Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 7, 2024

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

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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 Therefore, the NATCEP prohibition is rescinded.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

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 7, 2024

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

Re: Reinspection Results
Event ID: BU3K12

Dear Administrator:

On January 22, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 20, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 2, 2024

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

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

Dear Administrator:

On December 18, 2023, we informed you of imposed enforcement remedies.

On December 20, 2023, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

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

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of November 20, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 2, 2024.

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to

validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 2, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://forms.web.health.state.mn.us/form/NH-Dispute-Resolution

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. BUILDING _____ B. WING _____	C 12/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/19/23 and 12/20/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53448066C (MN00099289) and H53448148C (MN00098840) with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 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:	F 689		1/19/24

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

Electronically Signed | 01/05/2024

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

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F 689	Continued From page 1 Based on observation, interview and document review the facility failed to complete comprehensive safety assessments for electric lift recliners to prevent and/or reduce falls from electric recliners for 2 of 3 residents (R1, R2) who had falls from electric recliners. Findings Include: R1 admission record dated 12/10/12, identified R1 had diabetes mellitus with diabetic nephropathy, dementia without behavioral disturbances, general anxiety disorder, and asthma. R1's annual Minimum Data Set (MDS) dated 10/4/23, identified R1 had severe cognitive impairment with no behaviors. R1 was frequently incontinent of bowel and bladder and was dependent on staff for transfers, toilet use, personal hygiene, and bathing. R1's MDS identified no falls since admission or previous assessment. R1's flexion, abduction, and external rotation (FABER) fall risk dated 10/4/23, identified R1 was at significant risk for falls. R1's care plan dated 7/7/23, identified R1 had an alteration in mobility related to falls risk, impaired mobility and required two staff assist for transfers with Hoyer (full body) lift. Interventions added on 11/27/23, informed staff R1 was non-weight bearing on right leg and remote to recliner to be kept in pocket of recliner. Facility Incident tracker log dated 12/16/23 at 6:30 p.m., indicated R1 had a fall in room from recliner after raising the recliner chair up and fell to the	F 689	1. How corrective action will be accomplished for the resident(s) found to have been affected by the deficient practice: " Fairview□s Recliner Assessment Policy and procedure was created and implemented. " A recliner/lift chair safety observation assessment was created and implemented to evaluate each resident□s ability to safely use a recliner and/or recliner lift chair. " Resident R2 was evaluated for her ability to safely use a recliner lift chair and the care plan was updated. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. " Fairview□s Recliner Assessment Policy and procedure was created and implemented. " A recliner/lift chair safety observation assessment was created to evaluate each resident□s ability to safely use a recliner and/or lift chair. " All residents will have an assessment to assure their ability to safely use a recliner lift chair and/or recliner on admission and quarterly. " All resident□s care plans will continue to be updated to better reflect each	

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F 689	Continued From page 2 floor resulting in a laceration to left eye. The report indicated R1's care plan was not followed and an investigation was needed. In house manual recliner ordered. The report did not identify how the care plan was not followed. R1's progress note dated 12/15/23, at 10:27 a.m., indicated interdisciplinary team (IDT) met yesterday afternoon and R1 is working with physical therapy (PT) she is 2 assist with Hoyer lift at this time. PT is working on tolerating some weight bearing to her right leg with goal to get her back to standing lift transfer. R1's progress note dated 12/16/23 at 9:04 p.m., indicated at 6:30 p.m. R1 was found on the floor in her room in front of her recliner. The fall resulted in a 1.5-centimeter (cm) laceration above R1's left eye. and a bruise on her left hand around pinky knuckle that measured 5.0 cm by 4.0 cm. Root cause analysis was R1 was unable to control her recliner chair. Immediate intervention was to unplug chair and place a sign above the chair to alert staff to unplug the chair if resident is using. R1's record reviewed after the fall on 12/16/23, did not include assessments for safety of the electric lift recliner and/or a restraint assessment for when R1 was sitting in the chair with the chair unplugged and/or chair remote not available. During an interview on 12/20/23, at 10:39 a.m. with registered nurse (RN)-A stated she had worked in the facility for over 10 years and was not sure if facility had a policy for lift recliners or not. RN-A stated some of the recliners in the facility were the resident's personal recliners and some were the facility's. If a resident was not safe	F 689	resident□s condition as well as individualized interventions and goals to help avoid falls or injury. " Nursing staff will be provided training on Purposeful Rounding during next meeting on Tuesday 1-9-24. " Falls are reviewed daily (Monday-Friday) at Morning Meeting. " Falls are reviewed at the weekly IDT meeting for fall intervention effectiveness. A root cause analysis is conducted reviewing contributing factors for the fall and the selection of the best interventions to support resident safety. " Fall trends are also reviewed at the Monthly QAPI meetings. 3. The date that each deficiency will be corrected. Deficiency tag F-689 will be in compliance by 01-19-2024.	

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F 689	Continued From page 3 to control the remote for the chair the staff would put it in the pocket of the chair so the resident wouldn't have access to it. RN-A thought the ability for residents to use a lift chair was determined by the IDT based on the resident's cognition level. During interview on 12/20/23, at 10:54 a.m. clinical manager (CM)-A stated any resident could request a recliner in the facility. CM-A was not aware of a current system, standard or protocol in place for recliner use. Residents may be assessed for recliner safety after the recliner was involved in a fall or if staff noticed concerns related to the residents cognition and their ability to use the recliner. CM-A indicated the IDT made the overall decision as to if residents were able to use lift chairs safely. During an interview on 12/20/23, at 11:15 a.m. PT stated they did not make the distinction if a resident could have a recliner or not. PT was more involved with wheelchair, walker, raised toilet seats, more of the adaptive equipment versus the comfort. PT felt the recliners were more comfort related. During an interview on 12/20/23, at 11:26 a.m. social services designee (SSD) stated she had worked at this facility for 20 years. SSD indicated she thought there was an assessment for recliners but was not familiar with it and had not used it. She was not aware of a system in place for deciding if a resident could have a lift recliner. SSD indicated historically recliners were given to residents who had recliners at home and/or the facility would complete a cognition assessment within two weeks of admission.	F 689		

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F 689	Continued From page 4 R2's admission MDS dated 10/18/23, identified R2 was cognitively intact with no behaviors and had a history of falls, but no falls since admission into the facility. MDS also indicated R2 was dependent on staff for toileting, moderate assistance with transfers, and dependent on staff for mobility. R2's care plan dated 10/12/23, identified R2 had a sign on her walker to push call light and wait for assistance. The care plan directed staff to toilet R2 every 2 hours during the night and ambulate R2 with assist of 1 with front wheeled walker. R2's care plan did not address lift recliner. R2's progress note dated 11/4/23 at 5:15 a.m., indicated at 4:50 a.m. R2 was found laying on her stomach with her head by her room door and her feet by the bathroom door. Call light was not used. Resident had been sitting in the recliner prior to her fall per her request at 1:00 a.m. Resident indicated she was trying to go to the bathroom when she reached for the door handle and fell. R2's progress note dated 11/23/23 at 4:59 p.m., indicated R2 self-transferred into the bathroom and fell when getting herself off of the toilet. Facility incident tracking log indicated R2 had a fall on 11/23/23, at 4:30 p.m. when she self-transferred to the bathroom and didn't use her call light till after the fall. Resident scored a 14 out of 30 on her Saint Louis University Mental Status (SLUMS) assessment, indicating dementia. Intervention was to put sign on her walker. R2's progress note dated 11/27/23, at 3:50 p.m.,	F 689		

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F 689	Continued From page 5 indicated IDT reviewed fall history related to fall from self-transfer in the bathroom. The note included R2's SLUMS score and a review of FABER score identified R2 was at significant risk for falls. R2's record did not include an assessment or a plan of care that identified R2's ability to use the lift chair without supervision or safety interventions while R1 was sitting in the chair before or after her fall on 11/23/23. Facility incident tracking log indicated on 12/15/23, at 4:45 a.m. R2 had an unwitnessed fall in room from her recliner. NA went to open bathroom door to turn light on and turned to see resident had raised recliner chair up and fell to the floor. Intervention was to let R2 know to wait for NA to be ready for her before raising the chair. R2's progress note dated 12/15/23, at 5:13 a.m., identified R2's fall from the recliner as per the tracking log. The note further indicated the NA had seen R2 falling to her right side. R2 scraped her knee on the carpet and her right knee was a little sore. R2's care plan was revised on 12/15/23, with the intervention of remind resident to wait to lift recliner until staff were next to her and ready to transfer dated. However, there was no corresponding comprehensive safety assessment included in the R2's record. During an observation on 12/20/23 at 2:18 p.m., R2 was assisted by PT to recliner. PT used the remote to bring the chair to upright position. PT provided R2 instructions to reach behind her before attempting to sit down and to sit back in	F 689		

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F 689	Continued From page 6 the chair. PT then pushed button to lower recliner and raise R2's feet in reclined position before leaving R2's room. During an interview on 12/20/23, at 10:34 a.m. R2 stated she was currently using a facility recliner in her room but had not requested it. R2 had previously used a recliner at home. She had a fall from the recliner in the facility but was unable to recall when or what day it had happened. R2 remembered she had raised the recliner, wasn't strong enough, and fell to the ground. During an interview on 12/20/23, at 2:27 p.m., CM-B stated she was not aware of how it was determined if a resident could have an electric lift recliner but thought "the team" made the decision. She was not aware of a formal assessment, system, or process that was used to determine safety of residents who use lift recliners. During an interview on 12/20/23, at 4:58 p.m. director of nursing (DON) stated she did not know what the process was for assessing residents for the use of electric recliners. DON stated at a previous facility she had worked at they assessed all residents as they admitted to the facility but did not think there was any system or assessment in place for this facility. Residents in this facility would only be assessed for safety of a recliner if there was a concern such as repeat falls from a recliner or the resident had a lot of falls in general. DON felt a process for recliners should be in place and should be done at admission and quarterly for safety. During an interview on 12/20/23, at 5:24 p.m. administrator stated she was unsure of the	F 689		

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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 689	Continued From page 7 current or previous system in place for recliners and was only aware of an assessment being done if a resident was bringing a recliner from home or if the recliner was changed. Administrator felt unplugging a chair or putting the recliner remote in a side pocket of the chair would not be a good intervention; a different chair that was safe for the resident would be a preferred intervention for safety. She would expect assessments for recliners would be done quarterly and be talked about with the IDT in the future. A lift chair or recliner device assessment policy was requested but not received.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 2, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: BU3K11

Dear Administrator:

The above facility was surveyed on December 19, 2023 through December 20, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00103	A. BUILDING: _____ B. WING _____	12/20/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/19/23 and 12/20/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were reviewed: H53448066C (MN00099289) and H53448148C (MN00098840) with a licensing order issued at (0830). 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
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 complete comprehensive safety assessments for electric lift recliners to prevent and/or reduce falls from electric recliners for 2 of 3 residents (R1, R2) who had falls from electric recliners. Findings Include: R1 admission record dated 12/10/12, identified R1 had diabetes mellitus with diabetic nephropathy, dementia without behavioral	2 830	CORRECTED	1/19/24

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2 830	Continued From page 3 disturbances, general anxiety disorder, and asthma. R1's annual Minimum Data Set (MDS) dated 10/4/23, identified R1 had severe cognitive impairment with no behaviors. R1 was frequently incontinent of bowel and bladder and was dependent on staff for transfers, toilet use, personal hygiene, and bathing. R1's MDS identified no falls since admission or previous assessment. R1's flexion, abduction, and external rotation (FABER) fall risk dated 10/4/23, identified R1 was at significant risk for falls. R1's care plan dated 7/7/23, identified R1 had an alteration in mobility related to falls risk, impaired mobility and required two staff assist for transfers with Hoyer (full body) lift. Interventions added on 11/27/23, informed staff R1 was non-weight bearing on right leg and remote to recliner to be kept in pocket of recliner. Facility Incident tracker log dated 12/16/23 at 6:30 p.m., indicated R1 had a fall in room from recliner after raising the recliner chair up and fell to the floor resulting in a laceration to left eye. The report indicated R1's care plan was not followed and an investigation was needed. In house manual recliner ordered. The report did not identify how the care plan was not followed. R1's progress note dated 12/15/23, at 10:27 a.m., indicated interdisciplinary team (IDT) met yesterday afternoon and R1 is working with physical therapy (PT) she is 2 assist with Hoyer lift at this time. PT is working on tolerating some weight bearing to her right leg with goal to get her back to standing lift transfer.	2 830		

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2 830	Continued From page 4 R1's progress note dated 12/16/23 at 9:04 p.m., indicated at 6:30 p.m. R1 was found on the floor in her room in front of her recliner. The fall resulted in a 1.5-centimeter (cm) laceration above R1's left eye. and a bruise on her left hand around pinky knuckle that measured 5.0 cm by 4.0 cm. Root cause analysis was R1 was unable to control her recliner chair. Immediate intervention was to unplug chair and place a sign above the chair to alert staff to unplug the chair if resident is using. R1's record reviewed after the fall on 12/16/23, did not include assessments for safety of the electric lift recliner and/or a restraint assessment for when R1 was sitting in the chair with the chair unplugged and/or chair remote not available. During an interview on 12/20/23, at 10:39 a.m. with registered nurse (RN)-A stated she had worked in the facility for over 10 years and was not sure if facility had a policy for lift recliners or not. RN-A stated some of the recliners in the facility were the resident's personal recliners and some were the facility's. If a resident was not safe to control the remote for the chair the staff would put it in the pocket of the chair so the resident wouldn't have access to it. RN-A thought the ability for residents to use a lift chair was determined by the IDT based on the resident's cognition level. During interview on 12/20/23, at 10:54 a.m. clinical manager (CM)-A stated any resident could request a recliner in the facility. CM-A was not aware of a current system, standard or protocol in place for recliner use. Residents may be assessed for recliner safety after the recliner was involved in a fall or if staff noticed concerns	2 830		

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2 830	Continued From page 5 related to the residents cognition and their ability to use the recliner. CM-A indicated the IDT made the overall decision as to if residents were able to use lift chairs safely. During an interview on 12/20/23, at 11:15 a.m. PT stated they did not make the distinction if a resident could have a recliner or not. PT was more involved with wheelchair, walker, raised toilet seats, more of the adaptive equipment versus the comfort. PT felt the recliners were more comfort related. During an interview on 12/20/23, at 11:26 a.m. social services designee (SSD) stated she had worked at this facility for 20 years. SSD indicated she thought there was an assessment for recliners but was not familiar with it and had not used it. She was not aware of a system in place for deciding if a resident could have a lift recliner. SSD indicated historically recliners were given to residents who had recliners at home and/or the facility would complete a cognition assessment within two weeks of admission. R2's admission MDS dated 10/18/23, identified R2 was cognitively intact with no behaviors and had a history of falls, but no falls since admission into the facility. MDS also indicated R2 was dependent on staff for toileting, moderate assistance with transfers, and dependent on staff for mobility. R2's care plan dated 10/12/23, identified R2 had a sign on her walker to push call light and wait for assistance. The care plan directed staff to toilet R2 every 2 hours during the night and ambulate R2 with assist of 1 with front wheeled walker. R2's care plan did not address lift recliner.	2 830		

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2 830	Continued From page 6 R2's progress note dated 11/4/23 at 5:15 a.m., indicated at 4:50 a.m. R2 was found laying on her stomach with her head by her room door and her feet by the bathroom door. Call light was not used. Resident had been sitting in the recliner prior to her fall per her request at 1:00 a.m. Resident indicated she was trying to go to the bathroom when she reached for the door handle and fell. R2's progress note dated 11/23/23 at 4:59 p.m., indicated R2 self-transferred into the bathroom and fell when getting herself off of the toilet. Facility incident tracking log indicated R2 had a fall on 11/23/23, at 4:30 p.m. when she self-transferred to the bathroom and didn't use her call light till after the fall. Resident scored a 14 out of 30 on her Saint Louis University Mental Status (SLUMS) assessment, indicating dementia. Intervention was to put sign on her walker. R2's progress note dated 11/27/23, at 3:50 p.m., indicated IDT reviewed fall history related to fall from self-transfer in the bathroom. The note included R2's SLUMS score and a review of FABER score identified R2 was at significant risk for falls. R2's record did not include an assessment or a plan of care that identified R2's ability to use the lift chair without supervision or safety interventions while R1 was sitting in the chair before or after her fall on 11/23/23. Facility incident tracking log indicated on 12/15/23, at 4:45 a.m. R2 had an unwitnessed fall in room from her recliner. NA went to open bathroom door to turn light on and turned to see	2 830		

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2 830	Continued From page 7 resident had raised recliner chair up and fell to the floor. Intervention was to let R2 know to wait for NA to be ready for her before raising the chair. R2's progress note dated 12/15/23, at 5:13 a.m., identified R2's fall from the recliner as per the tracking log. The note further indicated the NA had seen R2 falling to her right side. R2 scraped her knee on the carpet and her right knee was a little sore. R2's care plan was revised on 12/15/23, with the intervention of remind resident to wait to lift recliner until staff were next to her and ready to transfer dated. However, there was no corresponding comprehensive safety assessment included in the R2's record. During an observation on 12/20/23 at 2:18 p.m., R2 was assisted by PT to recliner. PT used the remote to bring the chair to upright position. PT provided R2 instructions to reach behind her before attempting to sit down and to sit back in the chair. PT then pushed button to lower recliner and raise R2's feet in reclined position before leaving R2's room. During an interview on 12/20/23, at 10:34 a.m. R2 stated she was currently using a facility recliner in her room but had not requested it. R2 had previously used a recliner at home. She had a fall from the recliner in the facility but was unable to recall when or what day it had happened. R2 remembered she had raised the recliner, wasn't strong enough, and fell to the ground. During an interview on 12/20/23, at 2:27 p.m., CM-B stated she was not aware of how it was determined if a resident could have an electric lift recliner but thought "the team" made the	2 830		

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2 830	Continued From page 8 decision. She was not aware of a formal assessment, system, or process that was used to determine safety of residents who use lift recliners. During an interview on 12/20/23, at 4:58 p.m. director of nursing (DON) stated she did not know what the process was for assessing residents for the use of electric recliners. DON stated at a previous facility she had worked at they assessed all residents as they admitted to the facility but did not think there was any system or assessment in place for this facility. Residents in this facility would only be assessed for safety of a recliner if there was a concern such as repeat falls from a recliner or the resident had a lot of falls in general. DON felt a process for recliners should be in place and should be done at admission and quarterly for safety. During an interview on 12/20/23, at 5:24 p.m. administrator stated she was unsure of the current or previous system in place for recliners and was only aware of an assessment being done if a resident was bringing a recliner from home or if the recliner was changed. Administrator felt unplugging a chair or putting the recliner remote in a side pocket of the chair would not be a good intervention; a different chair that was safe for the resident would be a preferred intervention for safety. She would expect assessments for recliners would be done quarterly and be talked about with the IDT in the future. A lift chair or recliner device assessment policy was requested but not received.	2 830		

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2 830	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		