STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Care Center	702 10th Avenue Northwest Dodge Center, MN 55927

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38685 51576 Based on observation, interview, and document review the facility failed to revise the plan of care after changes to fall prevention measure for 1 of 4 residents (R3) reviewed for accidents. Findings include: R3's Face sheet dated 12/31/24, identified diagnoses of Alzheimer's disease and repeated falls. R3's fall incident report dated 12/6/24, identified R3 had an unwitnessed fall at 7:00 a.m., R3 was found on the floor, leaning against the bed. Injuries of abrasion to right knee, bruise to right lower leg and left forearm. R3's progress notes dated 12/9/24, 12/10/24, 12/11/24, and 12/12/24, identified interdisciplinary team reviewed fall from 12/6/24 and determined to get R3 up if she is restless or trying to kick her legs out of bed. R3's care plan was not updated with this intervention until 12/30/24. R3's mobility focus care plan dated 12/30/24, identified R3 had a history of falls. R3's care plan identified an intervention: If resident is restless while in bed, and/or trying to kick her legs out of bed, she is to get up into her chair and brought out into hallway or dayroom, and R3 was to transfer with Hoyer (total mechanical lift) with two assists. R3's elimination focus care plan dated 10/31/24, also identified R3 was to toilet with an EZ stand (stand lift) with two assist. During an observation and interview on 12/31/24 at 10:13 a.m., R3 was lying in bed and nursing assistant (NA)-B was performing R3's cares. NA-B used a walkie talkie to ask for a second nursing assistant to bring the EZ Stand (stand-lift) to R3's room and assist with a transfer. NA-B placed stand lift near R3's bed and placed R3 in a seated position near the stand lift. Surveyor intervened and had NA-B review R3's care plan for transfers, NA-B removed a paper care sheet from her pocket and stated R3 had been changed to a Hoyer (total mechanical lift) transfer with two staff on 12/30/24. NA-B stated she has been off for 4 days and she was not aware R3's transfers had changed. NA-B stated she did not review R3's care sheet prior to starting her shift. (continued on next page)

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/31/24 at 2:07 p.m., Registered nurse (RN)-A stated care plans should be updated as soon as changes are made. RN-A stated that the change to R3's fall intervention after the interdisciplinary team met on 12/6/24 was not added to the NA care sheets or added to R3's care plan until 12/30/24. RN-A stated that R3's care plan did have two conflicting transfers for R3 and could be confusing for staff to tell how to transfer R3. RN-A stated the stand lift should have been removed when R3 was upgraded to a total mechanical lift. RN-A stated that the aides use a paper care sheet to tell them how cares are to be done for each resident and should be reviewing each of them prior to starting their shift to look for any changes. During an interview on 12/31/24 at 3:34p.m., director of nursing (DON) stated care plans should be updated promptly after discussion of changes and her expectation would be for staff to review NA care sheets prior to starting their shift. Review of facility's Care Plan Policy and Procedure dated 12/15/2023, identified the care plan will be evaluated and revised as the resident's status changes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review the facility failed to assess and monitor non-pressure related skin injuries (bruises) for changes until resolved for 1 of 3 residents (R1, R2 and R3), reviewed for injury of unknown origin. Findings include: R1's progress note dated 10/30/24 at 8:05 a.m., included R1 had whirlpool this morning. Continue to monitor skin. Various areas of bruising in stages of healing .Skin intact. R1's record did not include an assessment that identified skin integrity of and around the bruise location and size of the bruising and any associated pain. R1's admission, Minimum Data Set (MDS), dated [DATE], indicated R1's cognition was moderately impaired. R1's care plan dated 11/5/24, identified a focus of potential for pressure ulcer development related to impaired mobility, impaired cognition, occasional incontinence, variable intake, and left arm sling use. Interventions included to follow the facility policies for prevention and treatment of skin breakdown. R1's Incident Of Unknown Cause report dated 11/3/24 at 2:01 p.m., included, writer was called into R1's room by aide to observe R1 for some bruising. Aides reported they found bruising while toileting R1. R1 stated she does not know where they came from, was not hurt by anyone and she feels safe in her home. Measured bruising. Will continue to monitor. Left hip: 8.3 centimeters (cm) by 4 cm, back of thigh: 11.5 cm by 7 cm and left lower extremity posterior: 8.7 cm by 4.4 cm. R1's progress note dated 11/4/24 at 9:45 a.m., included team reviewed skin concern. Nurse was called into patient room by aide to observe R1 for some bruising. Aides reported they found bruising while toileting R1 Bruising noted to R1's left hip, back of thigh and lower leg. This bruising was noted upon admission. R1 fell on left side at home prior to hospitalization . Bruising is fading. No changes made at this time. R1's progress note dated 11/6/24 at 6:05 a.m., Whirlpool provided. Skin intact, slightly dry, older bruising fading as expected. No other description was included in the note. R1's progress note dated 11/18/24 at 7:53 a.m., included writer was called to tub room for skin assessment, purple bruise noted to left elbow measured 2cm x 2.5 cm. No further description was included. R1's record did not include any monitoring of the bruise to the left elbow nor an assessment to identify interventions to protect R1's skin from further injury. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Incident Of Unknown Cause report 11/21/24 at 3:42 p.m., included two stacked round bruises found on right lateral buttock- proximal 1cm, distal 2cm. Bruises are light green and purple in color, bruised areas do not appear suspicious. R1 has been reported to self-transfer frequently during NOC shift, bruising appears to be from normal life occurrence. R1 reported I don't know how I got them; I don't care. R1 denied pain, denied concern or fear of community. POA, DON and CM updated right lateral buttock had two bruises each measuring 1 cm and 2 cm. R1's progress note dated 11/22/24 at 12:03 pm., included no skin concerns at this time. R1's IDT progress note late entry dated 11/25/24 at 12:14 p.m., included the team reviewed skin concerns. Two stacked round bruises found on right lateral buttock- proximal 1cm, distal 2cm. Bruises are light green and purple in color, bruised areas do not appear suspicious. R1 has been reported to self-transfer frequently during night shift, bruising appears to be from normal life occurrence. R1 reported I don't know how I got them; I don't care. R1 denied pain, denied concern or fear of community. R1 had not had any recent falls, but team did discuss she self-transfers a lot. R1 was at the front of the hall to be observed more frequently as there is more foot traffic in that part of the hall. R1 likely bumped when attempting a self-transfer. R1 continued to deny pain to the area. Denied fear from other residents, family, staff. will continue to monitor until resolved. Right lateral buttock had two bruises each measuring 1 cm and 2 cm. R1's record was reviewed between 11/3/24 through 12/31/24 and did not include a comprehensive skin assessment and monitoring of the bruises identified on 11/3/24, 11/18/24 and 11/21/24. R2's quarterly, MDS, dated [DATE], indicated R2's cognition was severely impaired. R2's diagnoses included atrial fibrillation and anemia. R2's care plan dated 6/5/24, identified a focus of being at risk of bleeding and bruising secondary to anticoagulant therapy with interventions to observe for signs and symptoms of adverse side effects related to anticoagulant medication: excessive bruising, nose bleeds, uncontrolled bleeding, hemoptysis, black tarry stools, frank blood in stools, blood in urine. An additional focus included alteration in skin integrity related to impaired mobility, weakness, debility, pressure injury. Interventions included to Inspect skin with cares. Report reddened areas, rashes, bruising, or open areas to charge nurse. R2's progress note dated 11/20/24 at 10:25 p.m., included R2 had first shower of the week this evening and had no new skin issues and no redness over bony prominences . R2's Incident Of Unknown Cause report dated 11/21/24 at 1:33 p.m., included bruise found on dorsal right hand between thumb and index finger that measured 3 cm x 4 cm, has appearance of a broken blood vessel. R2 used hands to wheel self and frequently moves throughout different areas of facility. R2 frequently wheeled self around tables, chairs, other objects and was at risk for bumping and bruising of extremities. Bruise most likely from normal life occurrence. R2 denied pain, appeared to have no concern or fear of surrounding community. R2 had cognitive decline and unable to describe cause of bruising. DON, POA and CM updated. R2's progress note dated 12/4/24 at 9:33 p.m., included R2 had first shower of the week this evening .R2 had no new skin issues and no redness over bony prominences . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's record was reviewed between 11/21/24 through 12/31/24 and did not include a comprehensive skin assessment and monitoring of the bruises identified on 11/21/24. R3's quarterly, MDS, dated [DATE], indicated R3's cognition was severely impaired. R3's diagnoses included Alzheimer's disease and dementia. R3's care plan dated 6/5/24, included a focus of being at risk of bleeding and bruising secondary to anticoagulant therapy with interventions to observe for signs and symptoms of adverse side effects related to anticoagulant medication: excessive bruising, nose bleeds, uncontrolled bleeding, hemoptysis, black tarry stools, frank blood in stools, blood in urine. An additional focus included alteration in skin integrity related to impaired mobility, weakness, debility, pressure injury. Interventions included to Inspect skin with cares. Report reddened areas, rashes, bruising, or open areas to charge nurse. R3's progress note dated 9/30/24 at 1:51 p.m., included staff found bruising around R3's wrists while doing cares. R3 felt safe and reported no one harmed her. Progress note lacked measurements. R3's Incident Of Unknown Cause report dated 9/30/24 at 1:44 p.m., included during R3's transfer, staff noticed bruising to R3's wrists. R3 was unable to verbalize what happened. Staff believe it was caused by grabbing herself around her wrists and squeezing when she was agitated with a situation. Staff witnessed this behavior two hours later during a later transfer. Report lacked measurements of bruises. R3's IDT note dated 10/2/24 at 3:16 p.m., included team reviewed skin concern from 9/30/24. R3 was found with bruising to bilateral wrists/forearms. R3 denied harm from other staff, residents, family and was not fearful of anyone. Writer measured areas this a.m. Right wrist/forearm bruise measures 10 cm x 5 cm and was faded purple. Left wrist/forearm bruise measures 12 cm x 7cm and was faded purple. Nurse that found bruising reported that R3 was seen grabbing at her own wrists/forearms this AM. R3 does flail arms out prior to transfers frequently. R3 has assist bed rails (ABR)'s to assist with bed mobility which she may have hit her arms on. R3 also may have hit her arms on the EZ stand when going to grab for the handles. Staff report they may at times have to physically guide her hands to hold onto the EZ stand as she needs one step at a time guiding/cuing with transfers. R3 self-propeled around the facility. Sometimes R3 gets caught on corners, tables, different objects and tries to push herself away, likely bumping her arms in the process. R3 was also on Eliquis (blood thinner), putting her at a higher risk of bruising. Due to all of these factors, team determined this to be a normal life occurrence. Will continue to monitor. R3's progress note dated 10/3/24 at 2:20 p.m., included writer was called to tub room for skin assessment. R3 had 12 cm x 4 cm scattered purple bruises to left posterior lower arm. R3's progress note dated 10/24/24 at 9:45 p.m., included skin assessment completed after shower, appears to have an old bruise on her right forearm, measured approximately 3 cm in diameter. No other areas of concern noted. R3's progress notes 12/12/24 at 12:09 p.m., included R3 had a 3 cm X 1 cm yellow bruise to right hip very light. R3 was very restless and swinging her arms, bumping, and grasping the side rails. Nurse instructed Wing 1 nurse to administer PRN (as needed) Ativan (anxiety medication). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's record was reviewed between 9/30/24 through 12/31/24 and did not include a comprehensive skin assessment and monitoring of the bruises identified on 9/30/24, 10/3/24, 10/24/24 and 12/12/24. During an observation on 12/31/24 at 10:13 a.m., R3 was lying in bed getting ready to be transferred. During an interview on 12/31/24 at 2:23 p.m., director of nursing (DON) stated nurses should be documenting bruising of unknown origin in an incident report in risk management. DON further stated they are not currently assessing/monitoring for healing. [NAME] indicated weekly skin assessments are completed in the progress note portion under skin/wound note. DON further stated that no comprehensive skin assessment or monitoring of R1's, R2's and R3's bruises for healing were in their medical records and there should be. Facility policy, ACCIDENT AND INCIDENT INVESTIGATION, policy revised 4/30/24 identified, 1. To investigate the cause of an injury that is suspicious because the source of the injury is not observed or unexplainable, the extent or location of the injury is unusual, or because of the number of injuries either at a single point in time or over time. 2.To identify any injuries after a resident sustains an accident or incident. PROCEDURE: 1. Handle resident gently. 2. Examine the entire skin surface. 3. Interview the resident to determine cause of any conditions identified and document response. Interview to include questions: a. Did anyone harm you? b. Do you feel safe? 4. Interview any witnesses to determine cause of any condition identified. 5. Measure vital signs. 6. Assess pain. 7. Identify and document all skin discolorations, redness, swelling, edema, tenderness, breaks, or change in temperature. Measure the size, depth, color and location of any skin conditions identified. 8. Gently perform passive and active range of motion for all joints. 9. Assess any change in mental and cognitive status through observation and interview of the resident. 10. Observe and assess all neurological signs. 11. Notify the resident's attending physician of a change of condition or any concerns that have been identified. 12. Notify the resident's representative of a change of condition or any concerns that have been identified. 13. Implement daily wound care/monitoring until healed and preventative interventions as appropriate. Requested non pressure skin policy and was not received.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review, the facility failed to ensure medications were administered according to physician order for 1 of 1 residents (R5) reviewed for medication errors. Findings include: Syndrome of inappropriate antidiuretic hormone (SIADH)-a condition that occurs when the body produces too much antidiuretic hormone (ADH), also known as vasopressin. ADH is a hormone that helps the kidneys regulate water loss through urine. When there's too much ADH, the body retains water and electrolytes like sodium in the blood fall. A normal blood sodium level is between 135 and 145 milliequivalents per liter (mEq/L). A sodium level below 135 mEq/L is called hyponatremia, or low blood sodium. Severe hyponatremia, defined as serum sodium below 120 mEq/L. R5's quarterly Minimum Data Set (MDS) dated [DATE], identified R5's cognition was intact and had diagnoses of chronic kidney disease stage 2 (mild damage), hypoosmolality (a fluid and electrolyte disorder that can occur when there is a loss of sodium or retention of water), and hyponatremia (low blood sodium). R5's Lab results dated 10/4/24, identified R5's sodium levels were 126. Start sodium chloride tablet give 1 gram each morning with AM meal for hyponatremia. R5's Lab results dated 11/21/24, identified R5's sodium level was 126, increase sodium chloride tablet give 1 gram twice a day with meals for hyponatremia. R5's Lab results dated 12/6/24, identified R5's sodium level was 123, continue sodium chloride tablets and fluid restriction. New orders to decrease Seroquel from 50 mg to 25 mg due to low risk of hyponatremia and urinalysis test. Encourage regular oral intake with small meals. Beverages with electrolytes preferred over regular water every shift for low sodium and If R1 developed an acute headache or change in mental status arrange for transport to ER every shift for low sodium. Repeat labs on 12/9/24. R5's Lab results dated 12/10/24, at 2:53 p.m., identified R5's sodium level was 125, awaiting urine results for additional assessment of hyponatremia. Continue on low dose Seroquel, current sodium tablets, and current fluid restrictions. Recheck sodium level on 12/12/24. R5's Lab results dated 12/10/24, at 3:53 p.m., identified urine studies were reviewed and now pursuing treatment for SIADH. Recheck sodium on 12/12/24 if sodium level does not improve may think about discontinuing Seroquel. R5's Lab results dated 12/12/24, identified R5's sodium level was 126, continue current management and recheck sodium in one week. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's progress note dated 12/19/24, identified per MD, due to todays labs send R5 to ED for management. At 4:33 p.m., R5's POA was notified of provider request to send to ED due to lab results. At 4:40 p.m., R5's paperwork was sent with to ED. R5's After Visit Summary (AVS), dated 12/19/24 to 12/24/24, identified R5 was admitted for acute on chronic asymptomatic hyponatremia with admitting sodium level of 115. At the ED, R5 was hemodynamically stable with initial labs demonstrating hyponatremia with sodium of 117 and low serum osmolality at 241. R5 received 1 liter normal saline which improved her sodium to 119 and was admitted to Medicine. R5's sodium gently increased over several days with the addition of urea and increasing her home salt tablet regimen to three times a day. Prior to discharge, her serum sodium improved to 130 on 12/23/24. She was stable for discharge but would require close monitoring in the outpatient setting. Discharge orders included to increase sodium chloride 1 gram tablet from two tabs daily to three tabs daily and Urea (medication used to treat low levels of sodium in the blood) 15-gram packet by mouth every evening, last given 12/23/24 at 5:57 p.m. R5's hospital discharge summary, dated 12/24/24, identified R5 was diagnosed with chronic hyponatremia secondary to SIADH and poor intake. Continue close monitoring of sodium, salt tablets increased to three times a day and Urea once daily. R5's order summary dated 12/24/24, identified R5 had an order for Urea Oral Packet to give 15 grams by mouth in the evening related to hypo-osmolality and hyponatremia and Sodium Chloride Oral Tablet to give 1 gram by mouth three times a day for hyponatremia take with meals. May administer whole in applesauce or crush per her preference. R5's medication administration record (MAR) dated December 2024, identified on 12/24/24 and 12/25/24, a 9 was documented and indicated other, see progress notes. R5's progress note dated 12/24/24 at 2:13 p.m., identified R5 returned from the hospital. At 4:17 p.m. identified Urea oral packet not received form the pharmacy. R5's progress note dated 12/25/24 at 4:33 p.m., identified Urea oral packet not received form the pharmacy. Review of R5's medical record does not identify if POA or physician was notified of omitted doses of Urea on 12/24/24 and 12/25/24. R5's nurse practioner (NP) visit dated 12/26/24, identified R5 was hospitalized from 12/19/24 to 12/24/24, for hyponatremia and COVID-19 illness. R5 was discharged with fluid restriction of 2 Liters, sodium tablets three times a day and urea. Just prior to my visit today, nursing reported that R5 did not receive Urea, it was going to be here today and R5 should receive a dose as soon as it is available. R5's progress note dated 12/26/24 at 10:34 p.m., identified R5's POA had concerns about a medication that we did not have on hand. POA had talked with facility nurse and told her that she wanted to make sure that medication had arrived at facility by having writer return a call when medication had arrived. Writer received medication on delivery run and writer dispensed medication to R5. R5 took medication powder mixed with four ounces of water and there were no complications noted. Writer called POA to inform her that medication had arrived and R5 took medication with no issues. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's progress note dated 12/27/24, identified R5 and POA were notified of sodium level of 133. During an interview on 12/31/24 at 8:24 a.m., licensed practical nurse (LPN)-A identified she was the nurse manager for R5. LPN-A indicated R5 had missed two doses of Urea and stated no one had called to notify the provider. LPN-A stated she was not aware that anyone filled out a medication error form for this medication error. LPN-A stated when a nurse omits a medication it would be a medication error. LPN-A further stated a paper medication error form would be filled out, the provider would be notified, and the form would go to the DON for review. During an interview on 12/31/24 at 9:24 a.m., registered nurse (RN)-A identified she was a nurse manager. RN-A stated we do not do incident reports in risk management for medication errors, we use the paper medication error form. RN-A indicated she would expect the nurse who did the error to fill out the form and turn it in to the DON. RN-A stated we do not typically call family members with medication errors or notify the pharmacist. RN-A indicated they used to talk about medication errors at their morning stand up meetings but thought it had gotten lost in the process. During an interview on 12/31/24 at 10:24 a.m., consultant pharmacist (CP)-A stated R5's baseline sodium levels have been running between 125 to 128. Urea is not very common to be given, usually to get sodium levels up you would start with fluid restriction and sodium chloride tablets, then the Urea. CP-A stated with a medication error the provider should be notified for further direction. During an observation on 12/31/24 at 10:52 a.m., R5 was seated in her recliner in her room. R5 declined an interview and stated the doctor here does a good job taking care of her. During an interview on 12/31/24 at 10:57 a.m., RN-B stated an omitted dose of medication would be a medication error and the paper medication error form would need to be filled out and given to the DON. During an interview on 12/31/24 at 11:45 a.m., medical director (MD)-A stated R5 had a diagnoses of SIADH which causes her body to retain too much water which can lead to low sodium levels. R5's baseline sodium levels were between 125-128, she got COVID on 12/14/24 and her sodium tanked to 115 which was a critical lab and why she was sent to the hospital. MD-A stated R5 will need continued monitoring of her chronic hyponatremia. MD-A further stated if medication doses are omitted it would be a medication error and a provider should be notified for further direction. Facility policy, Significant Medication Error, revised 11/1/24, identified POLICY: It is the policy of Fairview Care Center to assure that residents are free from any significant medication errors . 1. Medication errors will be reviewed daily with all Facility Incidents . Facility policy does not identify types of medication errors such as omission of medications as medication errors, the 5 rights of medication administration, or what the process the facility should follow for a medication error is. This should include notification to the medical provider and family.