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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZI37

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 **04/16/2019** (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 :
Gail Anderson, Unit Supervisor 04/17/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/17/2019 (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
04/16/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 17, 2019

CMS Certification Number (CCN): 245451

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 April 16, 2019 the above facility is certified 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/or 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 17, 2019

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

RE: Project Number S5451031 and H5451008C

Dear Administrator:

On April 16, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

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: ZI37

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00771

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(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 **03/07/2019** (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) :

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13.Total Certified Beds **51** (L17)

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___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 :
Jonathon Anderson, HFE - NE II — 04/03/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 04/11/2019 (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
(L33)

DETERMINATION APPROVAL

Electronically delivered March 22, 2019

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

RE: Project Number S5451031, H5451008C, H5451009C and H5451010C

Dear Administrator:

On March 7, 2019, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the March 7, 2019 standard survey the Minnesota Department of Health, completed an investigation of complaint numbers H5451008C that was found substantiated.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the March 7, 2019 standard survey, the Minnesota Department of Health, completed an investigation of complaint numbers H5451009C and H5451010C that were found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is April 16, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient

practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- 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 (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" 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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by June 7, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 7, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	C 03/07/2019

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 3/4/19, through 3/7/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 3/4/19 through 3/7/19, and a complaint investigation was also completed at the time of the standard survey. At the time of the survey, investigations of complaint #H5451008C, H5451009C and H5451010C were completed. H5451008C was found to be substantiated at F689. 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 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §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	F 676		4/16/19

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

Electronically Signed | 04/01/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	C 03/07/2019

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 1 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: Based on observation, interview and document review the facility failed to routinely provide ambulation services according to therapy recommendations to maintain function for 1 of 1 residents (R29) reviewed for ambulation.	F 676	On 3/7/19 R29 was offered to ambulate which R29 did. R29 has been offered to ambulate daily as resident is awake and receptive of walking. If R29 is not receptive to walking when offered to walk, staff will approach later in the day.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	C 03/07/2019

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 2 Findings include: R29's annual Minimum Data Set (MDS) dated 1/30/19 indicated R29 had severe cognitive impairment and diagnoses which included dementia, Diabetes Mellitus, and depression. The MDS identified R29 required supervision with eating, limited assistance to walk in her room, and extensive assistance with all other activities of daily living (ADL). R29's MDS further indicated R29 had walked in the hallway only once or twice during the seven-day MDS assessment period. R29's Care Area Assessment (CAA) dated 1/30/19 indicated R29 required limited assistance of one staff with walking in room and hallway. The CAA further indicated staff would continue to offer R29 help to accomplish ADLs daily, while making sure ADLs were completed safely. The CAA directed staff to encourage R29 in the FMP (Functional Maintenance Program) (a program to help maintain a residents functional status) as designed/ordered, work with R29 to help with walking with staff frequently as ordered, and get R29 to participate in other activities R29 enjoyed. R29's care plan revised 3/6/19 indicated R29 was limited in her ability to accomplish ADLs daily related to diagnoses, which included dementia with cognitive loss. The care plan listed various interventions, which included the need for limited assist of one staff for walking in the room and hall as R29 tolerated with a gait belt and four-wheeled walker (FWW). The care plan further indicated R29 did not go in the hallway much, was on the walking list twice a day as R29 allowed/agreed to, and please help R29 with walking to keep up her leg strength.	F 676	As of 3/11/19 a list of residents who need assistance with ambulation has been provided as a guide for staff for each Neighborhood. Residents who require assistance with ambulation will be screened or evaluated by Physical Therapy. Physical Therapy will determine the number of staff needed to ambulate each individual resident safely, if an assistive device is required for each individual resident, and the distance each individual resident is able to walk up too. These Physical Therapy screens/evaluations will be completed by 4/16/19. As of 3/29/19 all residents who need assistance with walking will be entered into the Point Of Care via Matrix. This will allow for the CNA□s to chart after walking each residents on a daily basis. Daily, the CNA□s will offer each resident who needs assistance with ambulation to ambulate and will chart in Point of Care of Matrix. As of 3/11/19 a list of residents who need assistance with ambulation has been provided as a guide for staff for each Neighborhood. As of 3/29/19 the floor nurse on Day shift and PM shift of each Neighborhood will print a report from Matrix, to use as a reference of which residents still need to be offered to walk and inform the CNA□s to complete. An all staff meeting was held on March	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	C 03/07/2019

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 3 On 3/4/19, at 3:21 p.m. R29 was observed seated in a wheelchair and propelled herself in a common area of the unit with her feet. R29 lightly bumped the wheelchair into pillars in the common area as she peddled around. R29 was alert as she made eye contact with others around her. On 3/4/19, at 7:31 p.m. during a phone interview with family member (FM)-A stated R29's balance could be off in the mornings and R29 needed to be reminded to stand tall, complete her exercises and walking. FM-A indicated they were unaware if staff were walking R29, and was something FM-A asked the staff to make sure they were doing. FM-A further stated R29's wheelchair was her main mode of transportation. On 3/4/19, at 7:33 p.m. R29 was seated in a wheelchair and propelled herself down the hallway of the unit. R29 was alert as she looked into other residents' rooms, but did not enter them. On 3/6/19, at 7:47 a.m. R29 was laying in a low bed, on her back, with eyes closed, curtains pulled and the lights were off. At 8:23 a.m., R29 remained laying in the bed. At 8:51 a.m. nursing assistant (NA)-A opened R29's door and walked out with two tied plastic bags and walked down the hall. R29 was seated in her wheelchair and pedaled herself from the room to the middle of the hallway. At 8:53 a.m., R29 remained seated in the wheelchair in the hallway and NA-A approached and asked R29 if she was ready for breakfast. R29 indicated she was, and NA-A pushed her wheelchair to a table in the dining room. On 3/6/19, at 12:47 p.m. R29 was seated in the	F 676	28, 2019. At this meeting it was discussed the importance of ambulating residents on a daily basis or as needed. This list of residents will be provided as a guide for staff that need assistance with ambulation and will be documented in Point of Care in Matrix. Staff will sign off on the Point of Care in Matrix when resident has been ambulated. A Quality Assurance/Performance Improvement audit has been developed to ensure residents are being ambulated as recommended. This Quality Assurance/Performance Improvement will be auditing two residents, per Neighborhood, three times a week for three months or until 100% compliant. Then random audits will be completed. The Quality Assurance/Performance Improvement audit results will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored by Neighborhood Nurse Leaders	

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wheelchair in the dining room at the noon meal. At 12:57 p.m., after R29 had finished the noon meal, she propelled the wheelchair with her feet and sat outside her bedroom door. R29 was alert and looking around the unit.

On 3/7/19, at 8:09 a.m. R29 was laying in a low bed, on her back, with eyes closed and window curtains pulled shut. At 8:53 a.m., R29 remained lying in bed. At 9:19 a.m., R29 was seated in the wheelchair and propelled self out of the room and straight to the dining room table for the breakfast meal.

Review of Therapy Communication/Screen Form, dated 1/22/19, indicated, "family/staff have noticed that resident seems weaker in transfers. She has not been walking much. Please assess for transfers and ambulation and give recommendations". The form indicated, by circling no, that R29 was not a candidate for a physical therapy evaluation. The physical therapist (PT)-A commented "[R29] cont. [continues] to be A [assist] x [times] 1 @ [at] this time. Staff has been encouraged to cont[inue] to walk c [with] res[ident]".

Review of R29's Point of Care History, Miscellaneous Tasks: Walk 150-350 FT [Feet] with FWW CGA [Contact Guard Assist] of 1 [staff] with W/C [wheelchair] to Follow Cue For Stride Length, Distance As Tolerated [Twice A Day], from 12/1/18, through 3/7/19, revealed the following:

-From 12/1/18, through 12/31/18, the question if R29 walked as above was marked as "unanswered" 30 times, marked as "Done" 27 times, and marked as "Not Done" five times due

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to refusal, combative or deferred due to condition.

-From 1/1/19, through 1/31/19, the question if R29 walked as above was marked as "unanswered" 28 times, marked as "Done" 31 times, and marked as "Not Done" three times due to refusal or deferred due to condition.

-From 2/1/19, through 2/28/19, the question if R29 walked as above was marked as "unanswered" 21 times, marked as "Done" 31 times, and marked as "Not Done" four times due to refusal.

-From 3/1/19, through 3/7/19, the question if R29 walked as above was marked as "unanswered" five times, marked as "Done" seven times, and marked as "Not Done" two times due to refusal.

On 3/6/19, at 1:28 p.m. NA-A stated R29 required extensive assistance with ADLs and walked with staff at times. NA-A stated some of her duties included walking residents, whom were able, to and from meals. NA-A stated some residents required extra walking in the hall and the extra walking was charted in the electronic health record (EHR). NA-A reviewed the Point of Care (POC) charting for R29 and confirmed R29 required extra walking.

On 3/7/19, at 9:34 a.m. NA-D stated R29 required extensive assistance for ADLs, and walks with staff one to two times per day, on a good day. NA-D indicated R29 was to walk twice a day, and stated, "She is supposed to be, I don't know if it gets done when I am not here". NA-D indicated R29 would walk from the bed to the bathroom and to the dining room. NA-D stated R29 walked to the bathroom from the bed that morning, and

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F 676	Continued From page 6 added, "She is stiff this morning". On 3/7/19, at 10:12 a.m. NA-E indicated she was directed to walk with the residents that were able to walk to the dining room and back. NA-E stated R29 required extensive assistance of one staff for walking with a gait belt and FWW, and two staff if R29 was tired. NA-E indicated she would walk R29 to the bathroom from her bed, and to the dining room. NA-E stated R29 was to walk at least two times per day, and indicated she had not had the chance to walk R29 in the hallway much. NA-E indicated R29 does not refuse walking, but if R29 was tired, staff would not attempt to walk with R29. NA-E reviewed POC walking instructions for R29 in the EHR, and was unable to determine how far 150 to 350 feet would be on the unit. On 3/7/19, at 10:30 a.m. registered nurse (RN)-A stated R29 abilities varied, and required one to two staff to walk, with a gait belt and FWW and wheelchair to follow to walk. RN-A stated R29 would walk from her room to the bathroom and to the dining room. RN-A stated she had not seen staff walk R29 down the hallway. On 3/7/19, at 10:48 a.m. nurse manager (NM)-C indicated R29's walking program was separate from the facility's Functional Maintenance Program (FMP) and the unit staff completed R29's walking program. NM-C stated the facility had a walk to dine program where staff were to walk residents to meals. NM-C stated R29's room was "extremely close" to the dining room and indicated the walk to dine program did not account for the closeness to the resident's room from the dining room. NM-C reviewed R29's POC instructions to walk R29 150-350 FT [Feet] with	F 676		

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F 676	Continued From page 7 FWW CGA [Contact Guard Assist] of 1 [staff] with W/C [wheelchair] to Follow Cue For Stride Length, Distance As Tolerated [Twice A Day], and documentation, and verified missing documentation in R29's walking program. NM-C indicated R29's alertness varied, but staff had the ability to chart refusals and would have to accommodate R29. NM-C stated the normal procedure for a resident refusing was for staff to document the refusal, update the nurse and reapproach the resident. NM-C stated she was unaware who reviewed R29's walking program, and indicated R29 would be at risk for a decrease in range of motion and increased fall risk. On 3/7/19, at 12:19 p.m. therapy site coordinator (TSC)-A stated therapy typically did not include walking on a resident's FMP, with hopes nursing staff were walking the resident to the dining room and the bathroom. TSC-A stated if R29 had specific instructions to walk 150 to 350 feet twice a day, it would have been a recommendation from therapy. TSC-A stated with R29's room being so close to the dining room, she would expect nursing staff to be walking R29 the 150-350 feet distance as well. TSC-A stated R29 would be at risk for a decrease in transfer ability and decrease in functional strength. On 3/7/19, at 3:03 p.m. director of nursing (DON) indicated R29 had varying levels of alertness, and added R29 had days, which she would sleep most of the day, but also R29 had multiple days in a row, which she was awake and alert. DON stated she would expect staff to walk R29 per instructions, and start R29's walk further from the dining room to increase the walking distance. The DON indicated the NM should be reviewing R29's walking to dine program.	F 676		

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F 676	Continued From page 8 A policy on walk to dine/walking program was requested, however one was not provided.	F 676		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to routinely provide range of motion services according to therapy recommendations to maintain function for 2 of 3 residents (R29, R45) reviewed for range of motion (ROM). Findings include: R29's annual Minimum Data Set (MDS), dated 1/30/19, indicated R29 had severe cognitive impairment, and had diagnoses which included	F 688	On 3/7/19 R29 was offered range of motion. R29 has been offered range of motion three to five times a week along with their Functional Maintenance Program and on 3/7/19 R45 was offered range of motion. R45 has been offered range of motion three times a week along with their Functional Maintenance Program. Facility developed a list on 3/11/19 of	4/16/19

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F 688	Continued From page 9 dementia, Diabetes Mellitus, and depression. The MDS identified R29 required supervision with eating, limited assistance to walk in her room, and extensive assistance with all other activities of daily living (ADL). R29's MDS further indicated, R29 had walked in the hallway only once or twice during the seven day MDS assessment period. R29's Care Area Assessment (CAA) dated 1/30/19, indicated R29 required limited assistance of one staff with walking in room and hallway. The CAA further indicated staff would continue to offer R29 help to accomplish ADLs daily, while making sure ADLs were completed safely. The CAA directed staff to encourage R29 in the FMP (Functional Maintenance Program) (a program to help maintain a residents functional status) as designed/ordered and get R29 to participate in other activities R29 enjoyed. R29's care plan, last revised 3/6/19, indicated R29 was limited in her ability to accomplish ADLs daily related to diagnoses which included dementia with cognitive loss. The care plan listed various interventions which included R29 would participate with therapies as ordered to the best of her ability, including establishing FMP after therapies are done, encourage R29's participation in the program and reapproach R29 if initially refuse or was uncooperative. On 3/4/19, at 3:21 p.m. R29 was observed seated in a wheelchair and propelled herself in a common area of the unit with her feet. R29 lightly bumped the wheelchair into pillars in the common area as she peddled around. R29 was alert as she made eye contact with others around her. On 3/4/19, at 7:31 p.m. during a phone interview	F 688	residents that require range of motion and will be offered as per their Functional Maintenance Program. Each resident that has a Functional Maintenance Program has been printed and placed in a binder as a resource for the Restorative Therapy staff. Restorative therapy program was restructured on 3/27/19 to include resident group participation including all residents who have range of motion as part of their Functional Maintenance Program to receive their range of motion as ordered. An Occupational Therapy Assistant will supervise the Restorative Therapy program under the supervision of Director of Nursing. Occupational Therapy Assistant will track delivery of services and give guidance to Restorative Therapy staff. An all staff meeting was held on March 28, 2019. At this meeting it was discussed the importance of residents that have a Functional Maintenance Program receive range of motion as ordered to prevent decrease of range of motion unless a clinical condition is unavoidable. A Quality Assurance/Performance Improvement audit has been developed to ensure range of motion has been offered to residents per their Functional Maintenance Program. This audit will be done by a record review of Restorative Therapy documentation. This audit will be	

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F 688	Continued From page 10 with family member (FM)-A stated R29's balance could be off in the mornings and R29 needed to be reminded to stand tall, complete her exercises and walking. FM-A indicated they were unaware if staff were walking R29, and was something FM-A asked the staff to make sure they were doing. FM-A further stated R29's wheelchair was her main mode of transportation. On 3/4/19, at 7:33 p.m. R29 was seated in a wheelchair and propelled herself down the hallway of the unit. R29 was alert as she looked into other residents' rooms, but did not enter them. On 3/6/19, at 7:47 a.m. R29 was lying in a low bed, on her back, with eyes closed and curtains pulled and the lights were off. At 8:23 a.m. R29 remained laying in the bed. At 8:51 a.m. nursing assistant (NA)-A opened R29's door and walked out with two tied plastic bags and walked down the hall. R29 was seated in her wheelchair and peddled herself from the room to the middle of the hallway. At 8:53 a.m. R29 remained seated in the wheelchair in the hallway and NA-A approached and asked R29 if she was ready for breakfast. R29 indicated she was, and NA-A pushed her wheelchair to a table in the dining room. On 3/6/19, at 12:47 p.m. R29 was seated in the wheelchair in the dining room at the noon meal. At 12:57 p.m. after R29 had finished the noon meal, she propelled the wheelchair with her feet and sat outside her bedroom door. R29 was alert and looking around the unit. On 3/7/19, at 8:09 a.m. R29 was lying in a low bed, on her back, with eyes closed and window	F 688	done by auditing two residents per Neighborhood, three times per week for three months or until 100% compliant. Then random audits will be completed. The Quality Assurance/Performance Improvement audit will be reported monthly to the Quality Assurance/Performance meeting. This will be monitored by OTA/ Restorative Therapy Supervisor	

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curtains pulled shut. At 8:53 a.m. R29 remained lying in bed. At 9:19 a.m. R29 was seated in the wheelchair and propelled self out of the room and straight to the dining room table for the breakfast meal.

On 3/6/19, at 1:28 p.m. NA-A stated R29 required extensive assistance with ADLs and walked with staff at times. NA-A stated, nursing assistants do not complete resident's FMP on the units. NA-A stated, staff may complete a little stretching of hands in the room, but the facility had restorative therapy staff and they complete FMPs.

On 3/7/19, at 9:34 a.m. NA-D stated R29 required extensive assistance for ADLs, and walks with staff one to two times per day, on a good day. NA-D indicated R29 had a FMP and restorative therapy aide (RA) would work with R29 once in a while. NA-D stated, there are some days we [staff] do not get RA down on the unit, and staff make sure to complete walking with R29. NA-D stated R29 walked to the bathroom from the bed that morning, and added "she is stiff this morning".

On 3/7/19, at 10:30 a.m. registered nurse (RN)-A stated R29 abilities varied, and required one to two staff to walk, with a gait belt and four wheeled walker and wheelchair to follow, to walk. RN-A stated RA staff completed all resident's FMP. RN-A indicated an RA was available Monday through Friday, and NA floor staff were not trained to complete a resident's FMP.

On 3/7/19, at 10:48 a.m. nurse manager (NM)-C indicated after R29 completed therapy, therapy ordered a FMP to assist in maintaining R29's functional mobility. NM-C stated after FMP orders

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were received, they are placed into R29's orders and into her care plan. NM-C stated R29's FMP was reviewed monthly by the night shift, licensed practical nurse (LPN)-A. NM-C reviewed R29's monthly FMP progress note from LPN-A and indicated R29's FMP was completed 8 times last month. NM-C stated she would expect R29's FMP to be completed as instructed, and if not, R29 was at risk for a decrease in ROM, increased fall risk, and contractures.

On 3/7/19, at 11:55 a.m. restorative therapy aide (RA)-A stated she was one of two RAs responsible for completing resident's FMP. RA-A confirmed restorative therapy (RT) was completed Monday through Friday at the facility, and usually only one RA worked per day. RA-A stated the facility currently had 37 FMP programs, and if the RA could not get to a resident, due to not having enough time, the RAs were instructed to chart the resident as "unavailable". RA-A stated if a resident was sleeping, with company or an activity she would then put in a comment as to why the FMP was not done that day. RA-A confirmed R29 had a FMP, and stated R29 did not refuse often, and if R29 did refuse, she would add refuse to the comments.

Review of R29's FMP documentation from 1/1/19, to 3/7/19, was completed and revealed "resident unavailable" was documented 70 times in January, 70 times in February, and 28 times in March.

On 3/7/19, at 12:19 p.m. therapy site coordinator (TSC)-A stated a resident's FMP was set up after therapy was complete, to maintain balance and ROM. TSC-A stated R29 does participate with her FMP when in the therapy room with RA-A. TSC-A

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F 688	Continued From page 13 stated R29 last received therapy from 10/19/18, through 11/1/18, and therapy recommended different activities R29 could complete safely in the dining room, and for R29's FMP to continue. TSC-A indicated if R29's FMP was not completed, R29 would be at risk for a decrease in functional strength and increased risk for contracture. On 3/7/19, at 2:24 p.m. during a follow up interview, NM-C stated facility NAs were not trained to complete resident's FMPs and only two RA staff were trained to complete the FMPs. NM-C stated she was unaware of a time the RT staff reported to her that they were unable to complete R29's FMP. On 3/7/19, at 3:03 p.m. director of nursing (DON) indicated R29 had varying levels of alertness, and added R29 had days which she would sleep most of the day, but also R29 had multiple days in a row which she was awake and alert. The DON stated she was responsible for the facility's FMP, and her expectation for R29's FMP would be RT staff follow the orders from the chart. DON stated two RT aides were trained to complete FMPs, and no other staff. The DON indicated if the RAs were unable to complete the required FMPs for each day, the RAs would tell her. She was unaware residents were not being provided their FMPs as ordered. The DON stated moving forward resident's FMPs would be completed in groups so RA staff can complete all FMPs. R45 R45's significant change Minimum Data Set (MDS) dated 2/18/19 indicated R45 was cognitively intact and had diagnoses which	F 688		

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F 688	Continued From page 14	F 688		

included coronary artery disease, depression, Parkinson's, chronic pain, and chronic pneumonitis related to aspiration of food. R45 required extensive assist of one person with bed mobility, transfers, dressing, toileting, and locomotion on/off the unit. In addition, R48 needed supervision with personal hygiene.

R45's significant change Care Area Assessment (CAA) dated 2/18/19, identified R45 had degenerative bowel and bladder related to Parkinson's. As a result, R45 was occasionally incontinent of bowel and bladder and needed extensive assistance from one staff to toilet, provide incontinence cares, and assist with dressing. The CAA further identified R45 was at a risk for falls related to psychotropic drug use of Remeron taken for depression, and diagnosis of Parkinson's. R45 had a history of falls and difficulty with freezing movements, impulsivity, and balance problems while standing related to diagnosis of Parkinson's.

R45's care plan dated 2/21/19, addressed numerous areas including chronic pain from arthritis, severe headaches, as well as muscle cramping/freezing pain from Parkinson's disease. The care plan instructed staff to use non-medicated pain relief measures including physical therapy, stretching, strengthening exercises. The care plan also addressed R45's fall risk and included various interventions. In addition, the care plan addressed R45's need for assistance with activities of daily living (ADL)s and indicated he required extensive assistance from 1-2 staff with ambulation in his room or hallway using a front wheeled walker. Further, the care plan instructed staff to provide a functional maintenance program (FMP) to help

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F 688	Continued From page 15 maintain strength and mobility. On 3/7/19, at 9:06 a.m. R45 was interviewed with family member FM-B present in the room. R45 stated he had fallen a couple of times, and was not supposed to transfer himself but indicated he had to wait 5-10 minutes for staff sometimes, and stated that was often too late. FM-B stated R45 has had physical therapy in the past and indicated R45 currently had a functional maintenance program (FMP) 2-3 times per week to help maintain his strength and balance. FM-B indicated she did not think staff was offering R45 the FMP. R45 stated he was willing to go any time, stated he was not allowed to stand to urinate independently, indicated he did not like the motion sensor alarm in his chair and wished he could stand to urinate independently. R45 and FM-B stated they had expressed the concern for use of the chair alarm, and staff stated it was for safety. FM-B stated they had a therapy evaluation done a couple of weeks ago to address the concerns with wanting to stand to urinate independently, but indicated that insurance would not cover the cost of therapy and they had opted to use the FMP instead. R45 stated he had not been offered FMP exercises. On 3/7/19, 9:27 a.m. restorative aide (RA)-A entered the room and stated she had worked with R45 in the past but indicated it had been a long time. RA-A stated she had R45 on her schedule for the last few months, and indicated she could come get him later for the FMP exercises. Review of R48's restorative therapy FMP documentation from 12/1/18 to 3/7/19, was completed and revealed "resident unavailable" was documented 32 times in December, 71 times	F 688		

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in January, 36 times in February, and 15 times in March which indicated he had not been offered the FMP exercises in his restorative therapy program.

On 3/7/19, at 9:43 a.m. the physical therapy assistant (PTA) - A stated R45 was in therapy after a hospital stay in November 11/22/18, and was discharged from physical therapy (PT), occupational therapy (OT), and speech on 12/4/18. A review of R45's discharge summary indicated at the end of therapy he was able to walk 10-30 feet with FWW, contact guard assist up to minimal assist. PTA-A indicated R45 was at risk for falls and decline in mobility related to his diagnosis of Parkinson's disease, impulsive behavior, poor balance, and safety awareness. PTA-A stated R45 was set up with a FMP on 12/5/19, and indicated the plan included doing large amplitude movements, toe taps, NuStep, walking in the parallel bars to encourage more fluid movements and less freezing episodes.

PTA-A reviewed R45's restorative documentation and stated R45 usually refused "resident unavailable", and indicated if he continued to refuse restorative therapy he would be discharged from the program. PTA-A explained that R45 could have a more progressive decline in his mobility without the FMP, and stated restorative therapy can delay the progression of his Parkinson's symptoms. PTA-A verified the RA's documentation "resident unavailable" and stated she would interpret that as a refusal, but indicated the restorative aide could clarify the information documented. PTA-A stated if R45 was refusing the FMP the restorative aide should communicate if there was any concern of decline in mobility and function, and indicated she was

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not aware of any decline with R45 at this point.

On 3/7/19, at 9:48 a.m. during a group interview, director of nurses (DON) and RN-A indicated R45 had been on the restorative program 3 times per week since the hospital stay in November and indicated the felt resident frequently refused, or was unavailable.

On 3/7/19, at 10:43 a.m. RA-A who verified R45 was on her list for the FMP 3-5 times per week. RA-A verified she had not offered R45 restorative therapy this week, and indicated she had 37 other resident on the list. RA-A stated she did not have time to get to him this week yet, and stated R45 had not refused. RA-A stated she did not have time to get to everyone on her list every week, and indicated she would choose the residents on her list who are likely to accept first. RA-A stated she could on average see 11-12 residents each day, and stated that if she was unable to get to someone on the list she was instructed during restorative training to document "resident unavailable". RA-A confirmed documentation in restorative FMP "resident unavailable" meant the restorative aide did not get to the resident and FMP was not offered.

On 3/7/19, at 11:19 a.m. DON stated she would expect the RA to communicate with her if a resident refused or if they were not able to get to someone. The DON stated the workflow should be changed, and she expected that every resident in the FMP should have it offered. The DON stated she was not aware that people were not being offered the FMP, and indicated the RA had stated "I was not able to get to everyone I wanted to today" but did not know that it meant she was not getting to the residents at all. The

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F 688	Continued From page 18 DON was not aware of any concerns with a resident decline in ADL function. On 3/7/19, at 2:47 p.m. nursing assistant NA-C stated the restorative aides have a list of people they walk or do exercises with, and it had not communicated to her if they were not able to get to someone on the list. NA-C stated the residents to be walked popped up on their task list and they do walk those residents but indicated they are not trained to complete the FMB restorative aides' duties. NA-C stated R45 required extensive assistance of one staff with toileting/transfers and stated she does not walk R48 due to his shuffled gait, and indicated she transferred R45 into his wheelchair then took him to the bathroom. During a follow up interview on 3/7/19, at 3:03 p.m. the DON stated she would expect to offer, reapproach, then document the refusal and update the nurse. The DON indicated she was in charge of the restorative program, and indicated they coordinate with big stone therapy to develop and update the FMP. The DON stated licensed practical nurse (LPN)-A reviews the charts and documentation on a weekly basis, looking for increase in refusals, and stated the FMP may get discontinued if there is a change in condition and the FMP was not appropriate or if the resident did not participate. The DON stated if the RA was unable to complete workload, she would expect them to notify her. The DON stated LPN-A may have interpreted unavailable as a refusal and indicated she was not aware that the RA documentation "resident unavailable" meant the FMP restorative program was not offered. The DON stated she would expert if RA staff cannot get to everyone in a day that it would be communicated clearly to the DON and unit	F 688		

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F 688	Continued From page 19 leaders. The facility provided policy titled Restorative Therapy Program reviewed on 9/2018, indicated the purpose of the restorative program was to provide residents a planned therapy program that promoted each resident to maintain the highest level of function and independence. The policy indicated that a resident who refused the restorative therapy program for 3 consecutive months would be discharged from the program.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow manufacturer's guidelines for the proper use of a wheeled walker to prevent accident hazards for 1 of 1 resident (R3) who utilized a walker for ambulation. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/4/18, indicated R3 had intact cognition and diagnoses which included Polymyalgia rheumatica (causes muscle pain and stiffness in the neck, shoulder, and hip), chronic obstructive pulmonary disease (COPD), and Diabetes	F 689	On 3/7/19 R3 and staff were reeducated on the wheeled walker that should not be used as a mode of transportation device. If R3 becomes tired during walking, may sit to rest before continuing to walk. R3 wheeled walker has been labeled by a highly visible label stating do not use for transport. As of 3/8/19 any residents that have wheeled walker with a seat will not be used as a mode of transportation per manufacturer□s recommendation. This communication to staff was relayed	4/15/19

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F 689	Continued From page 20 Mellitus. The MDS further indicated R3 required limited assistance with transfers and walking, extensive assistance with bed mobility, toileting, dressing, and personal hygiene and utilized a walker. R3's care plan, revised 3/6/19, indicated R3 was at risk for falls due to balance problems, weakness and had fallen in the past. R3's care plan listed various interventions which included keeping R3's walker at bedside when in bed, education on ways to reduce falls and verbal reminders not to ambulate/transfer without assistance. On 3/6/19, at 3:08 p.m. R3 was observed seated on the seat of a four wheeled walker (FWW), with feet off the ground, and was being pushed backwards as she sat on the FWW, down the hall of the unit by activity director (AD)-A. R3 was pushed, as above, from outside the unit's door, down the hall and into R3's room. AD-A stated she was unaware if R3's FWW was safe to operate as a wheelchair or to transport R3. AD-A stated R3 had attended a Church service and organ music activity in the facility's theater. She stated R3 began to walk back to her room, got tired and sat down on the seat of the FWW. At 3:22 p.m. AD-A stated a sticker on R3's FWW indicated not to use the FWW for resident transport, and stated she was a former occupational therapy assistant, and added "I know better". At 3:24 p.m. director of nursing (DON) stated her expectation for FWW was staff would not transport a resident seated on a FWW. The DON indicated R3's FWW was not owned by the	F 689	through facility rounding. As of 3/27/19 all wheeled walkers with a seat attached have been labeled by a highly visible label stating do not use for transport. An all staff meeting was held on March 28, 2019, to educate all staff the importance of not using a wheeled walker as a mode of transportation as this could cause an accident resulting in resident harm. It was discussed at this meeting that wheeled walkers with a seat attached, have been labeled stating do not use for transport. A Quality Assurance/Performance Improvement has been developed to ensure wheeled walkers are not used as a mode of transportation and to ensure label is intact. This audit will be done by viewing residents who use wheeled walkers with a seat on it. The audit will view two residents per week for three months or until 100% compliant. Then random audits will continue. The Quality Assurance/Performance audit results will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored by OTA/Restorative Therapy Supervisor	

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F 689	Continued From page 21	F 689		

facility, and would and would have to locate the manufacture's recommendations. The DON stated R3 would be at risk for tipping and falling if staff utilized her FWW as a seat to transport her.

On 3/6/19, at 3:30 p.m. R3's FWW was observed in her room. The green and black, Nova Zoom 20 walker, Item number 4220GN had a "Warning" sticker on the right side frame by the wheels which indicated, "Do not use as a w/c [wheelchair] or transport someone".

On 3/7/19, at 9:12 a.m. nursing assistant (NA)-E indicated R3 and other residents would sit on their FWW and request staff transport them to locations. NA-E stated she had pushed R3 while seated on the FWW once, but had seen other staff do this as well. NA-E stated she had received education on safety risk of using a FWW for resident transport in the past.

On 3/7/19, at 9:31 a.m. NA-D stated R3 utilized a wheelchair for long distances, and a FWW otherwise. NA-D stated we [staff] do not use the FWW as a seat to transport her very often, maybe once or twice. NA-D was unaware of any education not to use a FWW for resident transport, and was unaware of any safety risks for doing so.

On 3/7/19, at 10:22 a.m. team lead (TL)-B stated R3 used a wheelchair for distances and a FWW on and off the unit. TL-B stated staff were not to push residents seated on FWW, as it was not stable and when pushing them, they could tip over and fall.

On 3/7/19, at 10:46 a.m. nurse manager (NM)-C stated staff were educated not to use FWW to

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F 689	Continued From page 22 transport residents as it was a tipping hazard and risk for falls. On 3/7/19, at 2:05 p.m., physical therapist (PT)-A stated FWW were not recommended to be used as a transport device for residents as it increased the risk of falls. Review of Nova FWW Rolling Walker User Guide, last revised 3/24/17, directed uses under "Safety Warning Instructions", "DO NOT use as a wheelchair or to transport someone". The User Guide indicated, "Failure to follow these instructions can lead to serious injury or result in death".	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		4/15/19

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F 761	Continued From page 23 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eye drop medications were discarded after 28 days after opening per standard of practice for 3 of 4 residents (R20, R11, R5) observed during the medication storage review of the Harvest Trail medication storage closets. Findings include: On 3/7/19, at 8:20 a.m. the Harvest Trail household medication storage closets were observed with trained medication aid (TMA)-A. The following were noted: -At 8:23 a.m., R20's medication storage closet was observed to have a bottle of Timolol eye drops (a medication to prevent pressure in the eye) with an opened date of 2/5/19, written in pen on the label. - At 8:23 a.m., TMA-A verified the bottle of Timolol were labeled for use by R20 and the label identified the open date as 2/5/19, and R20 currently received the eye drops from the bottle. R20's Physician Order Report dated 3/1/19, identified R20 had diagnoses which included severe stage Glaucoma in both eyes, which treatment included Timolol 0.5 %, instill one drop in each eye twice a day.	F 761	As of 3/7/19 R20, R11, and R5 eye drop medications were discarded and new eye drops were ordered to replace when it was noted being administered after 28 days of being opened. As of 3/8/19 any residents receiving eye drops have been checked and verified to be in compliance with the 28 day expiration. If eye drops were opened longer than the 28 days, new eye drops were ordered and replaced. Per standard of practice, all eye drops will be discarded and replaced on medication change over day which is every 28 days. An all staff meeting was held on March 28, 2019, to educate staff on the importance of eye drop medication are discarded after 28 days after opening per standard practice and replaced with a new eye drop medication. Quality Assurance/Performance Improvement has been developed to ensure eye drops will be discarded after 28 days after opening. This audit will be done by checking two residents who receive eye drops per week per Neighborhood for three months or until 100% compliant. Then random audits will	

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F 761	Continued From page 24 R20's Medication Administration Record (MAR) reviewed for the month of February and March 2019, identified R20 currently received Timolol 0.5 %, instill one drop in each eye, twice a day. - At 8:25 a.m., R11's medication storage closet was observed with TMA-A to have a bottle of Timolol eye drops which had a very small amount of medication remaining in the bottle. The bottle lacked a hand written date the medication bottle was opened. The medication refill date of 11/30/18 was on the pharmacy printed label. - At 8:25 a.m., TMA-A verified the bottle of Timolol was labeled for use by R11, the label lacked a hand written date of opening; however, identified the refill date as 11/30/18. TMA-A verified R11 currently had an order for Timolol eye drops to the left eye at bedtime. R11's Physician Order Report dated 3/1/19, identified R11 had diagnoses, which included Glaucoma which treatment included Timolol 0.5 %, instill one drop in the left eye at bedtime. R11's MAR reviewed for the month of February and March 2019, identified R11 currently received Timolol 0.5 %, instill one drop in the left eye at bedtime. - At 8:43 a.m. R5's medication storage closet was observed with TMA-A to have a bottle of Timolol eye drops with an opened date of 2/2, written in pen on the label, and a bottle of Combigan eye drops which lacked a hand written date the medication bottle was opened. The Combigan medication had a refill date of 1/26/19, printed on the pharmacy label.	F 761	be completed. The Quality Assurance/Performance Improvement audit results will be reported monthly to the Quality Assurance/Performance Improvement meeting. This will be monitored by Neighborhood Leads	

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- At 8:43 a.m. TMA-A verified the bottle of Timolol was labeled for use by R5 and had a hand written open date of 2/2. TMA-A further identified the Combigan eye medication was labeled for use by R5 and lacked a hand written date of opening; however, identified the refill date as 1/26/19. TMA-A verified R11 currently had orders for Timolol eye drop to both eyes daily and Combigan eye drop to the left eye twice a day.

R5's Physician Order Report dated 2/7/19, identified R5 had diagnoses which included Glaucoma which treatment included Timolol 0.5 %, instill one drop in both eyes daily, and Combigan 0.2-0.5% one drop in the left eye twice daily.

R5's MAR reviewed for the month of February and March 2019, identified R5 currently received Timolol 0.5 %, instill one drop in both eyes once a day. Combigan 0.2-0.5% instill one drop in the left eye twice daily.

On 3/07/19, at 9:03 a.m. the nurse leader (NL)-A reviewed the eye drop medications listed above. NL-A indicated staff typically do label eye drop medications when opened; however, if not labeled when open, would use the medication fill date printed on the pharmacy label as the opened date. NL-A indicated the above-mentioned eye medications possibly were expired. NL-A identified the facility had delegated the night shift to routinely review all resident medication storage closets to ensure medications were not in use after the expiration dates.

On 3/7/19, at 9:45 a.m. NL-A entered the director of nursing's (DON) office and stated, she had called a facility's pharmacy and was informed to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 26 follow the expiration dates printed on the medication. On 3/7/19, at 9:47 a.m. the director of nursing (DON) indicated the facility used the expiration date printed on all eye drop medication including Timolol and Combigan. The DON indicated in the past these medications were to be discarded 28 days after opening, but they no longer were on the list provided by the pharmacy. On 3/07/19, at 12:40 p.m. a call was placed to the pharmacy consultant with a message to return the call. A return call was not received during the survey. Review of the facility provided medication packaging for Timolol Maleate Ophthalmic (eye) Solution 0.25% and 0.5%, and Combigan brimodine tartrate/timolol maleate ophthalmic solution 0.2 % / 0.5%. did not identify the expiration date after the medication was opened. On 3/07/19, at 1:44 p.m. the Allergan information line was utilized. The Medical information specialist (MIS) verified Timolol 0.25% and 0.5% was to be discarded in 28 days after opening, sooner if it became contaminated. The MIS verified the Combigan eye medication was also to be discarded 28 days after opening the bottle. On 3/07/19, at 2:04 p.m. the DON verified the facility utilized a list of medications which expired sooner than the printed expiration date, provided by the facility pharmacy consulting company. The DON verified the facility used that guide and would call the local pharmacy with questions. The DON indicated the facility would not consult the medications manufacturer, but would leave that	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245451	A. BUILDING _____ B. WING _____	C 03/07/2019

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 761	Continued From page 27 up to the local pharmacy if they didn't have the answers. The facility form titled Medication Expiration Dating, dated 8/2017, identified, "If an item is not on the list below use manufacturers OR pharmacy label expiration. The requested facility policy was not provided.	F 761		

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 _____	**03/05/2019**

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 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 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 and the 2012 edition of NFPA 99 Health Care Facilities Code. 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 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

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

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.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 22, 2019

Administrator
Fairway View Neighborhoods
201 Mark Drive
Ortonville, MN 56278

Re: State Nursing Home Licensing Orders - Project Number S5451031, H5451008C, H5451009C and H5451010C

Dear Administrator:

The above facility was surveyed on March 4, 2019 through March 7, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5451008C, H5451009C and H5451010C; H5451009C and H5451010C were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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

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

Please feel free to call me with any questions.
Sincerely,

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
	00771	A. BUILDING: _____ B. WING _____	C 03/07/2019

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 3/4/19 through 3/7/19, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow manufacturer's guidelines for the proper use of a wheeled walker to prevent accident hazards for 1 of 1 resident (R3) who utilized a walker for ambulation. Findings include: R3's quarterly Minimum Data Set (MDS) dated 12/4/18, indicated R3 had intact cognition and diagnoses which included Polymyalgia rheumatica (causes muscle pain and stiffness in the neck, shoulder, and hip), chronic obstructive pulmonary disease (COPD), and Diabetes	2 830	Corrected.	4/15/19

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2 830	Continued From page 3 Mellitus. The MDS further indicated R3 required limited assistance with transfers and walking, extensive assistance with bed mobility, toileting, dressing, and personal hygiene and utilized a walker. R3's care plan, revised 3/6/19, indicated R3 was at risk for falls due to balance problems, weakness and had fallen in the past. R3's care plan listed various interventions which included keeping R3's walker at bedside when in bed, education on ways to reduce falls and verbal reminders not to ambulate/transfer without assistance. On 3/6/19, at 3:08 p.m. R3 was observed seated on the seat of a four wheeled walker (FWW), with feet off the ground, and was being pushed backwards as she sat on the FWW, down the hall of the unit by activity director (AD)-A. R3 was pushed, as above, from outside the unit's door, down the hall and into R3's room. AD-A stated she was unaware if R3's FWW was safe to operate as a wheelchair or to transport R3. AD-A stated R3 had attended a Church service and organ music activity in the facility's theater. She stated R3 began to walk back to her room, got tired and sat down on the seat of the FWW. At 3:22 p.m. AD-A stated a sticker on R3's FWW indicated not to use the FWW for resident transport, and stated she was a former occupational therapy assistant, and added "I know better". At 3:24 p.m. director of nursing (DON) stated her expectation for FWW was staff would not transport a resident seated on a FWW. The DON indicated R3's FWW was not owned by the facility, and would and would have to locate the	2 830		

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2 830	Continued From page 4 manufacture's recommendations. The DON stated R3 would be at risk for tipping and falling if staff utilized her FWW as a seat to transport her. On 3/6/19, at 3:30 p.m. R3's FWW was observed in her room. The green and black, Nova Zoom 20 walker, Item number 4220GN had a "Warning" sticker on the right side frame by the wheels which indicated, "Do not use as a w/c [wheelchair] or transport someone". On 3/7/19, at 9:12 a.m. nursing assistant (NA)-E indicated R3 and other residents would sit on their FWW and request staff transport them to locations. NA-E stated she had pushed R3 while seated on the FWW once, but had seen other staff do this as well. NA-E stated she had received education on safety risk of using a FWW for resident transport in the past. On 3/7/19, at 9:31 a.m. NA-D stated R3 utilized a wheelchair for long distances, and a FWW otherwise. NA-D stated we [staff] do not use the FWW as a seat to transport her very often, maybe once or twice. NA-D was unaware of any education not to use a FWW for resident transport, and was unaware of any safety risks for doing so. On 3/7/19, at 10:22 a.m. team lead (TL)-B stated R3 used a wheelchair for distances and a FWW on and off the unit. TL-B stated staff were not to push residents seated on FWW, as it was not stable and when pushing them, they could tip over and fall. On 3/7/19, at 10:46 a.m. nurse manager (NM)-C stated staff were educated not to use FWW to transport residents as it was a tipping hazard and risk for falls.	2 830		

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2 830	Continued From page 5 On 3/7/19, at 2:05 p.m., physical therapist (PT)-A stated FWW were not recommended to be used as a transport device for residents as it increased the risk of falls. Review of Nova FWW Rolling Walker User Guide, last revised 3/24/17, directed uses under "Safety Warning Instructions", "DO NOT use as a wheelchair or to transport someone". The User Guide indicated, "Failure to follow these instructions can lead to serious injury or result in death". Suggested Method of Correction: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize the risk for falls for residents at risk to assure they are receiving the necessary treatment/services. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	2 890		4/16/19

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2 890	Continued From page 6 A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to routinely provide range of motion services according to therapy recommendations to maintain function for 2 of 3 residents (R29, R48) reviewed for range of motion (ROM). Findings include: R29's annual Minimum Data Set (MDS), dated 1/30/19, indicated R29 had severe cognitive impairment, and had diagnoses which included dementia, Diabetes Mellitus, and depression. The MDS identified R29 required supervision with eating, limited assistance to walk in her room, and extensive assistance with all other activities of daily living (ADL). R29's MDS further indicated, R29 had walked in the hallway only once or twice during the seven day MDS assessment period. R29's Care Area Assessment (CAA) dated 1/30/19, indicated R29 required limited assistance of one staff with walking in room and hallway. The CAA further indicated staff would continue to offer R29 help to accomplish ADLs daily, while making sure ADLs were completed safely. The CAA directed staff to encourage R29 in the FMP (Functional Maintenance Program) (a program to help maintain a residents functional	2 890	Completed.	

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2 890	Continued From page 7 status) as designed/ordered and get R29 to participate in other activities R29 enjoyed. R29's care plan, last revised 3/6/19, indicated R29 was limited in her ability to accomplish ADLs daily related to diagnoses which included dementia with cognitive loss. The care plan listed various interventions which included R29 would participate with therapies as ordered to the best of her ability, including establishing FMP after therapies are done, encourage R29's participation in the program and reapproach R29 if initially refuse or was uncooperative. On 3/4/19, at 3:21 p.m. R29 was observed seated in a wheelchair and propelled herself in a common area of the unit with her feet. R29 lightly bumped the wheelchair into pillars in the common area as she peddled around. R29 was alert as she made eye contact with others around her. On 3/4/19, at 7:31 p.m. during a phone interview with family member (FM)-A stated R29's balance could be off in the mornings and R29 needed to be reminded to stand tall, complete her exercises and walking. FM-A indicated they were unaware if staff were walking R29, and was something FM-A asked the staff to make sure they were doing. FM-A further stated R29's wheelchair was her main mode of transportation. On 3/4/19, at 7:33 p.m. R29 was seated in a wheelchair and propelled herself down the hallway of the unit. R29 was alert as she looked into other residents' rooms, but did not enter them. On 3/6/19, at 7:47 a.m. R29 was lying in a low bed, on her back, with eyes closed and curtains pulled and the lights were off. At 8:23 a.m. R29	2 890		

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2 890	Continued From page 8	2 890		

remained laying in the bed. At 8:51 a.m. nursing assistant (NA)-A opened R29's door and walked out with two tied plastic bags and walked down the hall. R29 was seated in her wheelchair and peddled herself from the room to the middle of the hallway. At 8:53 a.m. R29 remained seated in the wheelchair in the hallway and NA-A approached and asked R29 if she was ready for breakfast. R29 indicated she was, and NA-A pushed her wheelchair to a table in the dining room.

On 3/6/19, at 12:47 p.m. R29 was seated in the wheelchair in the dining room at the noon meal. At 12:57 p.m. after R29 had finished the noon meal, she propelled the wheelchair with her feet and sat outside her bedroom door. R29 was alert and looking around the unit.

On 3/7/19, at 8:09 a.m. R29 was lying in a low bed, on her back, with eyes closed and window curtains pulled shut. At 8:53 a.m. R29 remained lying in bed. At 9:19 a.m. R29 was seated in the wheelchair and propelled self out of the room and straight to the dining room table for the breakfast meal.

On 3/6/19, at 1:28 p.m. NA-A stated R29 required extensive assistance with ADLs and walked with staff at times. NA-A stated, nursing assistants do not complete resident's FMP on the units. NA-A stated, staff may complete a little stretching of hands in the room, but the facility had restorative therapy staff and they complete FMPs.

On 3/7/19, at 9:34 a.m. NA-D stated R29 required extensive assistance for ADLs, and walks with staff one to two times per day, on a good day. NA-D indicated R29 had a FMP and restorative therapy aide (RA) would work with R29 once in a

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2 890	Continued From page 9 while. NA-D stated, there are some days we [staff] do not get RA down on the unit, and staff make sure to complete walking with R29. NA-D stated R29 walked to the bathroom from the bed that morning, and added "she is stiff this morning". On 3/7/19, at 10:30 a.m. registered nurse (RN)-A stated R29 abilities varied, and required one to two staff to walk, with a gait belt and four wheeled walker and wheelchair to follow, to walk. RN-A stated RA staff completed all resident's FMP. RN-A indicated an RA was available Monday through Friday, and NA floor staff were not trained to complete a resident's FMP. On 3/7/19, at 10:48 a.m. nurse manager (NM)-C indicated after R29 completed therapy, therapy ordered a FMP to assist in maintaining R29's functional mobility. NM-C stated after FMP orders were received, they are placed into R29's orders and into her care plan. NM-C stated R29's FMP was reviewed monthly by the night shift, licensed practical nurse (LPN)-A. NM-C reviewed R29's monthly FMP progress note from LPN-A and indicated R29's FMP was completed 8 times last month. NM-C stated she would expect R29's FMP to be completed as instructed, and if not, R29 was at risk for a decrease in ROM, increased fall risk, and contractures. On 3/7/19, at 11:55 a.m. restorative therapy aide (RA)-A stated she was one of two RAs responsible for completing resident's FMP. RA-A confirmed restorative therapy (RT) was completed Monday through Friday at the facility, and usually only one RA worked per day. RA-A stated the facility currently had 37 FMP programs, and if the RA could not get to a resident, due to not having enough time, the RAs were instructed	2 890		

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2 890	Continued From page 10 to chart the resident as "unavailable". RA-A stated if a resident was sleeping, with company or an activity she would then put in a comment as to why the FMP was not done that day. RA-A confirmed R29 had a FMP, and stated R29 did not refuse often, and if R29 did refuse, she would add refuse to the comments. Review of R29's FMP documentation from 1/1/19, to 3/7/19, was completed and revealed "resident unavailable" was documented 70 times in January, 70 times in February, and 28 times in March. On 3/7/19, at 12:19 p.m. therapy site coordinator (TSC)-A stated a resident's FMP was set up after therapy was complete, to maintain balance and ROM. TSC-A stated R29 does participate with her FMP when in the therapy room with RA-A. TSC-A stated R29 last received therapy from 10/19/18, through 11/1/18, and therapy recommended different activities R29 could complete safely in the dining room, and for R29's FMP to continue. TSC-A indicated if R29's FMP was not completed, R29 would be at risk for a decrease in functional strength and increased risk for contracture. On 3/7/19, at 2:24 p.m. during a follow up interview, NM-C stated facility NAs were not trained to complete resident's FMPs and only two RA staff were trained to complete the FMPs. NM-C stated she was unaware of a time the RT staff reported to her that they were unable to complete R29's FMP. On 3/7/19, at 3:03 p.m. director of nursing (DON) indicated R29 had varying levels of alertness, and added R29 had days which she would sleep most of the day, but also R29 had multiple days in a	2 890		

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2 890	Continued From page 11 row which she was awake and alert. The DON stated she was responsible for the facility's FMP, and her expectation for R29's FMP would be RT staff follow the orders from the chart. DON stated two RT aides were trained to complete FMPs, and no other staff. The DON indicated if the RAs were unable to complete the required FMPs for each day, the RAs would tell her. She was unaware residents were not being provided their FMPs as ordered. The DON stated moving forward resident's FMPs would be completed in groups so RA staff can complete all FMPs. R48 R48's significant change Minimum Data Set (MDS) dated 2/18/19 indicated R48 was cognitively intact and had diagnoses which included coronary artery disease, depression, Parkinson's, chronic pain, and chronic pneumonitis related to aspiration of food. R48 required extensive assist of one person with bed mobility, transfers, dressing, toileting, and locomotion on/off the unit. In addition, R48 needed supervision with personal hygiene. R48's significant change Care Area Assessment (CAA) dated 2/18/19, identified R48 had degenerative bowel and bladder related to Parkinson's. As a result, R48 was occasionally incontinent of bowel and bladder and needed extensive assistance from one staff to toilet, provide incontinence cares, and assist with dressing. The CAA further identified R48 was at a risk for falls related to psychotropic drug use of Remeron taken for depression, and diagnosis of Parkinson's. R48 had a history of falls and difficulty with freezing movements, impulsivity, and balance problems while standing related to diagnosis of Parkinson's.	2 890		

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2 890	Continued From page 12 R48's care plan dated 2/21/19, addressed numerous areas including chronic pain from arthritis, severe headaches, as well as muscle cramping/freezing pain from Parkinson's disease. The care plan instructed staff to use non-medicated pain relief measures including physical therapy, stretching, strengthening exercises. The care plan also addressed R48's fall risk and included various interventions. In addition, the care plan addressed R48's need for assistance with activities of daily living (ADL)s and indicated he required extensive assistance from 1-2 staff with ambulation in his room or hallway using a front wheeled walker. Further, the care plan instructed staff to provide a functional maintenance program (FMP) to help maintain strength and mobility. On 3/7/19, at 9:06 a.m. R48 was interviewed with family member FM-B present in the room. R48 stated he had fallen a couple of times, and was not supposed to transfer himself but indicated he had to wait 5-10 minutes for staff sometimes, and stated that was often too late. FM-B stated R48 has had physical therapy in the past and indicated R48 currently had a functional maintenance program (FMP) 2-3 times per week to help maintain his strength and balance. FM-B indicated she did not think staff was offering R48 the FMP. R48 stated he was willing to go any time, stated he was not allowed to stand to urinate independently, indicated he did not like the motion sensor alarm in his chair and wished he could stand to urinate independently. R48 and FM-B stated they had expressed the concern for use of the chair alarm, and staff stated it was for safety. FM-B stated they had a therapy evaluation done a couple of weeks ago to address the concerns with wanting to stand to urinate	2 890		

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2 890	Continued From page 13 independently, but indicated that insurance would not cover the cost of therapy and they had opted to use the FMP instead. R48 stated he had not been offered FMP exercises. On 3/7/19, 9:27 a.m. restorative aide (RA)-A entered the room and stated she had worked with R48 in the past but indicated it had been a long time. RA-A stated she had R48 on her schedule for the last few months, and indicated she could come get him later for the FMP exercises. Review of R48's restorative therapy FMP documentation from 12/1/18 to 3/7/19, was completed and revealed "resident unavailable" was documented 32 times in December, 71 times in January, 36 times in February, and 15 times in March which indicated he had not been offered the FMP exercises in his restorative therapy program. On 3/7/19, at 9:43 a.m. the physical therapy assistant (PTA) - A stated R48 was in therapy after a hospital stay in November 11/22/18, and was discharged from physical therapy (PT), occupational therapy (OT), and speech on 12/4/18. A review of R38's discharge summary indicated at the end of therapy he was able to walk 10-30 feet with FWW, contact guard assist up to minimal assist. PTA-A indicated R48 was at risk for falls and decline in mobility related to his diagnosis of Parkinson's disease, impulsive behavior, poor balance, and safety awareness. PTA-A stated R48 was set up with a FMP on 12/5/19, and indicated the plan included doing large amplitude movements, toe taps, NuStep, walking in the parallel bars to encourage more fluid movements and less freezing episodes. PTA-A reviewed R48's restorative documentation	2 890		

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2 890	Continued From page 14 and stated R48 usually refused "resident unavailable", and indicated if he continued to refuse restorative therapy he would be discharged from the program. PTA-A explained that R48 could have a more progressive decline in his mobility without the FMP, and stated restorative therapy can delay the progression of his Parkinson's symptoms. PTA-A verified the RA's documentation "resident unavailable" and stated she would interpret that as a refusal, but indicated the restorative aide could clarify the information documented. PTA-A stated if R48 was refusing the FMP the restorative aide should communicate if there was any concern of decline in mobility and function, and indicated she was not aware of any decline with R48 at this point. On 3/7/19, at 9:48 a.m. during a group interview, director of nurses (DON) and RN-A indicated R48 had been on the restorative program 3 times per week since the hospital stay in November and indicated the felt resident frequently refused, or was unavailable. On 3/7/19, at 10:43 a.m. RA-A who verified R48 was on her list for the FMP 3-5 times per week. RA-A verified she had not offered R48 restorative therapy this week, and indicated she had 37 other resident on the list. RA-A stated she did not have time to get to him this week yet, and stated R48 had not refused. RA-A stated she did not have time to get to everyone on her list every week, and indicated she would choose the residents on her list who are likely to accept first. RA-A stated she could on average see 11-12 residents each day, and stated that if she was unable to get to someone on the list she was instructed during restorative training to document "resident unavailable". RA-A confirmed documentation in restorative FMP "resident unavailable" meant the	2 890		

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2 890	Continued From page 15 restorative aide did not get to the resident and FMP was not offered. On 3/7/19, at 11:19 a.m. DON stated she would expect the RA to communicate with her if a resident refused or if they were not able to get to someone. The DON stated the workflow should be changed, and she expected that every resident in the FMP should have it offered. The DON stated she was not aware that people were not being offered the FMP, and indicated the RA had stated "I was not able to get to everyone I wanted to today" but did not know that it meant she was not getting to the residents at all. The DON was not aware of any concerns with a resident decline in ADL function. On 3/7/19, at 2:47 p.m. nursing assistant NA-C stated the restorative aides have a list of people they walk or do exercises with, and it had not communicated to her if they were not able to get to someone on the list. NA-C stated the residents to be walked popped up on their task list and they do walk those residents but indicated they are not trained to complete the FMB restorative aides' duties. NA-C stated R48 required extensive assistance of one staff with toileting/transfers and stated she does not walk R48 due to his shuffled gait, and indicated she transferred R48 into his wheelchair then took him to the bathroom. During a follow up interview on 3/7/19, at 3:03 p.m. the DON stated she would expect to offer, reapproach, then document the refusal and update the nurse. The DON indicated she was in charge of the restorative program, and indicated they coordinate with big stone therapy to develop and update the FMP. The DON stated licensed practical nurse (LPN)-A reviews the charts and documentation on a weekly basis, looking for	2 890		

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2 890	Continued From page 16 increase in refusals, and stated the FMP may get discontinued if there is a change in condition and the FMP was not appropriate or if the resident did not participate. The DON stated if the RA was unable to complete workload, she would expect them to notify her. The DON stated LPN-A may have interpreted unavailable as a refusal and indicated she was not aware that the RA documentation "resident unavailable" meant the FMP restorative program was not offered. The DON stated she would expert if RA staff cannot get to everyone in a day that it would be communicated clearly to the DON and unit leaders. The facility provided policy titled Restorative Therapy Program reviewed on 9/2018, indicated the purpose of the restorative program was to provide residents a planned therapy program that promoted each resident to maintain the highest level of function and independence. The policy indicated that a resident who refused the restorative therapy program for 3 consecutive months would be discharged from the program. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policy/procedure/system for identifying and assessing resident's range of motion and needs for range of motion services. The DON/designee could then educate staff on performing range of motion and importance. The DON/designee could then develop and implement an auditing system to ensure services are provided according to the resident's care plan and assessed need. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		

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2 915	Continued From page 17	2 915		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to routinely provide ambulation services according to therapy recommendations to maintain function for 1 of 1 residents (R29) reviewed for ambulation. Findings include: R29's annual Minimum Data Set (MDS) dated 1/30/19 indicated R29 had severe cognitive impairment and diagnoses which included dementia, Diabetes Mellitus, and depression. The MDS identified R29 required supervision with eating, limited assistance to walk in her room,	2 915	Completed.	4/9/19

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2 915	Continued From page 18 and extensive assistance with all other activities of daily living (ADL). R29's MDS further indicated R29 had walked in the hallway only once or twice during the seven-day MDS assessment period. R29's Care Area Assessment (CAA) dated 1/30/19 indicated R29 required limited assistance of one staff with walking in room and hallway. The CAA further indicated staff would continue to offer R29 help to accomplish ADLs daily, while making sure ADLs were completed safely. The CAA directed staff to encourage R29 in the FMP (Functional Maintenance Program) (a program to help maintain a residents functional status) as designed/ordered, work with R29 to help with walking with staff frequently as ordered, and get R29 to participate in other activities R29 enjoyed. R29's care plan revised 3/6/19 indicated R29 was limited in her ability to accomplish ADLs daily related to diagnoses, which included dementia with cognitive loss. The care plan listed various interventions, which included the need for limited assist of one staff for walking in the room and hall as R29 tolerated with a gait belt and four-wheeled walker (FWW). The care plan further indicated R29 did not go in the hallway much, was on the walking list twice a day as R29 allowed/agreed to, and please help R29 with walking to keep up her leg strength. On 3/4/19, at 3:21 p.m. R29 was observed seated in a wheelchair and propelled herself in a common area of the unit with her feet. R29 lightly bumped the wheelchair into pillars in the common area as she peddled around. R29 was alert as she made eye contact with others around her. On 3/4/19, at 7:31 p.m. during a phone interview with family member (FM)-A stated R29's balance	2 915		

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2 915	Continued From page 19	2 915		

could be off in the mornings and R29 needed to be reminded to stand tall, complete her exercises and walking. FM-A indicated they were unaware if staff were walking R29, and was something FM-A asked the staff to make sure they were doing. FM-A further stated R29's wheelchair was her main mode of transportation.

On 3/4/19, at 7:33 p.m. R29 was seated in a wheelchair and propelled herself down the hallway of the unit. R29 was alert as she looked into other residents' rooms, but did not enter them.

On 3/6/19, at 7:47 a.m. R29 was laying in a low bed, on her back, with eyes closed, curtains pulled and the lights were off. At 8:23 a.m., R29 remained laying in the bed. At 8:51 a.m. nursing assistant (NA)-A opened R29's door and walked out with two tied plastic bags and walked down the hall. R29 was seated in her wheelchair and pedaled herself from the room to the middle of the hallway. At 8:53 a.m., R29 remained seated in the wheelchair in the hallway and NA-A approached and asked R29 if she was ready for breakfast. R29 indicated she was, and NA-A pushed her wheelchair to a table in the dining room.

On 3/6/19, at 12:47 p.m. R29 was seated in the wheelchair in the dining room at the noon meal. At 12:57 p.m., after R29 had finished the noon meal, she propelled the wheelchair with her feet and sat outside her bedroom door. R29 was alert and looking around the unit.

On 3/7/19, at 8:09 a.m. R29 was laying in a low bed, on her back, with eyes closed and window curtains pulled shut. At 8:53 a.m., R29 remained lying in bed. At 9:19 a.m., R29 was seated in the

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2 915	Continued From page 20 wheelchair and propelled self out of the room and straight to the dining room table for the breakfast meal. Review of Therapy Communication/Screen Form, dated 1/22/19, indicated, "family/staff have noticed that resident seems weaker in transfers. She has not been walking much. Please assess for transfers and ambulation and give recommendations". The form indicated, by circling no, that R29 was not a candidate for a physical therapy evaluation. The physical therapist (PT)-A commented "[R29] cont. [continues] to be A [assist] x [times] 1 @ [at] this time. Staff has been encouraged to cont[inue] to walk c [with] res[ident]". Review of R29's Point of Care History, Miscellaneous Tasks: Walk 150-350 FT [Feet] with FWW CGA [Contact Guard Assist] of 1 [staff] with W/C [wheelchair] to Follow Cue For Stride Length, Distance As Tolerated [Twice A Day], from 12/1/18, through 3/7/19, revealed the following: -From 12/1/18, through 12/31/18, the question if R29 walked as above was marked as "unanswered" 30 times, marked as "Done" 27 times, and marked as "Not Done" five times due to refusal, combative or deferred due to condition. -From 1/1/19, through 1/31/19, the question if R29 walked as above was marked as "unanswered" 28 times, marked as "Done" 31 times, and marked as "Not Done" three times due to refusal or deferred due to condition. -From 2/1/19, through 2/28/19, the question if R29 walked as above was marked as "unanswered" 21 times, marked as "Done" 31	2 915		

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2 915	Continued From page 21 times, and marked as "Not Done" four times due to refusal. -From 3/1/19, through 3/7/19, the question if R29 walked as above was marked as "unanswered" five times, marked as "Done" seven times, and marked as "Not Done" two times due to refusal. On 3/6/19, at 1:28 p.m. NA-A stated R29 required extensive assistance with ADLs and walked with staff at times. NA-A stated some of her duties included walking residents, whom were able, to and from meals. NA-A stated some residents required extra walking in the hall and the extra walking was charted in the electronic health record (EHR). NA-A reviewed the Point of Care (POC) charting for R29 and confirmed R29 required extra walking. On 3/7/19, at 9:34 a.m. NA-D stated R29 required extensive assistance for ADLs, and walks with staff one to two times per day, on a good day. NA-D indicated R29 was to walk twice a day, and stated, "She is supposed to be, I don't know if it gets done when I am not here". NA-D indicated R29 would walk from the bed to the bathroom and to the dining room. NA-D stated R29 walked to the bathroom from the bed that morning, and added, "She is stiff this morning". On 3/7/19, at 10:12 a.m. NA-E indicated she was directed to walk with the residents that were able to walk to the dining room and back. NA-E stated R29 required extensive assistance of one staff for walking with a gait belt and FWW, and two staff if R29 was tired. NA-E indicated she would walk R29 to the bathroom from her bed, and to the dining room. NA-E stated R29 was to walk at least two times per day, and indicated she had not had the chance to walk R29 in the hallway	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00771	A. BUILDING: _____ B. WING _____	C 03/07/2019

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

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2 915	Continued From page 22 much. NA-E indicated R29 does not refuse walking, but if R29 was tired, staff would not attempt to walk with R29. NA-E reviewed POC walking instructions for R29 in the EHR, and was unable to determine how far 150 to 350 feet would be on the unit. On 3/7/19, at 10:30 a.m. registered nurse (RN)-A stated R29 abilities varied, and required one to two staff to walk, with a gait belt and FWW and wheelchair to follow to walk. RN-A stated R29 would walk from her room to the bathroom and to the dining room. RN-A stated she had not seen staff walk R29 down the hallway. On 3/7/19, at 10:48 a.m. nurse manager (NM)-C indicated R29's walking program was separate from the facility's Functional Maintenance Program (FMP) and the unit staff completed R29's walking program. NM-C stated the facility had a walk to dine program where staff were to walk residents to meals. NM-C stated R29's room was "extremely close" to the dining room and indicated the walk to dine program did not account for the closeness to the resident's room from the dining room. NM-C reviewed R29's POC instructions to walk R29 150-350 FT [Feet] with FWW CGA [Contact Guard Assist] of 1 [staff] with W/C [wheelchair] to Follow Cue For Stride Length, Distance As Tolerated [Twice A Day], and documentation, and verified missing documentation in R29's walking program. NM-C indicated R29's alertness varied, but staff had the ability to chart refusals and would have to accommodate R29. NM-C stated the normal procedure for a resident refusing was for staff to document the refusal, update the nurse and reapproach the resident. NM-C stated she was unaware who reviewed R29's walking program, and indicated R29 would be at risk for a decrease	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 915	Continued From page 23 in range of motion and increased fall risk. On 3/7/19, at 12:19 p.m. therapy site coordinator (TSC)-A stated therapy typically did not include walking on a resident's FMP, with hopes nursing staff were walking the resident to the dining room and the bathroom. TSC-A stated if R29 had specific instructions to walk 150 to 350 feet twice a day, it would have been a recommendation from therapy. TSC-A stated with R29's room being so close to the dining room, she would expect nursing staff to be walking R29 the 150-350 feet distance as well. TSC-A stated R29 would be at risk for a decrease in transfer ability and decrease in functional strength. On 3/7/19, at 3:03 p.m. director of nursing (DON) indicated R29 had varying levels of alertness, and added R29 had days, which she would sleep most of the day, but also R29 had multiple days in a row, which she was awake and alert. DON stated she would expect staff to walk R29 per instructions, and start R29's walk further from the dining room to increase the walking distance. The DON indicated the NM should be reviewing R29's walking to dine program. A policy on walk to dine/walking program was requested, however one was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their ambulation needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one	2 915		

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2 915	Continued From page 24 (21) days.	2 915		