	K 020		

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K 020	Continued From page 2 rooms. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 020	Meets by FSES FB	11-14-13

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7661

December 3, 2013

Ms. Sharon Johnson, Administrator
Fairview University Transitional Services
2450 Riverside Avenue South
Minneapolis, Minnesota 55454

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5170023

Dear Ms. Johnson:

The above facility was surveyed on November 12, 2013 through November 14, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5170020 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File