

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245451	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/24/2025
NAME OF PROVIDER OR SUPPLIER Fairway View Neighborhoods		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Mark Drive Ortonville, MN 56278	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review, the facility failed to ensure 1 of 1 resident (R1) was free from neglect when R1 had a fall, intentionally not reported by staff, which delayed necessary medical care for two hours. This resulted in an immediate jeopardy (IJ) for R1 when, as a result of the fall, she was treated at the emergency department (ED) where she was diagnosed with a laceration to her forehead, an abrasion, bruising, concussion and a fracture of the sternum. The IJ began on 12/15/25 at 7 p.m., when nurse aide (NA)-A transferred R1 alone (care plan directs assist of two) and R1 fell off the edge of the bed which resulted in bleeding laceration on her forehead and NA-A intentionally did not report the fall or seek appropriate medical care until two hours later. The administrator, director of nursing (DON), and primary care provider medical doctor (MD) were notified of the IJ on 12/23/25 at 4:30 p.m. The facility implemented corrective action by 12/18/25, prior to the start of the survey, and therefore is issued as past non-compliance. Findings include: R1's significant change Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition, with disorganized and incoherent thinking (rambling, unclear, illogical flow of ideas, or irrelevant conversation) altered level of consciousness, and long and short-term memory loss. She was dependent (required assistance of two or more staff to complete) personal hygiene, bathing/shower, sit to stand, all transfers, and used a manual wheelchair for mobility. Her medical diagnoses included Alzheimer's Disease, dementia, and anxiety. Since admission she had two falls without injury and one with injury (except major). R1's Face Sheet identified diagnoses history of falling and transient ischemic attack (TIA) (stroke)/cerebral infarction (area of necrotic (death of) tissue in the brain due to disrupted blood supply), and osteoporosis (caused bones to become weak and brittle.) R1's care plan dated 11/5/25, identified R1 had difficulty understanding others due to dementia. Staff were directed to speak clearly, repeat phrases as needed, and ask simple yes or no questions. She required 24-hour supervision and care which placed her at a greater risk for abuse and neglect. She had altered ability to care for herself due to cognition, unable to walk, dependent upon staff for all transfers, and may use EZ stand as needed with a medium sling. She was at risk for falls due history of falls, staff were directed to give verbal reminders not to ambulate, transfer without assistance, bed in lowest position, observe frequently and place in supervised area when out of bed, pressure sensor when in bed to alert staff when trying to get out of bed, and call light within reach always. She had impaired decision making due to dementia and staff were directed to provide cues, supervision, determine if decisions made by her endangered herself or others and intervene if necessary. On 12/18/25, R1's care plan was updated to include stand pivot transfer (SPT) with assist of two if alert, Hoyer lift, and assist of two with medium sling. Physical therapy (PT) evaluation and plan of treatment dated 10/27/25, identified referral was made due to change in cognition and mobility status. Staff reported hard to transfer with assist of one to two with pivot transfers due to resident unable to understand completion of task. Staff reported the use of EZ stand had been difficult due to resident unsure of the task and hard to explain to her. She was identified as high risk for falls due to cognitive status and unable to follow cueing for safety. Clinical impression of evaluation: a cognitive decline was identified, a hard time with constant movement and conversation causing limitations in orientation to task. She was able to complete the SPT from wheelchair to chair with moderate assistance but attempted to sit in the middle of transfer and required maximum assistance to reposition. EZ stand transfer was completed and required assist of two throughout to attend to task, keep safely of extremities, and allow for best maneuver of transfer. PT discussed with staff on this date, will maintain SPT and EZ stand, with discussion on addition of Hoyer as needed in upcoming sessions. R1's order start date 10/27/25 through 12/18/25, listed under activities of daily living (ADL) flow sheet, identified activity as tolerated; SPT assist of two or EZ stand transfer with assist of two per patient cognition and ability to follow cues (this had not been added to R1's care plan). R1's order start date 12/18/25, listed under ADLs flow sheet, identified activity as tolerated; stand pivot transfer with assist of two if alert. Hoyer lift due to fracture and medium sling. R1's fall risk assessment dated [DATE], identified intermittent confusion, poor recall judgment, and safety awareness. R1 had balance problems with standing, impaired mobility, and required the use of wheelchair. Fall risk score was 18 (16-20 had high likelihood of a fall occurring) and indicated high risk for falls. R1's progress notes from 12/15/25, through 12/19/25, identified: -On 12/16/25 12:19 a.m., nurse was called to R1's room at about 9:00 p.m. (12/15/25) She had a hematoma and discoloration on right side of face around eyebrow large</p>		