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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: S9GX
Facility ID: 00847

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245333**
2. STATE VENDOR OR MEDICAID NO. (L2) **138740500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRFAX COMMUNITY HOME**
(L4) **300 TENTH AVENUE SOUTHEAST**
(L5) **FAIRFAX, MN** (L6) **55332**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/27/2017** (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 **40** (L18)
13.Total Certified Beds **40** (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 |
|---|---|---|---|---|
| | 40 | | | |
| (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 :
Jane Teipel, HFE NEII 03/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/06/2017 (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
**08/01/1986**
(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
**01/31/2017**
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245333

April 6, 2017

Ms. Judith Sandmann, Administrator
Fairfax Community Home
300 Tenth Avenue Southeast
Fairfax, Minnesota 55332

Dear Ms. Sandmann:

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 January 22, 2017 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

*An equal opportunity employer.*

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2017

Ms. Judith Sandmann, Administrator
Fairfax Community Home
300 Tenth Avenue Southeast
Fairfax, Minnesota 55332

RE: Project Number S5333026

Dear Ms. Sandmann:

On January 3, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 14, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On January 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 23, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 22, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 14, 2016, effective January 22, 2017 and therefore remedies outlined in our letter to you dated January 3, 2017, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118    Fax: (651) 215-9697

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 245333 | A. Building<br>B. Wing | 1/27/2017 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FAIRFAX COMMUNITY HOME | 300 TENTH AVENUE SOUTHEAST<br>FAIRFAX, MN 55332 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix F0226<br>Reg. # 483.12(b)(1)-(3), 483.95(c)(1)-(3)<br>LSC | Correction Completed 01/22/2017 | ID Prefix F0280<br>Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)<br>LSC | Correction Completed 01/22/2017 | ID Prefix F0309<br>Reg. # 483.24, 483.25(k)(l)<br>LSC | Correction Completed 01/22/2017 |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| REVIEWED BY STATE AGENCY | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| x | GL/mm | 03/20/2017 | 33937 | 01/27/2017 |
| **REVIEWED BY CMS RO** | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |
| | | | | |

**FOLLOWUP TO SURVEY COMPLETED ON**
12/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 245333 | A. Building 01 - MAIN BUILDING<br>B. Wing | 1/23/2017 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FAIRFAX COMMUNITY HOME | 300 TENTH AVENUE SOUTHEAST<br>FAIRFAX, MN 55332 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0324 | Correction Completed 01/22/2017 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0353 | Correction Completed 01/22/2017 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0918 | Correction Completed 01/22/2017 |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| REVIEWED BY STATE AGENCY | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| x ☐ | TL/mm | 03/20/2017 | 34764 | 01/23/2017 |
| **REVIEWED BY CMS RO** ☐ | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |

**FOLLOWUP TO SURVEY COMPLETED ON**
12/13/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2017

Ms. Judith Sandmann, Administrator
Fairfax Community Home
300 Tenth Avenue Southeast
Fairfax, Minnesota 55332

Re: Reinspection Results - Project Number S5333026

Dear Ms. Sandmann:

On January 27, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 14, 2016, with orders viewed by you electronically on January 23, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 00847 | A. Building<br>B. Wing | 1/27/2017 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FAIRFAX COMMUNITY HOME | 300 TENTH AVENUE SOUTHEAST<br>FAIRFAX, MN 55332 |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| ITEM (Y4) | DATE (Y5) | ITEM (Y4) | DATE (Y5) | ITEM (Y4) | DATE (Y5) |
|---|---|---|---|---|---|
| ID Prefix 20302<br>Reg. # MN State Statute 144.6503<br>LSC | Correction Completed 01/27/2017 | ID Prefix 20570<br>Reg. # MN Rule 4658.0405 Subp. 4<br>LSC | Correction Completed 01/22/2017 | ID Prefix 20830<br>Reg. # MN Rule 4658.0520 Subp. 1<br>LSC | Correction Completed 01/22/2017 |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| REVIEWED BY STATE AGENCY [x] | REVIEWED BY (INITIALS) GL/mm | DATE 03/20/2017 | SIGNATURE OF SURVEYOR 33937 | DATE 01/27/2017 |
|---|---|---|---|---|
| REVIEWED BY CMS RO [ ] | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |
| FOLLOWUP TO SURVEY COMPLETED ON 12/14/2016 | [ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? | | | [ ] YES [ ] NO |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

ID: S9GX
Facility ID: 00847

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245333**
2. STATE VENDOR OR MEDICAID NO. (L2) **138740500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRFAX COMMUNITY HOME**
(L4) **300 TENTH AVENUE SOUTHEAST**
(L5) **FAIRFAX, MN** (L6) **55332**

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 **12/14/2016** (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 **40** (L18)
13. Total Certified Beds **40** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 40 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Jane Teipel, HFE NEII 01/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, **Enforcement Specialist** 01/30/2017 (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 **08/01/1986** (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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 3, 2017

Ms. Judith Sandmann, Administrator
Fairfax Community Home
300 Tenth Avenue Southeast
Fairfax, Minnesota 55332

RE: Project Number S5333026

Dear Ms. Sandmann:

On December 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. . This survey found the most serious deficiencies in your facility to be 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794    Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 23, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 14, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118     Fax: (651) 215-9697

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING ______ B. WING ______ | 12/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332** |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 226 SS=C | 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>483.12<br>(b) The facility must develop and implement written policies and procedures that:<br><br>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(2) Establish policies and procedures to investigate any such allegations, and<br><br>(3) Include training as required at paragraph §483.95,<br><br>483.95<br>(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>(c)(1) Activities that constitute abuse, neglect, | F 226 | | 1/22/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/10/2017

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 226 | Continued From page 1<br>exploitation, and misappropriation of resident property as set forth at § 483.12.<br><br>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure their abuse prevention policy addressed prohibiting demeaning or humiliating abuse related to social media. This had the potential to affect 22 residents who resided at the facility.<br><br>Findings include:<br><br>The facility's revised 10/14, Social Media policy lacked direction for staff related to potential for abuse including taking or using photographs or recordings in any manner that would demean or humiliate a resident.<br><br>In an interview on 12/13/16, at 2:40 p.m. the administrator verified she was aware of the new regulation from 8/16, regarding social media policies and training. The administrator explained she had completed some training for staff in 10/16, from the employee handbook which instructed staff not to take any pictures of residents. The administrator verified she had not updated the facility's policy regarding social media and stated, "It was something that just did not get done yet." | F 226 | F Tag 226 Staff Treatment of Residents<br>It is the policy of Fairfax Community Home to develop and implement policies and procedures regarding screening and training employees to prevent, identify, and report abuse, neglect, and mistreatment misappropriation of property. The interpretive guidelines for this F-tag refer to seven key components to be reviewed by surveyors to determine if facility is meeting the intent of F-226.<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? There were no residents directly affected by the deficient practice. Corrective action will be that the policy Abuse Prohibition will be reviewed and revised to include prohibition of utilization of photographs and audio/video material in a manner that would demean or humiliate a resident, regardless of resident consent will be prohibited. The employee hand book has also been updated to include use of photographs or recordings in any manner that would demean or humiliate a resident are prohibited. | |

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| F 226 | Continued From page 2 | F 226 | How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br>There were no residents directly affected by the deficient practice.<br><br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policy and procedure for Abuse Investigation has been reviewed and revised. The QA/QI Committee reviewed the policy to ensure all components are present. The employee hand book that was reviewed and updated as well to include the use of photographs or recordings in any manner that would demean or humiliate a resident is prohibited will also be reviewed by the QA/QI Committee to ensure all components are present. Staff members will be trained on 1/12/17.<br><br>How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. The policy on Abuse Prohibition and the employee hand book revisions will be reviewed at next QA/QI meeting.<br>Who is responsible for this plan of | |

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| F 226 | Continued From page 3 | F 226 | correction?<br>The Director of Nursing or designee will be responsible for compliance.<br><br>Date of Correction: January 22, 2017 | |
| F 280<br>SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--<br><br>(i) Facilitate the inclusion of the resident and/or | F 280 | | 1/22/17 |

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| F 280 | Continued From page 4 | F 280 | | |

resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in

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| F 280 | Continued From page 5 disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure care plans were revised related to a potential for bruising for 2 of 2 residents (R16, R10) reviewed for bruising.<br><br>Finding include:<br><br>R16 was interviewed in his room on 12/12/16, at 5:34 p.m. and multiple large bruises were observed on both of the resident's arms. The bruising was dark purple/reddish is color that went from below his shoulders to the top of his knuckles. R16 stated the bruising was from the use of the steriodal medication Prednisone. R16's care plan dated 9/27/16, however, did not identify risk factors for skin impairment such as bleeding or bruising related to Prednisone and aspirin (both medications known to contribute to bruising) with related interventions.<br><br>R16's 12/16, medication admission record (MAR) included physician orders for Prednisone 10 milligrams and aspirin 81 milligrams both daily. The MAR and/or treatment administration record lacked instruction for staff to monitor for bruising and/or healing of bruising.<br><br>During an interview on 12/13/16, at 5:00 p.m. registered nurse (RN)-A stated she was aware of bruising on R16's arms and said, "They have | F 280 | F Tag 280 Right to Participate Planning Care-Revise CP Comprehensive Care Plans (Qualified Persons)<br>It is the policy of Fairfax Community Home to provide care and services by qualified persons in accordance with each resident s written plan of care.<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>For Resident R16, R10 care plans were revised/updated to reflect Potential for bruising related to medication use, including Prednisone & ASA (both medications known to contribute to bruising)<br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?<br>For the facility residents who have deficit needs identified as a part of their MDS assessment, the current care plan interventions identified to assist the resident will be monitored for proper implementation. This will be done by observational audits.<br><br>What measures will be put into place or | |

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| F 280 | Continued From page 6<br>been there for some time now." (TMA)-A then stated she was familiar with R16 but was not sure how he got the bruises. "He does not bang into anything...We are not monitoring any of the bruises because they have been there since admission." At 5:36 p.m. the director of nursing (DON) stated R16's bruises were from bumping them on the bed rails.<br><br>R16 explained in an interview on 12/14/16, at 7:26 a.m. he utilized the siderails on his bed to turn and reposition himself. "I need to hold onto them when I turn on my side while in bed." R16 denied hitting his arms are the siderails.<br><br>In a follow-up interview on 12/14/16, at 7:38 a.m. the DON verified R16's care plan should have been revised to indicated he was at risk for skin impairment and related interventions to minimize bruising.<br><br>R10's potential for bruising was not noted on her current care plan with approaches to minimize the risk for bruising. R10 was observed in her room on 12/13/16 at 3:24 p.m. Large darkened area were noted on both of the resident's hands, with an additional approximate quarter-sized purple bruise on the right hand. The resident explained, "The bruise on my right hand was from Coumadin that I was taking--right now I am off of it. It does not really hurt me." R10 clarified no one had hurt her and added, "I think the nurses know about it."<br><br>R10's 11/16, physician orders included the steroid medication Prednisone (side effects included potential for bruising) for chronic obstructive pulmonary disease, as well as insulin injections for diabetes. | F 280 | what systemic changes will be made to ensure that the deficient practice does not recur? The policy and procedure for Comprehensive Care Plans were each reviewed. Monitoring of staff in regards to the Provision of Care with in plan of care will be performed by supervising nurses, the director of nursing, and/or administration.<br>Staff training is scheduled for 01/12/2017 and ongoing regarding their responsibilities.<br>How does the facility plan to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.<br>Random observation audits will be conducted monthly for two months. Audit findings will be shared with QA Committee at its next scheduled meeting for review and make further recommendations.<br><br>Who is responsible for this plan of correction?<br>The Director of Nursing or designee will be responsible for compliance.<br>Date of Correction: 01/22/2017 | |

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| F 280 | Continued From page 7 | F 280 | | |
| | On 12/13/16, 4:05 p.m. The director of nursing (DON) stated, "If the nursing aide knows about new bruises, they alert the nurses. Nobody reported the bruises on her hand. If it is not on the care plan, probably it is not documented." | | | |
| | The facility's 11/18/16, Care Plans--Comprehensive policy indicated, "Each resident's care plan is designed to identified problems, incorporate risk factors, aid in prevention or reducing declines in functional status and reflect treatment goals. In addition care plans are to identify problem areas, causes and develop interventions. Residents are assessed on an ongoing bases and revised as information is gathered or with change of conditions." | | | |
| F 309 SS=D | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING | F 309 | | 1/22/17 |
| | 483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care. | | | |
| | 483.25<br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences. | | | |

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| F 309 | Continued From page 8<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to identify and/or monitor bruising of 2 of 2 residents (R10, R16) reviewed for non-pressure related skin conditions.<br><br>Finding include:<br><br>R16 was interviewed in his room on 12/12/16, at 5:34 p.m. and multiple large bruises were observed on both of the resident's arms. The bruising was dark purple/reddish is color that went from below his shoulders to the top of his knuckles. R16 stated the bruising was from the use of the steriodal medication Prednisone explaining, "I need to take it or I wouldn't be here now. I have heart failure."<br><br>R16's 9/26/16, admission body audit revealed the resident had multiple bruising on the front of both arms and red/purple areas on the front of both lower legs. R16's bath sheets completed by a trained medication aide (TMA) dated 10/6/16 and 11/11/16, showed the resident had no new skin concerns. R16's comprehensive skin risk data collection sheet dated 10/3/16, indicated he was at risk for skin impairment due to risk factors including Prednisone use, as well as congestive heart failure and terminal pulmonary (lung) disease. R16's care plan dated 9/27/16, did not identify risk factors for skin impairment such as | F 309 | F Tag 309 Provide Care/Services For The Highest Well Being<br>It is the policy of Fairfax Community Home to utilize the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:<br>The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and<br>Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>For Resident R 10 & R16, the care plan | |

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| F 309 | Continued From page 9<br>bleeding or bruising related to Prednisone and aspirin (both medications known to contribute to bruising) with related interventions.<br><br>R16's 12/16, medication admission record (MAR) included physician orders for Prednisone 10 milligrams and aspirin 81 milligrams both daily. The MAR and/or treatment administration record lacked instruction for staff to monitor for bruising and/or healing of bruising. Nursing notes did not include documentation of bruising on any areas of R16's body.<br><br>During interviews on 12/13/16, starting at 4:55 p.m. two nursing assistants (NA)-A and (NA)-B both stated they were both caring for R16 that evening. Both NAs said they had just started working at the facility and were unsure about information regarding R16's bruises. NA-B stated the bruises had been present almost a week prior, but said they had not mentioned how he acquired the bruises, nor had they asked about them. At 5:00 p.m. registered nurse (RN)-A stated she was aware of bruising on R16's arms and said, "They have been there for some time now." (TMA)-A then stated she was familiar with R16 but was not sure how he got the bruises. "He does not bang into anything...We are not monitoring any of the bruises because they have been there since admission." At 5:36 p.m. the director of nursing (DON) stated R16's bruises were from bumping them on the bed rails.<br><br>R16 explained in an interview on 12/14/16, at 7:26 a.m. he utilized the siderails on his bed to turn and reposition himself. "I need to hold onto them when I turn on my side while in bed." R16 denied hitting his arms are the siderails. | F 309 | was reviewed and revised. Special note was made in reference to bruising and the combination of Prednisone & ASA combo. MAR was set up on residents to monitor every day and reassess on the next weekly bath skin audit day. With instructions for charge nurses to specifically write "No new skin concerns" if no new issues arise on weekly skin audit. Comprehensive care plans will be updated with appropriate interventions. Assessments are performed quarterly, annually, or if Significant change in status by the MDS nurse/coordinator.<br><br>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? For any other resident this could affect, a thorough review and potential new assessment would be completed with the addition on updating the care plan.<br>Care plans are reviewed quarterly or in the event of a significant change.<br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The policy for Comprehensive Care Plans has been reviewed by the Facility QA/QI Committee and the Interdisciplinary Team. Care plans are reviewed quarterly or if a significant change is noted.<br>How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING ______ B. WING ______ | 12/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332** |

| (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 |
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Continued From page 10

In a follow-up interview on 12/14/16, at 7:38 a.m. the DON stated she would have expected the staff to monitor bruises weekly until healed and to ensure bruises did not get worse. The DON stated she was aware of R16 medications he was taking that could possible cause bleeding/bruising (aspirin and Prednisone). The DON said they not put any interventions into place to minimize the risk for further skin issues for R16, but said they could have tried lambswool to his siderails.

R10 was observed in her room on 12/13/16 at 3:24 p.m. Large darkened area were noted on both of the resident's hands, with an additional approximate quarter-sized purple bruise on the right hand. The resident explained, "The bruise on my right hand was from Coumadin that I was taking--right now I am off of it. It does not really hurt me." R10 clarified no one had hurt her. The resident added, "I think the nurses know about it."

R10's 11/16, physician orders included the steroid medication Prednisone (side effects include potential for bruising) for chronic obstructive pulmonary disease, as well as insulin injections for diabetes.

R10's admission assessment dated 11/15/16, however, lacked any information related to bruising on the resident's hands. A potential for bruising was also not noted on her current care plan with approaches to minimize the risk for bruising.

The skin assessment (in the bath book) for R10 dated 11/22/16, revealed the resident had "various spots purple red marks under skin" on

F 309

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Care plan audits will be completed randomly for two months to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations.
Who is responsible for this plan of correction?
The Director of Nursing or designee will be responsible for compliance.

Date of Correction: 01/22/2017

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING ______ B. WING ______ | 12/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332** |

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| F 309 | Continued From page 11 | F 309 | | |

the right upper arm, and "bruise insulin site" on abdomen as well as "small historical mark old injury" on right lower inner ankle. However, there was no identification of the bruises on R10's hands.

On 12/13/16 at 3:33 p.m. licensed practical nurse (LPN)-B stated "Yes, I am aware of the bruise on her hand. I am not sure if it is documented. We do skin checks every week," which LPN-B stated could be found in the bath book.

On 12/13/16 4:05 p.m. The director on nursing (DON) stated, "If the nursing aide knows about new bruises, they alert the nurses. Nobody reported the bruises on her hand. If it is not on the care plan, probably it is not documented." At 4:13, the surveyor and DON went to R10's room to visualize the bruises. The DON looked at the resident's skin and stated, "This is a new bruise [on the right hand], but it could be from her bumping into something." The DON explained that at times R10's family members took her to appointments outside the facility. The DON stated, "I did not see this bruise documented in the progress note. No incident report was completed related to the bruises on her right hand. I am going to write an incident report immediately. The DON said R10 had a hearing aid appointment 12/9/16, but she did not see a note regarding the visit. The resident also had an appointment at a nearby hospital for a pacemaker check on 12/13/16, but the DON said, "...I do not have any report indicating she came back with these bruises."

An activity aide (A)-A stated on 12/13/16, at 5:14 p.m. "I have never noticed any bruises on her hand." Nursing assistant (NA)-A stated at 5:17

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING ______ B. WING ______ | 12/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332** |

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| F 309 | Continued From page 12<br>p.m. "I know the resident and I do take care of her. Yes, I have noticed bruises on her hand, but she's had it for long time, otherwise I would have reported to the nurse." Registered nurse (RN)-A then stated at 5:22 p.m. "The resident told me this when I did her head to toe [skin check] assessment. She said to me, 'Look at the bruises. It happened to me when they were poking me" when starting an IV (intravenous) or drawing blood. RN-A also stated, "I think I have this information in my admission assessment." At 5:38 p.m. NA-B stated, "Yes I do take care of her [R10], but I have never noticed any bruises on her. If I do notice a bruise, I will report to the charge nurse."<br><br>RN-B stated on 12/14/16, at 7:21 a.m. she worked at the facility full time and said, "Yes I do take care of her." When asked if she had noticed any bruising on R10 she replied, "I can't answer that question. I am not sure if she has bruises. I know she has some bruises on her belly from insulin [injections]."<br><br>A skin assessment policy and procedure was requested but was not provided. | F 309 | | |

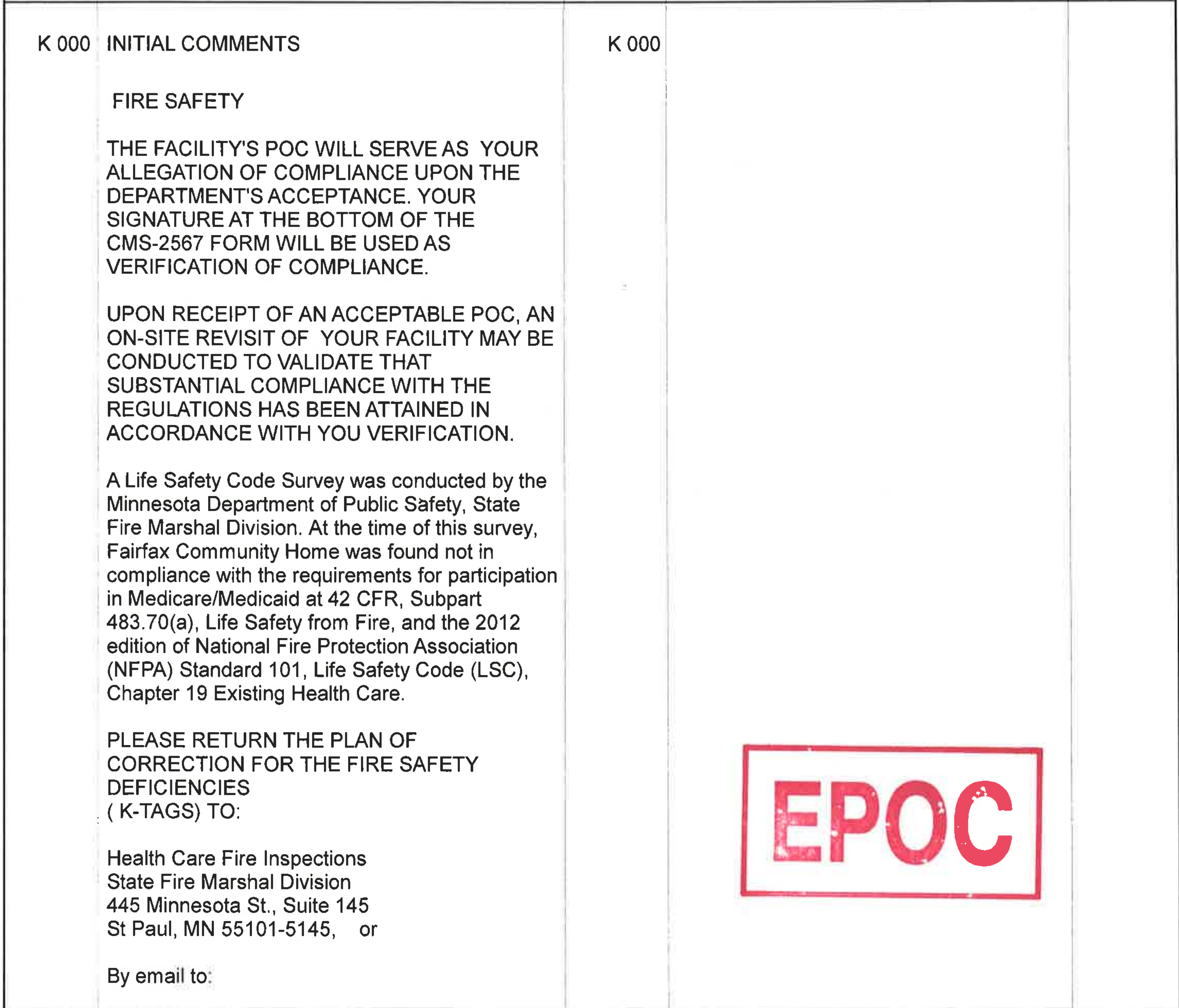
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5333026

PRINTED: 01/11/2017
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING **01 - MAIN BUILDING**<br>B. WING ______ | 12/13/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST**<br>**FAIRFAX, MN 55332** |



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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS | K 000 | | |

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Fairfax Community Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
( K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:

EPOC

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 01/10/2017 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING **01 - MAIN BUILDING**<br>B. WING | **12/13/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST**<br>**FAIRFAX, MN 55332** |

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|---|---|---|---|---|
| K 000 | Continued From page 1<br>Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency<br><br>Fairfax Community Home was constructed as follows:<br>The original building was constructed in 1965 and is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction;<br>The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction.<br><br>The nursing home is separated from an assisted living facility by a two-hour fire wall assembly. Also, the 1965 building of Type II(111) construction is separated from the 1995 addition of Type V(111) construction by a two-hour fire wall assembly.<br><br>The facility has a fire alarm system with smoke detection at smoke barrier doors and all spaces open to the corridors, which is monitored for automatic fire department notification. The facility also has single-station, battery-operated smoke | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 12/13/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST**<br>**FAIRFAX, MN 55332** |

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| K 000 | Continued From page 2<br>detection in all Resident Rooms. The facility has a capacity of 50 beds and had a census of 22 at time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 324 SS=C | NFPA 101 Cooking Facilities<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This STANDARD is not met as evidenced by:<br>Based on a review of documentation and an interview with staff, it was determined that the kitchen hood suppression system is not in accordance with NFPA 101 The Life Safety Code (edition 2012), Cooking equipment is protected in | K 324 | Maintenance Supervisor contacted contractor Simplex Grinnell. The hood suppression system inspection was completed on December 26, 2016 | 1/22/17 |

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|---|---|---|---|
| | 245333 | A. BUILDING **01 - MAIN BUILDING**<br>B. WING ______ | **12/13/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST**<br>**FAIRFAX, MN 55332** |

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|---|---|---|---|---|
| K 324 | Continued From page 3<br>accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>Findings Include:<br>During the facility tour at approximately Noon, on 12/13/2016, observations revealed that the maintenance on the hood suppression system was last completed in April 14, 2016.<br><br>This deficient practice was confirmed by the facility Maintenance staff at the time of discovery and at the exit conference. | K 324 | Proposed completion date: 1/22/17<br><br>Maintenance Supervisor is responsible for correction and monitoring to prevent reoccurrence of this deficiency. | |
| K 353<br>SS=C | NFPA 101 Sprinkler System - Maintenance and Testing<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are | K 353 | | 1/22/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING 01 - MAIN BUILDING<br>B. WING ______ | 12/13/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| FAIRFAX COMMUNITY HOME | 300 TENTH AVENUE SOUTHEAST<br>FAIRFAX, MN 55332 |

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|---|---|---|---|---|
| K 353 | Continued From page 4<br>maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>______<br>b) Who provided system test<br>______<br>c) Water system supply source<br>______<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This STANDARD is not met as evidenced by:<br>Based on a review of documentation and an interview with staff, it was determined that the Sprinkler Suppression system is not in accordance with NFPA 101 The Life Safety Code (edition 2012), Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br><br>Findings Include:<br>During the facility tour at approximately Noon, on 12/13/2016, observations revealed there are 2 sprinkler heads that are painted in a clean linen closet on the 400 wing.<br><br>This deficient practice was confirmed by the facility Maintenance staff at the time of discovery and at the exit conference. | K 353 | Maintenance Supervisor has ordered 2 new sprinkler heads to replace the 2 sprinkler heads in the clean linen closet on the 400 Wing.<br>Proposed completion date: 1/22/17<br><br>Maintenance Supervisor is responsible for correction and monitoring to prevent reoccurrence of this deficiency. | |
| K 918 | NFPA 101 Electrical Systems - Essential Electric | K 918 | | 1/22/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 12/13/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| FAIRFAX COMMUNITY HOME | 300 TENTH AVENUE SOUTHEAST<br>FAIRFAX, MN 55332 |

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|---|---|---|---|---|
| K 918<br>SS=D | Continued From page 5<br>Syste<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This STANDARD is not met as evidenced by:<br>Based on a review of documentation and an interview with staff, it was determined that the Electrical Systems - Essential Electric System Maintenance and Testing is not in accordance | K 918 | Maintenance Supervisor has added the "cool down time" to the Emergency Generator - Monthly Test Log. The proper testing of the emergency generator along | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING **01 - MAIN BUILDING**<br>B. WING ______ | **12/13/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST**<br>**FAIRFAX, MN 55332** |

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|---|---|---|---|---|
| K 918 | Continued From page 6<br>with NFPA 101 The Life Safety Code (edition 2012). The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br><br>Findings Include:<br>During the facility tour at approximately Noon, on 12/13/2016, observations revealed that from December 2015- December 2016 the facility stated the required generator cool down was performed but failed to provide the documentation. | K 918 | with proper documentation of the required testing data will be completed by the Maintenance Supervisor.<br><br>Proposed Completion Date: 1/22/17<br><br>Maintenance Supervisor is responsible for correction and monitoring to prevent reoccurrence of this deficiency. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245333 | A. BUILDING **01 - MAIN BUILDING**<br>B. WING | **12/13/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST**<br>**FAIRFAX, MN 55332** |

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|---|---|---|---|---|
| K 918 | Continued From page 7<br><br>This deficient practice was confirmed by the facility Maintenance staff at the time of discovery and at the exit conference. | K 918 | | |

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 3, 2017

Ms. Judith Sandmann, Administrator
Fairfax Community Home
300 Tenth Avenue Southeast
Fairfax, MN 55332

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5333026

Dear Ms. Sandmann:

The above facility was surveyed on December 12, 2016 through December 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number . that was 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 Department of Health orders being submitted 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 after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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 Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00847 | A. BUILDING: ______ B. WING ______ | 12/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332** |

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| 2 000 | Initial Comments | 2 000 | | |

*****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

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| 2 000 | Continued From page 1 | 2 000 | | |

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 December 12, 13 and 14, 2016 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.

Minnesota Department of Health

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| 2 000 | Continued From page 2<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 302 | MN State Statute 144.6503 Alzheimer's disease or related disorder train<br><br>ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING:<br>MN St. Statute 144.6503<br><br>(a) If a nursing facility serves persons with Alzheimer's<br>disease or related disorders, whether in a segregated or general unit, the facility's direct care staff<br>and their supervisors must be trained in dementia care.<br><br>(b) Areas of required training include:<br>(1) an explanation of Alzheimer's disease and related disorders;<br>(2) assistance with activities of daily living;<br>(3) problem solving with challenging behaviors; and<br>(4) communication skills.<br>(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.<br>(d) The facility shall document compliance with this section.<br><br>This MN Requirement is not met as evidenced by: | 2 302 | | 1/1/17 |

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| 2 302 | Continued From page 3<br><br>Based on interview and observation, the facility failed to provide information to the consumer either in an electronic or written form a description of the training program, the categories of training, the frequency of training and the basic topics covered for Alzheimer's and dementia disorders. This has the potential to affect all 22 residents in the facility.<br>Finding include:<br>During an interview on 12/12/16, at 6:00 p.m. with the administrator, she stated needed to find the information in the admissions packet related to consumer dementia training. When the information was again requested on 12/13/16, at 3:30 p.m. the administrator stated she needed to "look for it."<br>On 12/13/16, at 4:23 p.m. the social services/admissions staff person reported she did not provide any consumer information in the admission packets related to dementia training. She stated, "I was not aware of that, so no, I do not have it." On 12/14/16, at 7:28 a.m. the administrator confirmed no information was being provided to consumers as required.<br>SUGGESTED METHOD OF CORRECTION:<br>The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information. The DON or designee could educate staff about this requirement and conduct audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 2 302 | Corrected | |
| 2 570 | MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision<br><br>Subp. 4. Revision. A comprehensive plan of | 2 570 | | 1/3/17 |

Minnesota Department of Health

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| 2 570 | Continued From page 4<br>care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure care plans were revised related to a potential for bruising for 2 of 2 residents (R16, R10) reviewed for bruising.<br><br>Finding include:<br><br>R16 was interviewed in his room on 12/12/16, at 5:34 p.m. and multiple large bruises were observed on both of the resident's arms. The bruising was dark purple/reddish is color that went from below his shoulders to the top of his knuckles. R16 stated the bruising was from the use of the steriodal medication Prednisone. R16's care plan dated 9/27/16, however, did not identify risk factors for skin impairment such as bleeding or bruising related to Prednisone and aspirin (both medications known to contribute to bruising) with related interventions.<br><br>R16's 12/16, medication admission record (MAR) included physician orders for Prednisone 10 milligrams and aspirin 81 milligrams both daily. The MAR and/or treatment administration record lacked instruction for staff to monitor for bruising | 2 570 | Corrected | |

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| 2 570 | Continued From page 5 | 2 570 | | |

and/or healing of bruising.

During an interview on 12/13/16, at 5:00 p.m. registered nurse (RN)-A stated she was aware of bruising on R16's arms and said, "They have been there for some time now." (TMA)-A then stated she was familiar with R16 but was not sure how he got the bruises. "He does not bang into anything...We are not monitoring any of the bruises because they have been there since admission." At 5:36 p.m. the director of nursing (DON) stated R16's bruises were from bumping them on the bed rails.

R16 explained in an interview on 12/14/16, at 7:26 a.m. he utilized the siderails on his bed to turn and reposition himself. "I need to hold onto them when I turn on my side while in bed." R16 denied hitting his arms are the siderails.

In a follow-up interview on 12/14/16, at 7:38 a.m. the DON verified R16's care plan should have been revised to indicated he was at risk for skin impairment and related interventions to minimize bruising.

R10's potential for bruising was not noted on her current care plan with approaches to minimize the risk for bruising. R10 was observed in her room on 12/13/16 at 3:24 p.m. Large darkened area were noted on both of the resident's hands, with an additional approximate quarter-sized purple bruise on the right hand. The resident explained, "The bruise on my right hand was from Coumadin that I was taking--right now I am off of it. It does not really hurt me." R10 clarified no one had hurt her and added, "I think the nurses know about it."

R10's 11/16, physician orders included the steroid medication Prednisone (side effects included

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| 2 570 | Continued From page 6<br>potential for bruising) for chronic obstructive pulmonary disease, as well as insulin injections for diabetes.<br><br>On 12/13/16, 4:05 p.m. The director of nursing (DON) stated, "If the nursing aide knows about new bruises, they alert the nurses. Nobody reported the bruises on her hand. If it is not on the care plan, probably it is not documented."<br><br>The facility's 11/18/16, Care Plans--Comprehensive policy indicated, "Each resident's care plan is designed to identified problems, incorporate risk factors, aid in prevention or reducing declines in functional status and reflect treatment goals. In addition care plans are to identify problem areas, causes and develop interventions. Residents are assessed on an ongoing bases and revised as information is gathered or with change of conditions."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies and re-educate staff as appropriate regarding care plan revisions. Audits could be conducted and the results brought to the quality committee for review.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 570 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>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 | 2 830 | | 1/3/17 |

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| 2 830 | Continued From page 7 | 2 830 | | |

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 identify and/or monitor bruising of 2 of 2 residents (R10, R16) reviewed for non-pressure related skin conditions.

Plan of correction: corrected

Finding include:

R16 was interviewed in his room on 12/12/16, at 5:34 p.m. and multiple large bruises were observed on both of the resident's arms. The bruising was dark purple/reddish is color that went from below his shoulders to the top of his knuckles. R16 stated the bruising was from the use of the steriodal medication Prednisone explaining, "I need to take it or I wouldn't be here now. I have heart failure."

R16's 9/26/16, admission body audit revealed the resident had multiple bruising on the front of both arms and red/purple areas on the front of both lower legs. R16's bath sheets completed by a trained medication aide (TMA) dated 10/6/16 and 11/11/16, showed the resident had no new skin concerns. R16's comprehensive skin risk data collection sheet dated 10/3/16, indicated he was at risk for skin impairment due to risk factors including Prednisone use, as well as congestive

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| 2 830 | Continued From page 8<br><br>heart failure and terminal pulmonary (lung) disease. R16's care plan dated 9/27/16, did not identify risk factors for skin impairment such as bleeding or bruising related to Prednisone and aspirin (both medications known to contribute to bruising) with related interventions.<br><br>R16's 12/16, medication admission record (MAR) included physician orders for Prednisone 10 milligrams and aspirin 81 milligrams both daily. The MAR and/or treatment administration record lacked instruction for staff to monitor for bruising and/or healing of bruising. Nursing notes did not include documentation of bruising on any areas of R16's body.<br><br>During interviews on 12/13/16, starting at 4:55 p.m. two nursing assistants (NA)-A and (NA)-B both stated they were both caring for R16 that evening. Both NAs said they had just started working at the facility and were unsure about information regarding R16's bruises. NA-B stated the bruises had been present almost a week prior, but said they had not mentioned how he acquired the bruises, nor had they asked about them. At 5:00 p.m. registered nurse (RN)-A stated she was aware of bruising on R16's arms and said, "They have been there for some time now." (TMA)-A then stated she was familiar with R16 but was not sure how he got the bruises. "He does not bang into anything...We are not monitoring any of the bruises because they have been there since admission." At 5:36 p.m. the director of nursing (DON) stated R16's bruises were from bumping them on the bed rails.<br><br>R16 explained in an interview on 12/14/16, at 7:26 a.m. he utilized the siderails on his bed to turn and reposition himself. "I need to hold onto them when I turn on my side while in bed." R16 | 2 830 | | |

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| 2 830 | Continued From page 9 | 2 830 | | |

denied hitting his arms are the siderails.

In a follow-up interview on 12/14/16, at 7:38 a.m. the DON stated she would have expected the staff to monitor bruises weekly until healed and to ensure bruises did not get worse. The DON stated she was aware of R16 medications he was taking that could possible cause bleeding/bruising (aspirin and Prednisone). The DON said they not put any interventions into place to minimize the risk for further skin issues for R16, but said they could have tried lambswool to his siderails.

R10 was observed in her room on 12/13/16 at 3:24 p.m. Large darkened area were noted on both of the resident's hands, with an additional approximate quarter-sized purple bruise on the right hand. The resident explained, "The bruise on my right hand was from Coumadin that I was taking--right now I am off of it. It does not really hurt me." R10 clarified no one had hurt her. The resident added, "I think the nurses know about it."

R10's 11/16, physician orders included the steroid medication Prednisone (side effects include potential for bruising) for chronic obstructive pulmonary disease, as well as insulin injections for diabetes.

R10's admission assessment dated 11/15/16, however, lacked any information related to bruising on the resident's hands. A potential for bruising was also not noted on her current care plan with approaches to minimize the risk for bruising.

The skin assessment (in the bath book) for R10 dated 11/22/16, revealed the resident had "various spots purple red marks under skin" on

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00847 | A. BUILDING: ______ B. WING ______ | 12/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **FAIRFAX COMMUNITY HOME** | **300 TENTH AVENUE SOUTHEAST FAIRFAX, MN 55332** |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 10 | 2 830 | | |

the right upper arm, and "bruise insulin site" on abdomen as well as "small historical mark old injury" on right lower inner ankle. However, there was no identification of the bruises on R10's hands.

On 12/13/16 at 3:33 p.m. licensed practical nurse (LPN)-B stated "Yes, I am aware of the bruise on her hand. I am not sure if it is documented. We do skin checks every week," which LPN-B stated could be found in the bath book.

On 12/13/16 4:05 p.m. The director on nursing (DON) stated, "If the nursing aide knows about new bruises, they alert the nurses. Nobody reported the bruises on her hand. If it is not on the care plan, probably it is not documented." At 4:13, the surveyor and DON went to R10's room to visualize the bruises. The DON looked at the resident's skin and stated, "This is a new bruise [on the right hand], but it could be from her bumping into something." The DON explained that at times R10's family members took her to appointments outside the facility. The DON stated, "I did not see this bruise documented in the progress note. No incident report was completed related to the bruises on her right hand. I am going to write an incident report immediately. The DON said R10 had a hearing aid appointment 12/9/16, but she did not see a note regarding the visit. The resident also had an appointment at a nearby hospital for a pacemaker check on 12/13/16, but the DON said, "...I do not have any report indicating she came back with these bruises."

An activity aide (A)-A stated on 12/13/16, at 5:14 p.m. "I have never noticed any bruises on her hand." Nursing assistant (NA)-A stated at 5:17 p.m. "I know the resident and I do take care of

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her. Yes, I have noticed bruises on her hand, but she's had it for long time, otherwise I would have reported to the nurse." Registered nurse (RN)-A then stated at 5:22 p.m. "The resident told me this when I did her head to toe [skin check] assessment. She said to me, 'Look at the bruises. It happened to me when they were poking me" when starting an IV (intravenous) or drawing blood. RN-A also stated, "I think I have this information in my admission assessment." At 5:38 p.m. NA-B stated, "Yes I do take care of her [R10], but I have never noticed any bruises on her. If I do notice a bruise, I will report to the charge nurse."

RN-B stated on 12/14/16, at 7:21 a.m. she worked at the facility full time and said, "Yes I do take care of her." When asked if she had noticed any bruising on R10 she replied, "I can't answer that question. I am not sure if she has bruises. I know she has some bruises on her belly from insulin [injections]."

A skin assessment policy and procedure was requested but was not provided.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies and re-educate staff as appropriate regarding identification of monitoring of bruises. Audits could be conducted and the results brought to the quality committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.