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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UIWF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00771

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)
13.Total Certified Beds **51** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE - NE II 08/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialilst 08/24/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/21/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245451

August 23, 2018

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

Dear Administrator:

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 July 20, 2018 the above facility is recommended for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
August 24, 2018

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

RE: Project Number S5451029

Dear Administrator:

On July 10, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 15, 2018. (42 CFR 488.422)

On June 5, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 3, 2018. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of June 5, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 3, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on May 3, 2018, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on June 19, 2018. The most serious deficiencies at the time of the revisit were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 26, 2018, the Minnesota Department of Health and on July 27, 2018 the Department of Public Safety and the Centers for Medicare and Medicaid Services (CMS), completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 19, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 20, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 19, 2018, as of July 20, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 20, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of July 10, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 3, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 3, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 3, 2018, is to be rescinded.

In our letter of July 10, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 3, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 20, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UIWF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00771

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245451**
2.STATE VENDOR OR MEDICAID NO.
(L2) **545740800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/19/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)
13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE - NE II 07/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Da/te:
Joanne Simon, Enforcement Specialist 08/23/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/21/2018
(L33)

DETERMINATION APPROVAL

Electronically delivered

July 10, 2018

Mr. David Rogers, Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

RE: Project Number S5451029

Dear Mr. Rogers:

On May 21, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 3, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 23, 2018, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious cited as follows:

- K353 -- S/S: F -- NFPA 101 -- Sprinkler System - Maintenance and Testing
- K711 -- S/S: F -- NFPA 101 -- Evacuation and Relocation Plan

On June 5, 2018, CMS forwarded the results of the FMS to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 3, 2018. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of June 5, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 3, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 3, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 3, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

On June 19, 2018, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 3, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on May 3, 2018. The deficiency not corrected is/are as follows:

F0812 -- S/S: D -- 483.60(i)(1)(2) -- Food Procurement,store/prepare/serve-Sanitary

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) as evidenced by the electronically attached CMS-2567, whereby corrections are required.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the May 3, 2018 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective July 15, 2018. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 3, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 3, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 3, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Fairway View Neighborhoods is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 3, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 3, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	R 06/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 6/19/18. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of onsite PCR which are located on the CMS2567. 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}		
{F 812} SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	{F 812}	The black square spout on water/ice	7/20/18

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

Electronically Signed | 07/19/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	R 06/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 812}	Continued From page 1 review, the facility failed to maintain the water and ice machines for 2 of 3 units, to prevent potential contamination for their residents who currently resided in the facility. Findings include: On 6/19/18, at 10:42 a.m. in the Granite View unit kitchen, the water and ice machine was observed to have a moderate amount of hard water lime scale residue and white to light brown build up covering the inside of the black square spout and a small amount of white and brown hard water staining on the tray. On 6/19/18, at 10:49 a.m. in the Harvest Trail unit kitchen,the water and ice machine had a large amount of white, tan and light brown hard water lime scale buildup covering the inside of the black square spout. Homemaker (HM)-B viewed water and ice machine spout with surveyor and agreed buildup present. HM-B indicated she was new, but had received education on cleaning the water and ice machine. HM-B indicated it was cleaned twice a day with a spray of half water and half vinegar, then wiped it down with a special cloth. HM-B indicated when she cleaned the water and ice machine, she did not clean the inside of the spout where the ice and water were dispensed, only the outside of the spout. On 6/19/18, at 12:11 p.m. certified dietician (CD)-A toured the unit kitchens with surveyor. CD-A confirmed Granite View unit kitchen water and ice machine had hard water lime scale buildup inside the dispensing spout. CD-A confirmed Harvest Trail's unit kitchen water and ice machine had more buildup and residue like Granite View's unit kitchen water and ice	{F 812}	machines on Granite View and Harvest Trail were replaced on 6/20/18. The trays were cleaned on 6/20/18. Granite Views ice/water machine that had moderate amount of hard water lime scale residue and white to brown build up covering the inside of the black square spout was alleviated by replacing the spout. The small amount of white and brown hard water staining on the tray was cleaned. Harvest Trails ice/water machine that had a large amount of white, tan and brown hard water lime scale buildup covering the inside of the black square spout was alleviated by replacing the spout on June 20, 2018. Other ice/water machine black square spout was also replaced on 6/20/18 and tray was cleaned. The black square spout on the ice/water machines will be replaced once a week to alleviate hard water lime scale residue buildup on the spout. This will be replaced by the Maintenance Director or designee. This will begin the week of July 15, 2018. The ice/water machine trays will be cleaned two times a day according to the updated/revised ice/water machine policy. Certified dietary manager discussed with the homemakers the hard water staining on the tray of the ice/water machines. The grate(tray) of the ice/water machines will soak overnight in vinegar per updated/revised ice/water machine policy. Certified dietary manager has reeducated homemakers on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	R 06/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 812}	Continued From page 2 machine. CD-A indicated she had not seen this at other facilities she worked at, but indicated this facility was the only one who used this type of water and ice machine. On 6/19/18, at 12:20 p.m. director of senior clinical services (DSCS)-A visualized the ice machines. DSCS-A confirmed Harvest View unit kitchen's water and ice machine had some hard water lime scale residue inside the black square spout. DSCS-A indicated maintenance had replaced the water filters, spouts and trays and indicated they needed to be replaced again. DSCS-A indicated Granite View unit kitchen's water and ice machine had hard water lime scale residue and buildup and agreed the hard water buildup could harbor germs and could flake off into the ice and water. DSCS-A indicated the staff may need more education regarding cleaning of the water and ice machines. On 6/19/18, at 2:46 p.m. HM-C indicated the dietary manager had reviewed the procedure on how to wash the water and ice machine with the homemakers. HM-C indicated she used a spray of half vinegar and half water. HM-C demonstrated how she sprayed the machine down, then indicated she wiped it down afterwards. HM-C indicated she did not clean the inside of the spout. HM-C then touched the bottom of the spout where white hard water lime scale was visible, and scraped it with her thumbnail. The facility policy titled Cleaning Instructions, Ice Machine, dated 5/7/18, indicated ice machines would be cleaned thoroughly following the manufacture's instructions following food safety sanitary code standards. The procedure included	{F 812}	updated/revised policy of cleaning the ice/water machine. This education took place the week of July 16, 2018. A Quality Assurance Performance Improvement audit was developed to ensure ice/water machines black square spout will be free of hard water lime scale residue buildup and trays will be free of hard water staining. This Quality Assurance Performance Improvement will be done by replacing the black square spout on the ice/water machines one time per week and trays will be cleaned two times a day. This audit will be done for three months or until 100% compliant. Then random audits will be done. This will be reported monthly to Quality Assurance Performance Improvement meeting. This will be monitored by Certified Dietary Manager or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	R 06/19/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 812}	Continued From page 3 spraying the ice machine with 50/50 mixture of water and white vinegar. The policy instructed staff to spray the spigot and area around spigot with vinegar/water mixture, using a soft brush scrub spigot area to loosen deposits. Rinse with clean water and wipe area clean. The policy also indicated maintenance would do machine de-scaling as needed.	{F 812}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UIWF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00771

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

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

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/03/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)
13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Beth Nowling, HFE NE II 06/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 06/20/2018 (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
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

Mr. David Rogers, Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

RE: Project Number S5451029

Dear Mr. Rogers:

On May 3, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 12, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 3, 2018 (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 November 3, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	05/03/2018

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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/30/18, through 5/3/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		6/5/18

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

Electronically Signed | 05/31/2018

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dignity was maintained for 1 of 1 resident (R5) who utilized an incontinent pad. Findings include: R5's significant change in status assessment (SCSA) Minimum Data Set (MDS) dated 2/7/18, identified R5 had severe cognitive impairment and had diagnoses which included Alzheimer's	F 550	On May 4, 2018 the chair protector R5 was using was covered with a small lap blanket until new chair protectors arrive. All other residents using this type of chair protector in public areas have been covered with a small lap blanket until new chair protectors arrive. New chair protectors were ordered on May 7, 2018. New chair protectors	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 disease, arthritis and depression. The MDS identified R5 required extensive assistance with activities of daily living (ADL's,) including bed mobility, transfers and toileting. The MDS identified R5 was frequently incontinent of urine. R5's SCSA Care Area Assessment (CAA) dated 2/7/18, identified R5 had a decline in cognition and in performing ADL's. The CAA's identified R5 required extensive assistance with all ADL's except for eating. Further the CAA's revealed R5 was frequently incontinent of bladder. R5's care plan revised 5/2/18, revealed R5 required extensive assistance from facility staff with transfers, bed mobility, toileting and was frequently incontinent of urine. R5's care plan did not address the use of a cloth incontinent pad. On 5/1/18, at 12:28 p.m. R5 was seated in a wheelchair in the dining room at a table with a blanket covering her shoulders. On 5/1/18, at 1:04 p.m. R5 remained seated in a wheelchair in the dining room. At that time nursing assistant (NA)-C wheeled R5 out of the dining room and into the common seating area which held a television and two electric recliners. Both electric recliner seats were covered with a large (approximately 24 inches (in) length by 36 in of width,) white cotton incontinent pad. NA-C and NA-C assisted R5 to transfer from the wheelchair to one of the incontinent pad covered recliners. While R5 was seated in the recliner, the white incontinent pad was exposed and visible on the seat of the recliner and on both sides of her upper legs. NA-C then covered R5 with a small blanket from chin to feet, raised her legs in the recliner and walked away. The white incontinent pad	F 550	arrived on May 11, 2018. New chair protectors were implemented to R5 and others that needed chair protectors at this time. Current large white incontinent pads have been removed from public areas. An All Staff Meeting was held on May 23, 2018. Staff education was discussed on the use of new chair protectors that will be used in public areas. This Quality Assurance/Performance Improvement audit has been developed to ensure continued proper chair protectors are used in public areas. This will be a visual audit. This Quality Assurance/Performance Improvement audit will be done two times per week for four weeks or until 100% compliant. Then random audits will be completed. This audit will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored Neighborhood Leads	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550		

remained visible from the sides of recliner R5 was lying in.

On 5/1/18, at 3:01 p.m. R5 remained seated in the white incontinent pad seat covered recliner covered with a blanket. The white incontinent pad remained visible on the both sides of the seat cushion of R5's recliner.

On 5/2/18, at 8:02 a.m. R5 was seated in a wheelchair in the dining room. At that time, NA-C wheeled R5 to the common area, to an electric recliner. The recliner seat was covered with a large white cloth incontinent pad. NA-C and NA-H assisted R5 to transfer from the wheelchair to the incontinent pad covered recliner. NA-H covered R5 with a blanket and raised her legs in a reclined position. The large white cloth incontinent pad was visible at the seat and both sides of R5's upper legs.

On 5/2/18, at 10:16 a.m. R5 remained in reclined in the recliner in the common area of the unit. The white cloth incontinent pad remained visible on both sides of R5's seat and upper leg area.

On 5/2/18, at 1:08 p.m. NA-C stated R5 required extensive assistance with ADL's including toileting, bed mobility and transfers. NA-C stated the recliners in the common area were routinely covered with large white cloth incontinent pads. She stated she felt staff placed the pads to protect the fabric on the recliner from urine. NA-C stated R5 had occasional urinary incontinence, though had increasingly been continent of urine in the last month.

On 5/2/18, at 1:32 p.m. NA-H stated R5 routinely sat in a recliner in the common area after she ate

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 her meals. NA-H stated the recliners in the common area were routinely covered with the large white cloth incontinent pads in order to protect the fabric on the recliners for incontinence. On 5/3/18, at 8:35 a.m. registered nurse manager (NM)-B confirmed R5 routinely sat in one of the recliners in the common area after she ate her meals. NM-B confirmed both recliner seats in the common area were covered with large, white cloth incontinent pads. She stated the pads were used to protect the fabric on the recliners from incontinence, however, she stated the pads were large and indicated they did not fit the seats of the recliners. NM-B stated visitors would routinely walk by the common area due to the proximity of the outside entrance to the unit. NM-B confirmed the large white incontinent pads was visible when R5 was seated in the recliner. On 5/3/18, at 9:58 a.m. the director of nursing stated she would expect the large white cloth incontinence pads to be covered with a blanket. She stated the pads were used to protect the fabric on the recliners from incontinence. The DON stated she would expect the cloth incontinent pads to be covered when used. A facility policy was requested, one was not provided.	F 550		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:	F 574		5/18/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 5 (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42	F 574		

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 6 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide information to 3 of 3 residents (R6, R17, R7) who routinely attended the resident council meeting, for state agencies which would act as advocates for residents who resided in the facility with the name and telephone number of the state Ombudsman. This had the potential to affect all 51 residents residing in the facility. Findings include: On 5/2/18, at 10:56 a.m. a resident council group interview was held with R7, R6 and R17, who routinely attended the neighborhood resident council monthly meetings. R7, R6 and 17 stated	F 574	Updated Ombudsman information which included name and telephone number was done on May 4, 2018. R6, R17, R7 were informed of the updated information on May 17, 2018 and May 18, 2018 at Resident Council Meetings. Updated Ombudsman Information was posted in each Neighborhood and in the Town Center on May 16, 2018 for all residents to access. All residents were made aware of where to find updated Ombudsman information which included name and telephone number. Resident Council was held in	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 7 they were not aware of the the state advocacy agency (Ombudsman Office,) or where the information was posted in the facility. R7, R6 and R17 stated they did not know the purpose of the ombudsman, who she was, or how they would contact the office if needed. On 5/2/18, at 11:15 a.m. the facility activities director (AD)-A, stated the ombudsman's contact information was posted in the facility's town center, which was located outside of the facility's three neighborhoods, past closed doors. The AD-A stated the information may not be visible to residents, who did not leave their individual neighborhoods. ADA-A stated the information regarding ombudsman and contact information had not been reviewed with residents or at resident council meetings in the past. On 5/3/18, at 10:06 a.m. the facility director of senior clinical operations, (D)-A stated she would expect all residents to be informed of who their local ombudsman was and how to contact her. The D-A stated the facility had the information posted in the town center. The D-A confirmed residents who chose not to leave their individual neighborhoods would be unable to see the posted information. On 5/3/18, 10:03 a.m. the director of nursing (DON) stated she would expect all residents to be informed of who the ombudsman was and how to contact her. The DON confirmed the ombudsman posted information was not visible to all residents who chose not to leave their neighborhoods. A policy was requested, one was not provided.	F 574	Harvest Trail on May 17, 2018 and Granite View and Orton□'s Crossing on May 18, 2018. Discussion was held with the residents regarding updated Ombudsman information. Residents were shown in their Neighborhood where the updated Ombudsman information was. Residents were also made aware of Ombudsman information is posted in the Town Center. A Resident Council was held on May 17, 2018 in Harvest Trail and Granite View and Orton□s Crossing (all Neighborhoods) on May 18, 2018 to inform residents on the updated Ombudsman□s information which included name and telephone number and where to find the information in their Neighborhood or in the Town Center. The Ombudsman information will also be shared in monthly resident council meetings. A Quality Assurance/Performance Improvement audit has been developed to ensure posting of the Ombudsman accurate and current information is in each Neighborhood and Town Center and all residents are aware of the locations. This Quality Assurance/Performance Improvement audit will be done one time a month with resident council for three months or until 100% compliant. Results of the Quality Assurance/Performance Improvement audit will be reported monthly to the Quality Assurance/Performance Improvement meeting.	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 574	Continued From page 8	F 574	This will be monitored by Licensed Social Worker or designee	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents (R7, R6 and R17,) who routinely attended resident council, were made aware of the state agency (SA) survey results. This had the potential to	F 577	On May 17th and 18th, 2018, residents R7, R6, R17 were informed where to find state survey results during Resident Council meetings. Three clear plastic holders were ordered on May 6, 2018 to	5/18/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 9 affect all 51 residents who resided in the facility. Findings include: On 5/2/18, at 10:56 a.m. a resident council group interview was held with R7, R6 and R17, who routinely attended the neighborhood resident council monthly meetings. R7, R6 and 17 stated they were not aware of SA survey results were or where the information was posted in the facility. On 5/2/18, at 11:15 a.m. the facility activities director (AD)-A, stated the SA survey results were posted in the facility's town center, which was located outside of the facility's three neighborhoods, past closed doors. The AD-A stated the information may not be visible to residents, who did not leave their individual neighborhoods. On 5/3/18, at 10:06 a.m. the facility director of senior clinical operations, (D)-A stated she would expect all residents to have been informed of where the SA survey results were located. The D-A stated the facility had the information posted in the town center. The D-A confirmed residents which chose not to leave their individual neighborhoods would be unable to see the posted information. On 5/3/18, 10:03 a.m. the director of nursing (DON) stated she would expect all residents to be informed of where to locate the SA survey results. The DON confirmed SA survey results were located in the town center and may not visible to all residents who chose not to leave their neighborhoods.	F 577	insert survey results postings. Plastic holders arrived on May 16, 2018 and state survey results were placed in each Neighborhood. Residents were informed at Resident Council meetings on May 17, 2018 and May 18, 2018 where state survey results are posted in each Neighborhood and in the Town Center. A Resident Council was on May 17, 2018 in Harvest Trail and in Granite View and Orton's Crossing (all Neighborhoods) on May 18, 2018 to inform residents where to find state survey results. The state survey results are posted in each Neighborhood and in the Town Center. The location of State survey results will be shared at monthly resident council meetings. A Quality Assurance/Performance Improvement audit has been developed to ensure state survey posting are in each Neighborhood and Town Center and residents are aware of the locations. This Quality Assurance/Performance Improvement audit will be done one time a month with resident council for three months or until 100% compliant. Results of the Quality Assurance/Performance Improvement audit will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored by Activity Director.	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 577	Continued From page 10 A facility policy titled, Protocol File Wall Pocket for Survey Display, dated 5/11/17, identified it was the facility's policy to have the survey results mounted in areas that visitors and residents have access to.	F 577		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		6/12/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 11 Based on interview and document review, the facility failed to immediately report, no later than 2 hours, an allegation of physical and mental/emotional abuse to the administrator/designee and the State Agency (SA) for 1 of 1 resident (R34) reviewed for abuse. Finding include: R34's significant change Minimum Data Set (MDS) dated 1/8/18, indicated R34 had intact cognition and diagnoses which included heart failure, arthritis, depression and anxiety disorder. The MDS indicated R34 required extensive assistance with bed mobility, dressing and personal hygiene, and limited assistance with toilet use and transfers. R34's MDS further indicated no behaviors and R34 reported frequent moderate pain that made it hard for R34 to sleep at night and limited their day-to-day activities. R34's quarterly MDS dated 4/3/18, indicated R34 was moderately cognitively impaired, and required extensive assistance with dressing and personal hygiene as well as limited assistance with bed mobility and toileting. The MDS further indicated R34 had no hallucinations or delusions, no behaviors and no pain. R34's current care plan, revised 4/10/18, indicated R34 had a psychosocial well-being problem due to obsessive concerns with health, and had chronic pain related to osteoarthritis, anxiety and depression. R34's care plan listed various interventions which included social worker and household leaders will observe for and report any signs of abuse, staff will encourage R34 to communicate needs, express feelings and concerns and make daily choices, do	F 609	It is the policy of Fairway View Neighborhoods to immediately report within two hours to the state agency (OHFC) resident incident abuse. The administrator/designee will be notified immediately at the time the initial report is filed. A report was filed to the state agency (OHFC) on May 3, 2018 on R34. An investigation was completed and filed to OHFC on May 9, 2018. OHFC responded on May 10, 2018, that no further action by this office is necessary at this time. On May 29, 2018 all residents were interviewed to ensure there were no outstanding abuse or neglect allegations. No concerns were voiced. Reports will be filed immediately, no later than two hours of the reported incident. The administrator/designee will be notified immediately. An All Staff Meeting was held on May 23rd, 2018. At this meeting, education was provided by Licensed Social Worker to all staff on reporting events immediately, no later than two hours of reportable events. Education was also given to follow our Abuse and Neglect policy which is to report events immediately, no later than two hours and also notify administrator/designee immediately. Abuse and Neglect Policy was reviewed with all staff. This education was done by the Licensed Social Worker. A Quality Assurance/Performance	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 12 not make demands on R34, R34 does not like large groups, encourage resident to verbalize feelings, concerns and fears. On 4/30/18, at 2:39 p.m. R34 stated she was hospitalized about four weeks ago for fluid overload and during the hospitalization she felt that they therapy staff at the hospital was too rough with her and indicated if she did not participate in therapy, she would be responsible for the cost of her stay at the hospital. Review of R34's progress notes from 3/15/18, to 3/31/18, revealed the following: -3/15/18, R34 was transferred to the hospital for excess fluid. -3/19/18, R34 returned from the hospital, occupational therapy (OT) was ordered for a compression glove. -3/21/18, R34 voiced concerns about not wanting to work with therapy anymore. R34 was very agitated and stated she cannot take it anymore. R34 stated, "I am 89 years old and I have the right to refuse them". R34 then stated "I just cant [sic] get this out of my head". R34 stated she had flashbacks of therapy working with her on Monday, where she said "they were too rough and they injured me, they are harassing me". Nursing staff asked R34 if she meant they injured her mentally or physically and R34 stated "both." R34 stated three hospital staff were working with her one day and she stated "I don't need all these people here, its [sic] too much". R34 stated therapy threatened her if she did not do therapy then she would have to pay 720 dollars out of pocket to live there, otherwise she cannot stay	F 609	Improvement audit was developed to ensure event reporting is done immediately, no later than two hours, and administrator/designee was notified immediately in accordance with the policy. This Quality Assurance/Performance Improvement audit will be done weekly through a review of events that are submitted to OHFC to track file timeliness and the administrator/designee was notified immediately and the Abuse and Neglect policy was followed. This audit will be done for three months or until 100% compliant. This Quality Assurance/Performance Improvement audit will be reported monthly to the Quality Assurance/Performance Improvement meeting. A Quality Assurance/Performance Improvement audit was developed to ensure there are no abuse and neglect concerns. This audit will be done by reviewing daily facility activity report, which includes progress notes on all residents. Random resident interviews also will be conducted. This Quality Assurance/Performance Improvement will be done daily for three months or until 100% compliant. This will be monitored by Social Worker or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 13	F 609		

here. Message left for licensed social worker (LSW) to visit resident.

-3/22/18, R34 had a hospital stay and declined therapy upon her return back to the facility. R34's mood has improved and seems to be a good historian.

-3/22/18, R34 visited by LSW regarding frustration with therapy. R34 was upset that therapies were trying to "force" her to work with them. R34 requested no more visits from therapy.

-3/23/18, R34 was still very upset when speaking about therapy and stated, "I'm not going to see them! What don't they understand!" Staff reminded her that therapy would come and fit her for edema glove and that nursing staff would be with her the whole time. R34 seemed relieved that nursing staff would be there.

Review of facility form, Psychosocial Well-Being-Abuse/Neglect Risk, dated 3/28/18, indicated R34 had an abuse/neglect score of zero, which indicated R34 was not at risk for abuse or neglect. The form indicated no referrals were necessary at that time and to continue the current plan of care.

On 5/2/18, at 9:40 a.m. R34 stated she received OT at the facility for the edema glove, but therapy continued to push her to continue therapy. R34 stated the situation made her cry for the first time in a long time. R34 stated after she spoke with nursing staff about therapy, two therapy staff approached her and apologized.

On 5/3/18, at 9:52 a.m. nursing assistant (NA)-H stated R34 was a reliable historian and would

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 14	F 609		

take any concern from R34 seriously. NA-H stated she was aware that R34 had an issue with therapy and R34 did not want any more therapy. NA-H stated R34 was fitted for a new edema glove after the hospital and nursing staff had to educate R34 on the glove, not therapy.

On 5/3/18, at 9:59 a.m. NA-I stated she would take any concern from R34 seriously and would report it to the charge nurse. NA-I was not aware of any concerns R34 had with her hospitalization or therapy staff.

On 5/3/18, 10:08 a.m. registered nurse (RN)-D stated R34 was alert and oriented and had good cognition and does not fabricate stories. RN-D stated if R34 thought she was treated roughly, she would report that to the LSW immediately.

On 5/3/18, 10:17 a.m. clinical manager (CM)-B stated R34 was alert and oriented and had some anxiety for which she received scheduled anti-anxiety medication. She stated staff would report a concern from R34 and take it seriously. CM-B stated she was aware R34 felt that therapy at the hospital was forcing the therapy on her. CM-B stated she told therapy R34 did not want therapy and to stay out of R34's room. CM-B stated she was unaware of any investigation into R34's allegation.

On 5/3/18, at 10:27 a.m. LSW stated she was aware of R34's allegation after her hospitalization and recalled visiting with R34 on 3/22/18. LSW stated R34's allegation was discussed as an interdisciplinary team (IDT), but due to the allegation happening at the hospital the facility staff did not report the allegation to the SA. The LSW confirmed the same therapy staffed worked

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 15	F 609		

at both the nursing home and hospital and there had not been an investigation into R34's allegation of abuse.

On 5/3/18, at 10:42 a.m. director of nursing (DON) stated a report of rough treatment would be reported to the SA. DON stated R34's statement "they were too rough and they injured me, they are harassing me" should have been reported to the SA immediately. DON stated she recalled discussing R34's allegation in an IDT meeting, but could not recall the specifics of the discussion. She confirmed the therapy staff worked at both the nursing home and the hospital.

On 5/3/18, at 10:51 a.m. director of senior services (DSS) confirmed she was the administrator's designee for immediate notifications of vulnerable adult allegation reporting for the facility. The DSS stated R34's statement "they were too rough and they injured me, they are harassing me" should have been reported to the SA immediately, or staff should have called the hospital to ensure they reported the allegation.

On 5/3/18, at 10:58 a.m. therapy site coordinator (TSC)-A confirmed that the therapy company was contracted to perform therapy services with the facility and the associated hospital. She stated the company's therapists worked at each location interchangeable. TSC-A stated she was aware of R34's concerns with therapy. TSC-A stated OT had completed an evaluation on R34 and she was agreeable to an edema glove. Then LSW stated R34 no longer wanted contact with any therapy staff. She stated when the edema glove was delivered to the facility, therapy staff

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 16 educated the nursing staff on the glove and no further contact with R34 has occurred. A facility policy titled, Abuse Prevention Policy created 10/16/17, indicated it was the policy of Fairway View Neighborhoods (FWVN) that "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. FWVN will ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 610		6/12/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 17 by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of physical and mental/emotional abuse for 1 of 1 resident (R34) reviewed for abuse. In addition, the facility failed to protect 1 of 1 resident (R34) while the investigation was conducted. Finding include: R34's significant change Minimum Data Set (MDS) dated 1/8/18, indicated R34 had intact cognition and diagnoses which included heart failure, arthritis, depression and anxiety disorder. The MDS indicated R34 required extensive assistance with bed mobility, dressing and personal hygiene, and limited assistance with toilet use and transfers. R34's MDS further indicated no behaviors and R34 reported frequent moderate pain that made it hard for R34 to sleep at night and limited their day-to-day activities. R34's quarterly MDS dated 4/3/18, indicated R34 was moderately cognitively impaired, and required extensive assistance with dressing and personal hygiene as well as limited assistance with bed mobility and toileting. The MDS further indicated R34 had no hallucinations or delusions, no behaviors and no pain. R34's current care plan, revised on 4/10/18, indicated R34 had a psychosocial well-being problem due to obsessive concerns with health, and had chronic pain related to osteoarthritis, anxiety and depression. R34's care plan listed various interventions which included social worker and household leaders will observe for and report any signs of abuse, staff will	F 610	A VA was filed on May 3, 2018 on R34. An investigation was done following the submission of the event to Minnesota Department of Health (OHFC). The five day investigation was completed between May 3 and May 9, 2018. On May 9, 2018, the five day investigation report was completed and submitted to OHFC. OHFC responded on May 10, 2018, that no further action by this office is necessary at this time. Abuse and Neglect Policy will be followed for all resident events. An All Staff Meeting was held on May 23, 2018. At this meeting it was discussed the investigation process of a potential or actual VA. The Abuse and Neglect policy was reviewed. The reporting and investigation procedure of a potential or actual VA was discussed with staff during this meeting. Education was given by Licensed Social Worker. A Quality Assurance/Performance Improvement audit was developed to ensure reports are filed prior to the investigation. This Quality Assurance/Performance Improvement audit will be done by reviewing all events in the last week to ensure timely reporting and investigation of a potential or actual VA was completed. This Quality Assurance/Performance Improvement audit will be done every Tuesday for three months or until 100% compliant. This Quality Assurance/Performance	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 18 encourage R34 to communicate needs, express feelings and concerns and make daily choices, do not make demands on R34, R34 does not like large groups, encourage resident to verbalize feelings, concerns and fears. On 4/30/18, at 2:39 p.m. R34 stated she was hospitalized about four weeks ago for fluid overload and during the hospitalization she felt that they therapy staff at the hospital was too rough with her and indicated if she did not participate in therapy, she would be responsible for the cost of her stay at the hospital. Review of R34's progress notes from 3/15/18, to 3/31/18, revealed the following: -3/15/18, R34 was transferred to the hospital for excess fluid. -3/19/18, R34 returned from the hospital, occupational therapy (OT) was ordered for a compression glove. -3/21/18, R34 voiced concerns about not wanting to work with therapy anymore. R34 was very agitated and stated she cannot take it anymore. R34 stated, "I am 89 years old and I have the right to refuse them". R34 then stated "I just cant [sic] get this out of my head." R34 stated she had flashbacks of therapy working with her on Monday, where she said "they were too rough and they injured me, they are harassing me." Nursing staff asked R34 is she meant they injured her mentally or physically and R34 stated "both". R34 stated three hospital staff were working with her one day and she stated "I don't need all these people here, its [sic] too much". R34 stated therapy threatened her if she did not	F 610	Improvement audit will be reported monthly to the Quality Assurance/Performance Improvement meeting. A Quality Assurance/Performance Improvement audit was developed to ensure there are no abuse and neglect concerns. This audit will be done by reviewing daily facility activity report, which includes progress notes on all residents. Random resident interviews also will be conducted. This Quality Assurance/Performance Improvement will be done daily for three months or until 100% compliant. This will be monitored by Licensed Social Worker or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 19	F 610		

do therapy then she would have to pay 720 dollars out of pocket to live there, otherwise she cannot stay here. Message left for licensed social worker (LSW) to visit resident.

-3/22/18, R34 had a hospital stay and declined therapy upon her return back to the facility. R34's mood has improved and seems to be a good historian.

-3/22/18, R34 visited by LSW regarding frustration with therapy. R34 was upset that therapies were trying to "force" her to work with them. R34 requested no more visits from therapy.

-3/23/18, R34 was still very upset when speaking about therapy and stated, "I'm not going to see them! What don't they understand!" Staff reminded her that therapy would come and fit her for edema glove and that nursing staff would be with her the whole time. R34 seemed relieved that nursing staff would be there.

Further review of R34's medical record revealed no further investigation had been completed related to the 3/21/18, allegation of physical and mental/emotional abuse.

On 5/3/18, 10:17 a.m. clinical manager (CM)-B stated R34 was alert and oriented and had some anxiety for which she received scheduled anti-anxiety medication. She stated staff would report a concern from R34 and take it seriously. CM-B stated she was aware R34 felt that therapy at the hospital was forcing the therapy on her. CM-B stated she told therapy R34 did not want therapy and to stay out of R34's room. CM-B stated she was unaware of any investigation into R34's allegation.

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 20	F 610		

On 5/3/18, at 10:27 a.m. LSW stated she was aware of R34's allegation after her hospitalization and recalled visiting with R34 on 3/22/18. LSW stated R34's allegation was discussed as an interdisciplinary team (IDT), but due to the allegation happening at the hospital the facility staff did not report the allegation to the SA. The LSW confirmed the therapy staff worked both at the nursing home and the hospital and confirmed there had not been an investigation into R34's allegation of abuse.

On 5/3/18, at 10:42 a.m. director of nursing (DON) stated a report of rough treatment would be reported to the SA. DON stated R34's statement "they were too rough and they injured me, they are harassing me" should have been reported to the SA immediately. DON stated she recalled discussing R34's allegation in an IDT meeting, but could not recall the specifics of the discussion. She confirmed the therapy staff worked at both the nursing home and the hospital.

On 5/3/18, at 10:51 a.m. director of senior services (DSS) confirmed she was the administrator's designee for immediate notifications of vulnerable adult allegation reporting for the facility. The DSS stated R34's statement "they were too rough and they injured me, they are harassing me" should have been reported to the SA immediately, or staff should have called the hospital to ensure they reported the allegation.

On 5/3/18, at 10:58 a.m. therapy site coordinator (TSC)-A confirmed that the therapy company was contracted to perform therapy services with the

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 21 facility and the associated hospital. She stated the company's therapists worked at each location interchangeable. TSC-A stated she was aware of R34's concerns with therapy. TSC-A stated OT had completed an evaluation on R34 and she was agreeable to an edema glove, then LSW stated R34 no longer wanted contact with any therapy staff. She stated when the edema glove was delivered to the facility, therapy staff educated the nursing staff on the glove and no further contact with R34 had occurred. A facility policy titled, Abuse Prevention Policy created 10/16/17, indicated when an incident or suspected incident of "abuse" is reported, the Administrator or LSW or DON will investigate the incident immediately with the assistance of appropriate personnel. The investigation will include: who was involved, resident's statements, involved staff and witness statements of events, a description of the resident's behavior and environment at the time of the incident, injuries present including a resident assessment, observation of resident and staff behaviors during the investigation and environmental considerations.	F 610		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical	F 637		6/5/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 22 interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 1 residents (R45) reviewed for dementia care. Findings include: R45's annual Minimum Data Set (MDS) dated 8/20/17, identified R45 had diagnoses which included dementia, anxiety disorder and hypertension. R45's MDS identified R45 had moderate cognitive impairment and had a PHQ-9 (mood scale that may indicate depression) score of 01 which identified minimal depression. R45's activity of daily living (ADL) assessment identified R45 required limited assistant for bed mobility, walking and hygiene. R45 required extensive assistance with transfer, toilet use and dressing and was independent with eating. R45 was occasionally incontinent of urine, and continent of bowel. R45's quarterly MDS dated 11/1/17, identified R45 had moderate cognitive impairment and had a PHQ-9 score of 00, which indicated no signs of depression at that time. The MDS identified R45 required limited assistance with walking and hygiene and required extensive assistance with bed mobility, transfer, toilet use and dressing and was independent with eating. Further the MDS identified R45 was occasionally incontinent of	F 637	R45 was scheduled for a change of condition MDS on May 12, 2018. It was completed and submitted on May 25, 2018. All other residents were reviewed by May 30, 2018 to see if a change of condition was warranted. A review of electronic reports thru Matrix was compared to past MDS□s. At this time there were no residents needing a change of condition MDS. A resident review for each Neighborhood will be done each Tuesday of each week, to determine if a change of condition is warranted. A meeting with Nurse Leads was held on May 8, 2018. At this meeting it was discussed the importance of the timeliness of the completion of a significant change of condition MDS. An All Staff Meeting was held on May 23, 2018. Change of condition MDS for residents were discussed at this meeting and the importance of notifying nurse leader of changes in current condition. A Quality Assurance/Performance Improvement audit was developed to ensure change of condition MDS are	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 23 urine and continent of bowel. R45's quarterly MDS dated 1/24/18, identified R45 had severe cognitive impairment, with a BIMS score of 6 and PHQ-9 score of 05, which indicated mild depression. The MDS identified R45 required extensive assistance for bed mobility, transfer, toilet use, walking, dressing and hygiene. Further the MDS identified R45 was independent with eating and had occasional urine incontinence and was continent of bowel. R45's quarterly MDS dated 4/10/18, identified R45 had severe cognitive impairment with a BIMS score of 5. PHQ-9 score of 01, indicated minimal depression. R45 required extensive assitance with all ADLs except independent with eating and was frequently incontinent of urine and was continent of bowel. Review of the above assessments revealed R45 had a decline in her cognitive status from moderate cognitive impairment to severe cognitive impairment. R45's ADLs performance declined from limited assistance of staff to extensive assistance of staff in multiple areas and a decline in urine incontinence from occasional to frequent. R45's PHQ-9 scores changed which indicated she went from minimal depression to signs of no depression, to signs of mild depression then minimal depression. On 5/03/18, at 9:26 a.m. clinical manager (CM)-A indicated the facility's usual practice for a SCSA was determined if they noticed a change in the residents. This is done by their daily rounds and discussion of residents changes and daily observations. CM-A indicated she determined significant changes occurred by comparing a	F 637	recognized and completed timely as needed. This Quality Assurance/Performance Improvement audit will be done every Tuesday for three months or until 100% compliant. This Quality Assurance/Performance Improvement audit will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored by Neighborhood Nurse Leads	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 637	Continued From page 24 resident's current quarterly MDS data with the last quarterly MDS. If changes were noted, she indicated she then went back to the last comprehensive assessment for comparison. CM-A indicated she compared a resident's BIM score, PHQ-9 score and rug score for ADLs. CM-A indicated she looked for 2 or more changes in a resident's ADLs along with another change to determine if a significant change MDS was warranted. CM-A confirmed R45 should of had a SCSA completed. On 5/03/18, at 10:08 a.m. director of nursing (DON) identified each CM was responsible for MDS completion for their neighborhood. DON indicated her expectation was for a SCSA to be completed 14 days after changes were identified. DON indicated the facility used the MDS RAI (resident assessment instrument) instructions as their guide for MDS completion. The CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Resident Assessment Instrument 3.0 User's Manuel, Version 1.15 dated 10/17, identified a significant change is a decline or improvement in a residents's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and is not self-limiting. It impacts more than one area of the resident's health status and requires interdisciplinary review and or revision of the care plan. The SCSA must be completed no later than 14 days after the determination that the criteria for a SCSA were met.	F 637		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		6/11/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 25 §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 676		

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 26 Based on observation, interview, and document review, the facility failed to provide assistance with routine application of hearing aids for 1 of 1 residents (R25) reviewed for communication. Findings include: R25's significant change in status assessment (SCSA) Minimum Data Set (MDS) dated 3/12/18, identified R25 was moderately cognitively impaired and had diagnoses which included weakness, osteoarthritis and hypertension. The MDS also revealed R25 had minimal difficultly in some environments with hearing (when a person speaks softly or setting was noisy) and wore hearing aids (H/A). R25's current care plan revised on 5/2/18, identified R25 had hearing loss and staff were to check that H/A's were clean, functioning, properly placed in both ears, check batteries to make sure working properly and store H/A's in black box in room. The MDS further indicated staff were to gain R25's attention before speaking, speak clearly and adjust tone as needed, repeat and rephrase as needed. During observation on 4/30/18 at 2:53 p.m. R25 was seated in her recliner in her room visiting with her family. R25 was observed to have a H/A in her right ear and not one in her left ear. On R25's night stand next to her recliner sat a small black box which contained a H/A. R25's family indicated the H/A did not work and thought staff knew about this. R25 had a hard time understanding what her family was saying while they visited with her. During observations on 5/1/18 at 12:36 p.m. R25	F 676	R25 received hearing aids when discovered not in ears. R25 will be offered hearing aids daily for placement. Facility developed a resident list on May 15, 2018 of all residents having hearing aids. The list indicates if resident wear (R) (L) or both hearing aids or none. These residents that were identified needing assistance with hearing aids were entered in to point of care under the care needs sign off in Matrix. Each resident that needs assistance with hearing aids will be signed off by the CNA via the Care Needs Sign Off in Matrix effective June 6, 2018. This will alert CNAs to which residents need assistance with hearing aid placement(s). An all staff meeting was held on May 23, 2018. At this meeting it was discussed the importance of residents having or being offered hearing aids daily. To prevent the reoccurrence, the protocol will be to use Care Needs Sign Off in Matrix to indicate which residents need hearing aid(s) placement or removed. CNA(s) will sign off on the Care Needs in Matrix daily. Education of hearing aid protocol was discussed. A Quality Assurance/Performance Improvement audit was developed to ensure hearing aids for residents have been offered or in resident ears daily. This Quality Assurance/Performance Improvement audit will be auditing two residents per Neighborhood per week for	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 27 was seated in her wheel chair in her room, R25 was wearing glasses, had a H/A in her right ear but not her left ear and was watching the twins game with her husband. On R25's night stand next to her recliner sat a small black box which contained a H/A. -at 12:52 p.m. R25 was seated in her recliner with her feet up on the foot rest. R25 had a H/A in her right ear and a H/A sat in a black box on her night stand. -at 1:23 p.m. R25 was seated in her recliner with her feet up on the foot rest. R25 had a H/A in her right ear and a H/A sat in a black box on her night stand. -at 1:56 p.m. R25 was seated in her recliner with her feet up on the foot rest. R25 had a H/A in her right ear and a H/A sat in a black box on her night stand. During observations on 5/2/18 at 6:59 a.m. R25 was not in her room and was receiving a bath. R25's H/A's were laying in a black box which was located on top of her night stand by her recliner. -at 7:30 a.m. nursing assistant (NA)-E wheeled R25 out of the tub room and back to her room across the hallway. R25 was not wearing her H/A's, they remained in the black box on her night stand. -at 7:34 a.m. NA-E wheeled R25 down to the dining room via wheel chair and set her in front of the table by the window. R25 was not wearing her H/A's they remained in the black box on her night stand. -at 7:51 a.m. R25 was seated in her wheel chair up at the dining room table waiting for breakfast. R25 was not wearing her H/A's they remained in the black box on her night stand. -at 7:56 a.m. R25's husband walked over to the table, sat next to her and stated he was taking	F 676	three months or until 100% compliant. This Quality Assurance/Performance Improvement audit will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored by Neighborhood Leads	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 28	F 676		

care of the plants. R25's husband repeated himself several times and R25 stated "I cant hear that good."
-at 8:08 a.m. R25's husband was talking to her and repeated himself several times through out the conversation.
-at 8:38 a.m. R25 remained at the dining room table when NA-F approached R25, bent over and talked directly into R25's right ear and told her she would set her hair first today. R25 was not wearing her H/A's, they remained in the black box on her night stand.
-at 8:42 a.m. NA-F wheeled R25 out of the dining room via wheel chair down to the beauty shop to do her hair. NA-F removed R25's glasses, checked her ears for H/A, and R25 stated "I don't hear very well." NA-F bent over into R25's right ear and stated "you do pretty well."
-at 9:46 a.m. R25 was seated in her wheel chair in the dining room drinking a cup of tea. R25 was not wearing her H/A's, they remained in the black box on her night stand.
-at 10:11 a.m. R25 was seated in her recliner with her feet up on the foot rest when registered nurse (RN)-A entered R25's room with medications. R25 took her medications independently while RN-A asked her several times if she had company today, R25 had stated "I don't know." R25 was not wearing her H/A's, they remained in the black box on her night stand.
-at 11:25 a.m. R25 was seated in her recliner in her room visiting with her husband and a visitor. R25 indicated she had a hard understanding what they were saying. R25 was not wearing her H/A's, they remained in the black box on her night stand. R25 indicated she could not hear very well and if she had some good H/A it would help.
-at 11:51 a.m. NA-G entered R25's room, assisted R25 to get into her wheel chair and her

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 29	F 676		

husband pushed her down to the dining room for lunch. R25 was not wearing her H/A's, they remained in the black box on her night stand.
-at 12:28 p.m. R25 was seated in her wheel chair at the dining room table eating her lunch independently. R25 was not wearing her H/A's, they remained in the black box on her night stand.

On 5/1/18 at 1:58 p.m. R25 indicated she was hard of hearing and needed to wear H/A's to hear. R25 also indicated her left H/A did not work and her daughter had sent it in to be repaired a few times and continued not to work. R25 indicated she only wore her right H/A which worked well.

On 5/2/18 11:45 a.m. NA-E indicated she felt R25 was hard of hearing at times and other times she did fine. NA-E indicated she did not know R25 had H/A's and was never told R25 used H/A's.

On 5/2/18 at 11:52 a.m. NA-G indicated she felt R25 was hard of hearing and used H/A's. NA-G indicated R25 had a hard time hearing at times even with the H/A's in and indicated that R25 only wore the H/A in her right ear. NA-G indicated she did not know why R25 did not wear the left H/A, was not sure if it was broken or if R25 chose not to wear it. NA-G indicated R25 usually does understand you if you talk slow and in front of her.

On 5/2/18 at 1:02 p.m. family member (FM)-A confirmed R25 needed H/A's to hear and verified she had just put the right H/A in R25's ear when she got to the facility. FM-A indicated R25 did not wear the left H/A due to it not working well even after sending it in several times for repair. FM-A indicated R25's H/A's did not get put in by staff a

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 30 lot of the time in the past and she usually did it when she came to the facility to visit. On 5/2/18 1:36 p.m. RN-A confirmed R25 was hard of hearing and needed to wear H/A's to hear. RN-A indicated R25 only wore her H/A in her right ear and R25's daughter indicated the left one did not help R25 to hear anyway. RN-A indicated she would expect staff to put R25's H/A's in her ears and make sure she was wearing them during the day. RN-A indicated staff should also make sure R25's H/A's were working and functioning properly and indicated staff must have forgotten to put R25's H/A's in after her bath. On 5/2/18 at 1:56 p.m. director of nursing (DON) confirmed R25 was hard of hearing and needed the H/A's to hear. The DON indicated R25 had two H/A's and only wore the one in her right ear. The DON verified R25's care plan and indicated her expectation of staff would be to make sure R25 had her H/A in her right ear. The DON also indicated staff should also make sure the H/A was functioning, working properly and staff should be following the care plan. Review of facility policy titled, Hearing Aid Care revised on 8/17 indicated the purpose was to maintain hearing aids in good working condition and optimize the residents ability to hear. The policy also indicated under procedure: H/A's should be removed at night time and in every morning.	F 676		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726		6/11/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 31 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff were trained and assessed for competency following current manufacturer's recommendations for disinfection of glucometer machines in 3 of 3 neighborhoods (Granite View, Orton's Crossing, Harvest Trail), for 18 residents (R2, R5, R6, R11, R12, R13, R15, R16, R18, R22, R29, R30, R31, R34, R38, R39, R42, R100)	F 726	A review of the Electronic Treatment record and Physicians order were done of R2, R5, R6, R11,R12,R13, R15, R16, R18, R22, R29, R30, R31, R34, R38, R39, R42, R100 to identify those receiving glucometer checks. Of those residents, a review of diagnosis to see if any residents had blood type infection. No residents have any of the diagnosis.	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 32 who received blood glucose testing in the facility. Findings include: On 5/2/18, at 11:36 a.m. R100 was seated in a chair in his room. Registered nurse (RN)-A entered the room, with a light gray, plastic box labeled "Stat Strip" and gathered supplies to perform a blood glucometer test for R100. RN-A donned gloves, cleansed R100's finger using an alcohol wipe, obtained a sample of R100's blood finger and obtained a blood glucose reading from the Stat Strip glucometer. RN-A proceeded to set the glucometer on R100's bathroom counter and discard the used blood glucose testing supplies into a sharps container in the bathroom. RN-A picked up the glucometer, exited R100's room and walked to a computer cart located in the hallway. RN-A placed the glucometer between her upper arm and side while she cleaned her hands with hand sanitizer. RN-A then held the glucometer and opened an individual packet labeled "Covidien Webcol 70% isopropyl alcohol swab" and removed a 2-ply non-woven sponge, wiped the front portion of the glucometer and the test strip port and set the glucometer on the rolling computer cart outside of R100's room and rolled the cart to the nurses station. On 5/2/18, at 11:40 a.m. RN-A stated nursing staff always used alcohol pads to wipe off the glucometers and confirmed the Nova Stat Strip glucometer was now clean and ready to use for other residents on Orton's Crossing, as the glucometer was used to test blood samples on al residents who required blood glucose testing on the unit. On 5/2/18, at 11:43 a.m. R11 was seated in a	F 726	This is a complete list of residents that would receive or would have the potential to receive glucometer checks. The Glucometer Cleaning Policy has been updated/revised on May 4, 2018, per manufacturer's recommendations. Glucometers will be disinfected with Sani-Wipes (gray) between each resident use. An All Staff Meeting was held on May 23, 2018. Education on the updated/revised Glucometer Cleaning Policy on cleaning glucometer with Sani-Wipes (gray) between each resident use was discussed. Nursing Staff were trained and assessed for competency on May 8, 2018. Nursing staff will be trained and assessed for competency annually, on hire, and as needed. A Quality Assurance/Performance Improvement audit has been developed to ensure cleaning of glucometer is accurately being done between each use and nurses will be by visually observing for competency while cleaning Glucometers. This Quality Assurance/Performance Improvement will be done two times per week for four weeks or until 100% compliant. Then random audits will be done. This audit will be reported monthly to Quality Assurance/Performance Improvement meeting. This will be monitored by Nurse Leaders	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 33	F 726		

chair in her room. RN-B entered the room, RN-B washed hands in R11's bathroom, donned gloves, cleansed R11's finger using an alcohol swab, used lancet to puncture R11's skin, placed the glucometer strip near the blood on R11's finger and obtained a sample of blood on the testing strip. RN-B obtained the blood glucose level from the glucometer, removed the testing strip and placed the strip, alcohol swab and used lancet in the sharps container in R11's bathroom. RN-B then wiped the glucometer with one alcohol swab and set the glucometer in a plastic bin on the computer caddy.

On 5/2/18, at 11:48 a.m. RN-B stated nursing staff had always used an alcohol swab to clean the Nova Stat Strip glucometers, and confirmed the glucometer was a common use glucometer in the Harvest Trail Neighborhood.

On 5/2/18, at 12:13 p.m. R2 in a wheelchair in his room with RN-A present. RN-A donned gloves, gathered supplies to perform a blood glucometer check for R2. RN-A cleansed R2's finger with an alcohol swab, and obtained a sample of blood on the testing strip. RN-A disposed the used blood sugar testing supplies in a sharps container in the bathroom and exited the room. RN-A walked to the computer cart in the hallway, wiped the outside of the glucometer with one alcohol swab and placed the glucometer on the computer cart.

On 5/2/18, at 12:16 p.m. RN-A stated she always used alcohol swabs to clean the Nova Stat Strip glucometer and confirmed it was a common use glucometer.

On 5/2/18, at 1:08 p.m. director of nursing (DON) stated the policy for cleaning the Nova Stat Strip

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 34	F 726		

glucometers had recently been updated and referred directly to the updated policy. The DON stated the glucometers should be cleaned after each use with either a 10 % (percent) bleach solution or 70% isopropyl alcohol (rubbing alcohol) solution. The DON confirmed all facility glucometers were common use and could be used on any resident with blood glucose testing orders. She confirmed she was aware the usual facility practice was for staff to use alcohol wipes to disinfect the common use glucometers.

On 5/2/18, at 1:28 p.m. the DON provided the Stat Strip Glucose Hospital Meter, Instructions for Use Manual, dated 6/2011. The manual's Table of Contents showed, 6.3 Cleaning the Meter. 6.3 Cleaning the Meter instructed the user to use a 10% bleach solution or 70% isopropyl alcohol solution to clean the glucometer.

On 5/2/18, at 1:41 p.m. during a phone interview, Nova Biomedical Technician (NBT)-A stated the Nova Stat Strip glucometer should be cleaned utilizing a 10% bleach wipe, but other approved cleaning products could be used and would provide the approved Stat Strip cleaning product list.

On 5/3/18, at 9:41 a.m. the DON reviewed the Nova Biomedical Customer Information Bulletin dated 12/4/12, regarding the cleaning and disinfection procedure for the Stat Strip glucometer. The bulletin indicated Clorox Healthcare Bleach Germicidal Wipes were the only product validated for use with the Stat Strip system. The bulletin further indicated hospitals that utilized an alternate germicidal product and disinfection, should select a product on the Environmental Protection Agency (EPA) List D.

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 35	F 726		

The DON reviewed the EPA List D and indicated 70% isopropyl alcohol was not included on the list.

On 5/2/18, at 3:04 p.m. RN-C stated the common use glucometers were cleaned after use on the Granite View Neighborhood by using two by two alcohol swabs to wipe the glucometer. RN-C stated the last education she had received regarding glucometers was when they moved to the new facility last year. RN-C stated the education provided by the facility included the use of alcohol wipes to clean the common use glucometers. RN-C stated she was unsure what the current standard of practice for glucometer cleaning was.

On 5/3/18, at 8:46 a.m. clinical manager (CM)-B stated she expected staff to disinfect the common use glucometers with Cavi wipes (a disinfecting wipe, on EPA List D) . She indicated she was unaware staff were using the alcohol wipes, stated she was surprised and stated that method has been out of practice for years.

On 5/3/18, at 10:14 a.m. infection preventionist (IP) for the facility, who also identified herself as the associated hospital's infection preventionist, indicated the facility staff had questioned how to disinfect the glucometers and she had reviewed the manufacturer's guidelines for disinfection. IP stated she had trained nursing staff to use the isopropyl alcohol swabs for cleaning the common use glucometers between each resident.

The facility policy titled Nova Meter Cleaning and Disinfection, last revised 3/8/16, indicated the glucose meters that are used for more than one resident must be cleaned and disinfected after

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 36 each use. A 10% bleach solution or 70% isopropyl alcohol solution should be used to disinfect the Nova glucose meter.	F 726		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the water and ice machines for 3 of 3 units, to prevent potential contamination for their residents who currently resided in the facility. In addition, the facility failed to maintain the coffee machine for 1 of 3 units, Orton's Crossing, to prevent potential contamination. Findings include:	F 812	All three ice machines were cleaned on May 8, 2018. Coffee machine on Orton□s Crossing was cleaned on May 8, 2018. Plastic ice trays were ordered for each ice machine on May 2, 2018. Plastic trays arrived on May 9, 2018. Plastic tray for ice machine on Orton□'s Crossing was implemented on May 31, 2018. Plastic trays for Harvest Trail and Granite View will be done by June 12, 2018.	6/11/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 37 On 4/30/18, at 2:41 p.m. in the Harvest unit kitchen the water and ice machine was observed to have a crusted hard water lime scale build up on the tray, spigot and areas around the spigot. On 4/30/18, at 6:30 p.m. in the Granite View unit kitchen, the water and ice machine was observed to have a small amount of hard water lime scale build up on the spigot and a large amount of white and brown hard water buildup on the tray. Orton's Crossing unit kitchen was observed to also have a large amount of hard water lime scale build up on the water spigot and areas around the spigot of the ice machine. The coffee machine in Orton's Crossing kitchen also had a large amount of brown buildup on the spigot and areas of the machine had multiple brown splattered areas. On 4/30/18, at 6:35 p.m. dietary manager (DM)-A indicated the homemakers used a cleaning schedule daily, which had daily tasks each day of the week. DM-A and surveyor toured the kitchens on Harvest, Granite View and Orton's Crossing. DM-A confirmed the water and ice machines all had hard water build up on the spigots and trays and they were not clean. DM-A touched the coffee spigot on Orton's Crossing and wiped brown material off the spigot of the coffee machine and confirmed it had build up and splatters and was also not clean. DM-A indicated it should be cleaned daily. DM-A confirmed the homemakers were responsible for cleaning the equipment in the kitchens including the coffee makers and ice machine spigots and trays. On 5/02/18, at 1:54 p.m. DM-A confirmed she supervised the homemakers who were responsible for cleaning the facility unit kitchens.	F 812	Water filters for ice machine were ordered on May 8, 2018 from Nelson Electric for each ice machine. Water filter was installed in Orton□s Crossing on May 31, 2018. Water filters for all ice machines will be installed by June 11, 2018. All ice machines will have water filters and plastic trays. All coffee machines were cleaned on May 8, 2018. Certified dietary manager updated/revised policy on the cleaning of ice machine on May 7, 2018. Certified dietary manager discussed the hard water lime scale build up on the spigot, and areas around the spigot, and tray of the ice machines. Certified dietary manager updated/revised policy on cleaning instructions for coffee machines on May 7, 2018. Certified dietary manager discussed the large buildup on the spigot and areas of the machine had multiple brown splattered areas. Staff meetings for Homemakers were held on the week of May 7, 2018. Staff was educated on updated policy of cleaning ice machines and coffee machines. Ice machines and coffee machines are on the Homemakers cleaning checklist. A Quality Assurance/Performance Improvement audit has been developed to ensure hard water lime scale buildup on the spigot, areas around the spigot, and tray is alleviated on ice machines. This Quality Assurance/Performance Improvement audit will be done by checking ice machine for scaling and	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 38 On 5/03/18, at 11:00 a.m. homemaker (H)-C indicated she cleaned the kitchen area on a daily basis. She indicated the homemakers used a task list form daily and documented on the form. H-C indicated there were different tasks for different days, such as cleaning cupboards. H-C indicated she would wipe off the coffee maker when needed. H-C indicated she sprayed the water and ice machines daily with vinegar after each meal and cleaned the tray daily. Review of the untitled, undated forms provided as kitchen check lists contained daily and weekly tasks to be completed by AM shift and PM shift staff. The forms had areas for recording refrigerator and freezer temperatures, dishwasher and rinse temperatures and food temperatures. The forms also had tasks listed on the bottom for cleaning schedules. The forms instructed staff to run catch trays of water and coffee in the dishwasher on Wednesdays. The form lacked specific instructions for cleaning of the water and ice machine or coffee maker. The facility policy titled Household Kitchen Cleaning schedule dated 6/12/17, indicated each homemaker was responsible for checking the cleaning schedule daily to ensure that tasks scheduled for that day were performed. The policy further instructed the homemakers with listed areas and equipment to clean after the preparation of a meal or snack when used. The coffee maker was included in this list. The policy indicated the ice machine was to be cleaned monthly. The dietician, lead homemaker and/or dietary manager would review the documentation of cleaning tasks and perform a quality assurance process with a homemaker at least once a	F 812	buildup, two times a week for eight weeks or until 100% compliant. Then random audits will be done. This will be reported monthly to Quality Assurance/Performance Improvement meeting. A Quality Assurance/Performance Improvement audit has been developed to ensure buildup on the spigot and brown splattered areas are alleviated on the coffee machines. This Quality Assurance/Performance Improvement audit will be done two times a week for eight weeks or until 100% compliant. Then random audits will be done. This Quality Assurance/Performance Improvement audit will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored by Certified Dietary Manager	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 39 month. The facility policy titled Ice Machine-Cleaning reviewed 4/27/18, indicated the ice machine would be cleaned according to manufacture's directions. Insert procedure based on manufacture's direction. No manufacture's directions were included.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to dispose of garbage in a sanitary manner to prevent facilty contamination areas, including the kitchen, which had the potential to affect all 50 residents who resided in the facility. Findings include; On 4/30/18, at 2:20 p.m. a kitchen tour was completed with dietary manager (DM)-A which included the kitchen's garbage disposal area. DM-A indicated the kitchen staff disposed of the kitchen garbage by bringing closed bags to the maintenance room across the hall from the kitchen area. The room had two areas, with an open door between the areas. In the back area there was a small dumpster in the right corner and a garbage compactor machine next the the dumpster. An area approximately 2 feet in front of the dumpster and compactor was soiled with brown liquid spills, food partials and a few small white pieces of plastic. DM-A indicated the	F 814	The garbage compactor has been moved outside into a garage outside of the building. It was moved on May 9, 2018. A mat was also ordered on May 9, 2018 for the outside garage to be placed in front of the compactor for easily cleaning and rinsing off. The room that it was in, in the building was thoroughly cleaned and disinfected on May 9, 2018. This measure by moving and securing the garbage compactor outside of the facility, will alleviate any unsanitary conditions inside the EVS room. By moving and securing the garbage compactor outside, this will ensure there will be no unsanitary conditions in the facility. An All Staff Meeting was held on May 23, 2018; education was provided on policy of garbage disposal. It was discussed with staff that the garbage compactor was	6/5/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 40 maintenance staff would use the garbage compactor and then transport the garbage to the large dumpster's outside the facility near the garage area. At 6:35 p.m. DM-A confirmed the floor was dirty in front of the dumpster and compactor in the maintenance room. DM-A indicated kitchen staff routinely were in the room and agreed it was a problem for kitchen staff stepping on the soiled floor and returning to the kitchen area. DM-A indicated maintenance staff were responsible for cleaning the area and were not available at that time for interview. On 5/1/18, at 9:58 a.m. director of clinical operations (DCO)-A indicated she had been informed of the condition of the floor in the maintenance room near the dumpster and had spoken to the maintenance staff who had cleaned the area that morning. DCO-A and surveyor toured the area and the floor was no longer soiled. DCO-A indicated the facility plan was to remove the compactor from the facility to the garage to help keep the area clean. DCO-A confirmed the area was soiled prior to being cleaned that morning. On 5/02/18, at 10:20 a.m. DCO-A confirmed the facility had no cleaning schedule for the floor to be cleaned near the dumpster and compactor area. A facility policy titled Fairway View Garbage Disposal, dated 3/16/18, indicated garbage bags were brought to the EVS (environmental services)room. EVS staff would place trash in compactor for compacting, then remove the compacted trash to the dumpster for removal. EVS staff would clean compactor and compactor area periodically.	F 814	removed from the building. Staff will deliver garbage to EVS room where garbage (all bagged and tied) will be placed in a holder and Maintenance will remove garbage to the compactor outside. A Quality Assurance/Performance Improvement audit has been developed to ensure area around compactor will be cleaned on a routine basis. This Quality Assurance/Performance Improvement audit will be done by visual inspection. This Quality Assurance/Performance Improvement audit will be done one time a week for two months or until 100% compliant. Then random audits will be done. This Quality Assurance/Performance Improvement audit will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored by Maintenance Director	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		6/11/18

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the common use blood glucometer machines were disinfected according to current manufacture's recommendation after resident use in 3 of 3 neighborhoods (Granite View, Orton's Crossing, Harvest Trail), for 18 residents(R2, R5, R6, R11, R12, R13, R15, R16, R18, R22, R29, R30, R31, R34, R38, R39, R42, R100) who resided on the neighborhoods and received blood glucose testing in the facility.	F 880	A review of the Electronic Treatment record and Physicians order were done of R2, R5, R6, R11,R12,R13, R15, R16, R18, R22, R29, R30, R31, R34, R38, R39, R42, R100 to identify those receiving glucometer checks. Of those residents, a review of diagnosis to see if any residents had blood type infection. No residents have any of the diagnosis This is a complete list of residents that	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 43 Findings include: On 5/2/18, at 11:36 a.m. R100 was seated in a chair in his room. Registered nurse (RN)-A entered the room, with a light gray, plastic box labeled "Stat Strip" and gathered supplies to perform a blood glucometer test for R100. RN-A donned gloves, cleansed R100's finger using an alcohol wipe, obtained a sample of R100's blood finger and obtained a blood glucose reading from the Stat Strip glucometer. RN-A proceeded to set the glucometer on R100's bathroom counter and discard the used blood glucose testing supplies into a sharps container in the bathroom. RN-A picked up the glucometer, exited R100's room and walked to a computer cart located in the hallway. RN-A placed the glucometer between her upper arm and side while she cleaned her hands with hand sanitizer. RN-A then held the glucometer and opened an individual packet labeled "Covidien Webcol 70% isopropyl alcohol swab" and removed a 2-ply non-woven sponge, wiped the front portion of the glucometer and the test strip port and set the glucometer on the rolling computer cart outside of R100's room and rolled the cart to the nurses station. On 5/2/18, at 11:40 a.m. RN-A stated nursing staff always used alcohol pads to wipe off the glucometers and confirmed the Nova Stat Strip glucometer was now clean and ready to use for other residents on Orton's Crossing, as the glucometer was used to test blood samples on al residents who required blood glucose testing on the unit. On 5/2/18, at 11:43 a.m. R11 was seated in a chair in her room. RN-B entered the room, RN-B	F 880	would receive or would have the potential to receive glucometer checks. The Glucometer Cleaning Policy has been updated/revised on May 4, 2018, per manufacturer's recommendations, glucometers will be disinfected with Sani-Wipes (gray) between each resident. An All Staff Meeting was held on May 23, 2018. Education on the updated policy on cleaning glucometer with Sani-Wipes (gray) between each resident was discussed. A Quality Assurance/Performance Improvement audit has been developed to ensure cleaning of glucometer is accurately being done between each use with Sani-Wipes (gray). This will be done by a visual audit. This Quality Assurance Performance Improvement audit will be done two times a week for four weeks or until 100% compliant. Then random audits will be done. This audit will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored by Neighborhood Nurse Leads	

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 44	F 880		

washed hands in R11's bathroom, donned gloves, cleansed R11's finger using an alcohol swab, used lancet to puncture R11's skin, placed the glucometer strip near the blood on R11's finger and obtained a sample of blood on the testing strip. RN-B obtained the blood glucose level from the glucometer, removed the testing strip and placed the strip, alcohol swab and used lancet in the sharps container in R11's bathroom. RN-B then wiped the glucometer with one alcohol swab and set the glucometer in a plastic bin on the computer caddy.

On 5/2/18, at 11:48 a.m. RN-B stated nursing staff had always used an alcohol swab to clean the Nova Stat Strip glucometers, and confirmed the glucometer was a common use glucometer in the Harvest Trail Neighborhood.

On 5/2/18, at 12:13 p.m. R2 in a wheelchair in his room with RN-A present. RN-A donned gloves, gathered supplies to perform a blood glucometer check for R2. RN-A cleansed R2's finger with an alcohol swab, and obtained a sample of blood on the testing strip. RN-A disposed the used blood sugar testing supplies in a sharps container in the bathroom and exited the room. RN-A walked to the computer cart in the hallway, wiped the outside of the glucometer with one alcohol swab and placed the glucometer on the computer cart.

On 5/2/18, at 12:16 p.m. RN-A stated she always used alcohol swabs to clean the Nova Stat Strip glucometer and confirmed it was a common use glucometer.

On 5/2/18, at 1:08 p.m. director of nursing (DON) stated the policy for cleaning the Nova Stat Strip glucometers had recently been updated and

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45	F 880		

confirmed the policy had been updated on 3/8/16. The DON stated the facility policy directed glucometers should be cleaned after each use with either a 10 % (percent) bleach solution or 70% isopropyl alcohol solution. She indicated the policy included the manufacturer's recommendations for cleaning and disinfection the glucometer. The DON confirmed all facility glucometers were common use and would be used on any resident with blood glucose testing orders.

On 5/2/18, at 1:28 p.m. the DON provided the Stat Strip Glucose Hospital Meter, Instructions for Use Manual, dated 6/2011. The manual's Table of Contents showed, 6.3 Cleaning the Meter. 6.3 Cleaning the Meter instructed the user to use a 10% bleach solution or 70% isopropyl alcohol solution to clean the glucometer.

On 5/2/18, at 1:41 p.m. during a phone interview, Nova Biomedical Technician (NBT)-A stated the Nova Stat Strip glucometer should be cleaned utilizing a 10% bleach wipe, but other approved cleaning products could be used and would provide the approved Stat Strip cleaning product list.

On 5/2/18, at 3:04 p.m. RN-C stated the common use glucometers were cleaned after use on the Granite View Neighborhood by using two by two alcohol swabs to wipe the outside of the glucometer. RN-C stated the most recent education she had received regarding disinfecting glucometers was approximately one year ago. RN-C stated the education provided by the facility included the use of alcohol wipes to clean the common use glucometers. RN-C stated she was unsure what the current standard of practice for

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 _____	05/03/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46 glucometer cleaning was. On 5/3/18, at 9:41 a.m. the DON reviewed the Nova Biomedical Customer Information Bulletin dated 12/4/12, regarding the cleaning and disinfection procedure for the Stat Strip glucometer. The bulletin indicated Clorox Healthcare Bleach Germicidal Wipes were the only product validated for use with the Stat Strip system. The bulletin further indicated hospitals that utilized an alternate germicidal product and disinfection, should select a product on the Environmental Protection Agency (EPA) List D. The DON reviewed the EPA List D and indicated 70% isopropyl alcohol was not included on the list. The facility policy titled Nova Meter Cleaning and Disinfection, last revised 3/8/16, indicated the glucose meters that are used for more than one resident must be cleaned and disinfected after each use. A 10% bleach solution or 70% isopropyl alcohol solution should be used to disinfect the Nova glucose meter.	F 880		

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 _____	**05/01/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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 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. A Life Safety Code Certification 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 to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/31/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/01/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@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 prevent a reoccurrence of the deficiency Fairway View Neighborhoods was built in 2016 under the LSC 2000 Regulations, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 51at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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 _____	**05/01/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2	K 000		
K 131 SS=E	FIRE SAFETY Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition	K 131	Fire rated caulking was ordered from Barr-Conroy Electric on May 8, 2018. Fire rated caulking was received on May 14, 2018. The space around three 4 inch	5/22/18

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 _____	**05/01/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 131	Continued From page 3 section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and affect 16 of the 41 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 05/01/2018 observations revealed the annular space around three 4 inch conduit above the cross corridor doors at Harvest Trail 2 hour fire barrier was not properly fire stopped. This deficient condition was confirmed by the facility Maintenance Director	K 131	conduit above the cross corridor doors at Harvest Trail two hour fire barrier walls were caulked with fire rated caulking on May 22, 2018. All penetrations were filled with fire rated caulking on this date. Maintenance director verified there were no other penetrations on all two hour fire barrier walls. The maintenance director is responsible this is completion.	
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep exits free of obstructions as stated in the Life Safety Code (NFPA 101) 2012 edition sections 19.2.7 & 7.1.10. This deficient practice could restrict the exiting during an emergency and affect 14 of the 51 residents and an undetermined amount of staff and visitors. Findings Include:	K 271	Maintenance Director called Hasslen Construction May 1, 2018 regarding the elevation difference between the sections of the exit sidewalks of Harvest Trail and Granite View. Hasslen Construction came on May 18, 2018 to view sidewalks. Sidewalks will be replaced to ensure consistent height between each section of sidewalks. This will be completed by July	6/12/18

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 _____	**05/01/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 271	Continued From page 4 On the facility tour between 8:00 am to 12:00 pm on 05/01/2018 observations revealed the sidewalks outside of resident wings Harvest Trail and Granite view had an elevation difference of 1 1/2 inch between the sections at each location. This deficient condition was confirmed by the facility Maintenance Director	K 271	27, 2018. A Quality Assurance/Performance Improvement audit has been developed to ensure consistent height of all sidewalks will remain. This will be a visual audit of sidewalks. This audit will be done quarterly for one year, then random checks will continue. This audit will be reported to the monthly Quality Assurance/Performance Improvement meeting. The Maintenance director will be responsible for this audit.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one smoke barrier as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient	K 372	Smoke barrier at Orton□s Crossing has 2 conduits above the ceiling line at the cross corridor doors and the activity office that were caulked with fire rated caulking on	5/29/18

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 _____	**05/01/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 5 practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 16 of the 51 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:00 pm on 05/01/2018 observations revealed the smoke barrier at the Ortonville Crossing wing has 2 conduits above the ceiling line at the cross corridor doors and in the activity office that do not have the proper fire stopping in the ends. This deficient condition was confirmed by the facility Maintenance Director	K 372	May 29, 2018. Maintenance director verified there were no other penetrations on all two hour fire barrier walls. The maintenance director is responsible for ensuring this is completed.	