

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 07/10/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905</p> <p>Based on observation, interview and document review, the facility failed to provide assistance with routine grooming cares which included facial hair removal for 1 of 1 residents (R14) reviewed for activities of daily living (ADLs) who required assistance with grooming and personal hygiene.</p> <p>Findings include:</p> <p>R14's significant change Minimum Data Set (MDS) dated [DATE], identified R14 had moderate cognitive impairment and diagnoses which included: Alzheimer's disease, arthritis and hypertension. Indicated R14 required partial/moderate assistance for personal hygiene and dressing. R14 required maximum assistance with bathing. Identified R14 had physical and verbal behavior symptoms one to three days and did not exhibit rejection of cares.</p> <p>R14's care plan revised 6/18/24, identified R14 required assistance with ADLs related to Alzheimer's disease. R14's care plan approaches identified R14 required extensive assistance with bathing and dressing. In addition, R14 required cueing, set up and extensive assistance with grooming, which included brushing teeth and combing hair. R14's care plan lacked an approach for facial hair removal.</p> <p>During an observation on 7/8/24 at 12:28 p.m., R14 was seated in her recliner in her room. R14 had six to eight white facial hairs eight to twelve millimeter (mm) long on the front of her chin, and three to four white facial hairs above and beside her lips.</p> <p>During a telephone interview on 7/8/24 at 3:06 a.m., family member (FM)-A indicated it bothered her that R14 would have facial hair present and expected staff to assist with removing it. FM-A stated she was unaware if it bothered R14.</p> <p>During an observation on 7/9/24 at 8:45 a.m., R14 was dressed in street clothes and seated in her recliner in her room. R14 continued to have six to eight white facial hairs eight to twelve mm long on the front of her chin and three to four white facial hairs above and beside her lips.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on 7/9/24 at 9:36 a.m., nursing assistant (NA)-B stated her usual practice was to remove facial hair when observed. NA-B indicated she was aware R14 had long facial hairs on her chin. NA-B indicated R14's pen razor quit working a couple of weeks ago and her family was going to order one however, was unsure if R14 had a new one yet. NA-B stated it depended on R14's mood when they would assist R14 with cares and if needed, would leave her alone then re-approach later to complete cares. At 9:50 a.m. NA-B knocked and entered R14's room and located R14's razor in R14's drawer in her bathroom. NA-B asked R14 if she could shave her and R14 agreed. NA-B then removed R14's facial hair with the electric pen razor without difficulty and confirmed R14 had multiple facial hairs present that she had removed.</p> <p>During an interview on 7/9/24 at 10:09 a.m., registered nurse (RN)-B stated the nursing staff were expected to assist residents with facial hair removal if they were agreeable to it. RN-B indicated she was aware R14 had facial hairs present that morning and had planned to go back and shave R14 later that day. RN-B confirmed it appeared R14's facial hairs had been present more than a couple of days. RN-B stated R14 usually agreed to having her facial hair removed however, if she did refuse, staff would just re-approach her at another time. RN-B indicated it was important to assist R14 to remove facial hair as that was a dignity issue and could have been embarrassing to her.</p> <p>During an interview on 7/9/24 at 11:57 a.m., neighborhood nurse leader RN-C confirmed R14 required assistance with ADLs. RN-C indicated her expectation was staff would assist residents to remove facial hair and it was important to do so to promote dignity. RN-C stated R14 refused cares at times however, expected staff to re-approach R14 if refused.</p> <p>During an interview on 7/9/24 at 4:38 p.m., director of nursing (DON) indicated it was her expectation nursing staff removed facial hair for residents if they were agreeable. DON confirmed her expectation was if a resident refused to allow staff to remove the facial hair, the nursing staff would re-approach, and if continued to refuse to report to the nurse who would document in the progress notes. DON indicated if the resident continued to refuse, she would expect it would have been care planned. DON stated it was important to assist residents to remove facial hair for dignity purposes.</p> <p>The facility policy titled Shaving The Resident revised 3/14/24, identified the purpose was to promote cleanliness and to provide skin care. The policy instructed staff to notify the supervisor if the resident refused the procedure.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583</p> <p>Based on observation, interview and document interview, the facility failed to conduct an accurate and timely smoking assessment for 1 of 1 residents (R16) who currently smoked.</p> <p>Findings include:</p> <p>R16's admission Minimum Data Set (MDS) dated [DATE], indicated R16 was cognitively intact and was independent with mobility, transfers, toileting, and required limited assistance with dressing. Identified R16 had hypertension (high blood pressure), arthritis and a wound infection.</p> <p>R16's care plan updated 7/8/24, indicated R16 was a current smoker and was at risk for injury related to smoking. Identified R16 demonstrated safety with smoking and disposed cigarette butts in the appropriate designated location.</p> <p>R16's initial smoking assessment dated [DATE], was completed by therapy staff and indicated R16 was a safe smoker, was able to get to/from smoking location and demonstrated safe use/disposal of cigarette butts.</p> <p>During an observation and interview on 7/8/24 at 2:53 p.m., R16 indicated it was hard to go from the building to the smoking area and R16 was unable to get down the lip of the driveway to the road where R16 was supposed to be smoking. R16 revealed she was unable to reach the smoking butt receptacle so she placed her cigarette butts in her right pants' pocket and would dispose of them in the trash in her room. R16 smoked one cigarette, put the cigarette out on the right metal arm of her wheelchair and put the cigarette butt in her pocket. R16 obtained another cigarette and repeated the process. R16 obtained the third cigarette and repeated the process.</p> <p>During a continuous observation on 7/8/24:</p> <p>-6:29 p.m., R16 was seated in her wheelchair at the corner of the parking lot leading to the road. R16 put her cigarette out on the right metal arm of her wheelchair and placed the cigarette butt in her right pants' pocket.</p> <p>-6:39 p.m., R16 obtained another cigarette, lit and smoked it, put it out on the right metal arm of her wheelchair, twisted the end of the cigarette and placed the cigarette butt in her right pants' pocket.</p> <p>-6:48 p.m., R16 obtained the third cigarette, lit and smoked it, put her cigarette out on the right metal arm of her wheelchair, twisted the end of the cigarette and placed the cigarette butt in her right pants' pocket.</p> <p>During an observation on 7/8/24 at 6:56 p.m., R16 was seated in her wheelchair at the corner of the parking lot leading to the road. R16 put her cigarette out on the right metal arm of her wheelchair, twisted the butt of her cigarette and placed the cigarette butt in her right pants' pocket.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/10/24 at 7:04 a.m., R16 stated it would be easier if the facility moved the cigarette butt receptacle closer to the end of the driveway so R16 could throw her cigarette butts away outside. R16 confirmed she placed her cigarette butts in her right pants pocket and threw them away in the trash in her room when she went back into the facility. R16 indicated she did not even try to dispose of her cigarette butts in the receptacle since she was not able to reach it from where she sat.</p> <p>During an interview on 7/10/24 at 9:53 a.m., physical therapy assistant (PTA) indicated R16 was discharged from physical therapy (PT) on 7/5/24, as she met her goal of becoming independent. PTA stated PT was working with R16 and PT would occasionally go outside with R16 to smoke. PTA stated R16 never mentioned she was not able to get to the cigarette butt receptacle and PT never saw R16 place cigarette butts in her right pants pocket.</p> <p>During an interview on 7/10/24 at 11:29 a.m., registered nurse (RN)-D revealed R16 was admitted [DATE], and a smoking assessment was not completed upon admission. RN-D stated R16's smoking assessment was not completed until 7/8/24. RN-D indicated she was not aware R16 was putting her cigarettes out on the right metal arm of her wheelchair and placing them in her pocket to dispose of them in the facility. In addition, RN-D stated she was not aware R16 could not reach the cigarette receptacle to properly dispose of her cigarette butts.</p> <p>During an interview on 7/10/24 at 11:47 a.m., director of nursing (DON) indicated she was not aware a smoking assessment had not been completed on R16 upon admission. DON stated she was not aware R16 could not reach the cigarette butt receptacle and was placing her cigarette butts in her right pants' pocket to dispose of them in the facility. DON stated her expectations were if staff knew a resident smoked upon admission, a smoking assessment should have been completed at that time.</p> <p>Facility Policy titled Smoking Policy revised 2/14/24, if a resident strongly felt smoking added to their quality of life they would be allowed to continue to smoke. They must be assessed for safety upon admission, annually, or after a significant change.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844</p> <p>Based on observation, interview and document review, the facility failed to ensure proper hand hygiene during a medication pass for 3 of 7 (residents R44, R15, R48) observed for medication administration and during personal cares for 1 of 4 residents (R45) observed for captivities of daily living (ADL's). In addition, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices and to ensure PPE was readily available for use to prevent the spread of infection for 1 of 5 residents (R16) observed for enhanced barrier precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities).</p> <p>Findings include:</p> <p>HAND HYGIENE/MEDICATION PASS</p> <p>R44's quarterly Minimum Data Set (MDS) dated [DATE], identified R44 had intact cognition and diagnosis which included: hypertension (elevated blood pressure) Diabetes and glaucoma. Identified R44 required limited assistance with activities of daily living (ADL's) which included bed mobility, transfers, and personal hygiene.</p> <p>R44's care plan dated 11/13/23, identified R44 required limited assistance with ADL's. R44's care plan lacked an approach for medication administration.</p> <p>R15's significant change MDS dated [DATE], identified R15 had intact cognition and diagnosis which included anemia (a condition in which blood doesn't have enough healthy red blood cells and hemoglobin) Atrial fibrillation (rapid heart rate that causes poor blood flow), and Alzheimer's Disease. Identified R15 required limited assistance with ADL's which included bed mobility, transfers, and personal hygiene.</p> <p>R15's care plan dated 5/19/24, identified R15 required limited assistance and a walker for ambulation related to her cognition.</p> <p>R48's significant change MDS dated [DATE], identified R48 had intact cognition and diagnosis which included hypertension (elevated blood pressure) hyperlipidemia (elevated cholesterol) and Alzheimer's Disease. Identified R48 required limited assistance with ADL's which included bed mobility, transfers and personal hygiene.</p> <p>R48's care plan dated 5/18/24 identified R48 required limited assistance with ADL's. R48's care plan lacked interventions for medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 7/8/24 at 5:21 p.m., trained medication aide (TMA)-A entered R44's room with Timoptic (Eye drops used to treat elevated pressure in the eyes) eye drops in her hand. R44 was seated in her recliner and TMA-A proceeded to place gloves on both hands and while touching R44's face used her left hand to pull down on each of R44's eye lids as she administered the eye drop to each eye with her right hand. TMA-A removed her gloves and proceeded to dish up medications for R15. TMA-A administered R15's medications and then handed R15 her water pitcher. TMA-A proceeded to place a transfer belt around R15's waist and walked with her to supper. TMA-A removed the transfer belt from R15 and pushed R15's wheelchair up to the table. TMA-A proceeded to dish up medications for R48. TMA-A placed gloves on both hands and broke one of R48's medications in half and administered medications to R48 after obtaining a bottle out of R48's fridge and handing it to R44 to take her medications with. TMA-A wheeled R48 in her wheelchair to the dining room. At no time during the above observation had TMA-A performed hand hygiene.</p> <p>During an interview on 7/8/24 at 5:41 p.m., TMA-A confirmed the above observation and that she had not performed hand hygiene. TMA-A stated she should have performed hand hygiene after administering R44's eye drops and before assisting any other residents. TMA-A stated hand hygiene was important to reduce the spread of infection.</p> <p>48583</p> <p>EBP</p> <p>Centers for Disease Control and Prevention (CDC) guidelines dated 4/2/24, PPE use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs). Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities was indicated for nursing home residents with wound and/or indwelling medical devices regardless of MDRO colonization.</p> <p>Resident roster dated 7/9/24, lacked identification of R16 being on EBP.</p> <p>R16's admission MDS dated [DATE], indicated R16 was cognitively intact and was independent with mobility, transfers, toileting and required limited assistance with dressing. Identified R16 had hypertension (high blood pressure), arthritis, a wound infection, and a peripherally inserted central catheter (PICC).</p> <p>R16's care plan dated 7/8/24, indicated R16 was to receive intravenous (IV) antibiotics for an infection. R16's care plan lacked documentation R16 was on EBP.</p> <p>R16's provider progress notes dated 7/8/24, indicated R16 was in the nursing home due to an unexpected discovery of pyogenic arthritis when she received a hip replacement. R16 had required IV antibiotics and consultation with infectious disease.</p> <p>R16's treatment administration history dated 6/7/24 to 7/10/24, indicated R16 was to receive Ceftriaxone (antibiotic) one gram via IV route one time daily, change PICC caps every three days, measure arm circumference daily, PICC line dressing change every week, flush both PICC ports with 10 milliliters (ml) daily, and Vancomycin (antibiotic) 1000 milligrams (mg) via IV route one time daily.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 7/9/24 at 8:40 a.m., R16 was seated in her wheelchair in her room working on her computer. Registered nurse (RN)-E gathered supplies to administer R16's Vancomycin one gram in 200 ml solution via IV. RN-E washed her hands, applied gloves, opened an alcohol wipe, removed current IV tubing and cleansed the IV hub. RN-E flushed the port with 10 ml normal saline (NS). RN-E left the syringe hooked to the port while she opened the antibiotic and spiked the bag. RN-E primed the tubing, placed the tubing into the IV pump, removed the syringe, cleansed the hub with alcohol, attached the tubing to the port and programmed the pump. IV antibiotics began running. RN-E removed her gloves and washed her hands. RN-E was not observed to be wearing a gown as indicated for EBP. There was no signage present on the door identifying R16 was on EBP. In addition, there was no PPE available inside or outside the room for EBP.</p> <p>During an observation on 7/09/24 at 2:24 p.m., there continued to be no EBP PPE inside or outside R16's room. Additionally, there continued to be no signage indicating R16 was on EBP.</p> <p>During an interview on 7/10/24 at 7:04 a.m., R16 revealed staff only wore gloves when they were assisting her. R16 indicated staff had never worn a gown or any additional PPE when assisting R16.</p> <p>During an interview on 7/10/24 at 11:29 a.m., registered nurse (RN)-D confirmed R16 was to be on EBP and was not aware R16 did not have any PPE inside or outside of R16's room.</p> <p>48740</p> <p>HAND HYGIENE</p> <p>R45's admission MDS dated [DATE], identified R45 had mildly impaired cognition and was diagnosed with hypertension, dementia, and osteoporosis. R45 needed moderate assistance with transferring on and off the toilet, maximal assistance with perineal hygiene, moderate aid with dressing, and substantial assistance with personal hygiene.</p> <p>During an observation on 7/10/24 at 8:09 a.m., NA-A sanitized hands, and applied gloves. NA-A had R45 sit on the toilet. NA-A removed pajamas and brief. NA-A placed the brief in the garbage and applied a clean brief and pants while R25 was seated on the toilet. NA-A had R45 stand up and used a wet washcloth with soap and provided perineal hygiene using a circular wiping motion from front to back. NA-A took a moist washcloth without soap and washed R45's perineal area from front to back. NA-A took a dry towel and dried R45's perineal area from front to back. NA-A assisted R45 to a standing position, pulled up R45's briefs and pants. NA-A removed gloves and asked R45 to walk to the sink. NA-A combed R45's hair and assisted R45 with applying toothpaste to the toothbrush. NA-A asked R45 to sit in the wheelchair, wheeled R45 out of the room. At that time, NA-A used hand sanitizer that was located outside of the door and brought R45 to the dining room.</p> <p>During an interview on 7/10/24 at 8:25 a.m., NA-A verified she did not remove gloves between handing the soiled brief and the clean brief. NA-A verified hands were not sanitized between perineal care and oral hygiene care. NA-A verified not removing gloves and sanitizing hands could lead to cross-contamination.</p> <p>During an interview on 7/10/24 at 8:26 a.m., registered nurse RN-A stated her expectation would be for staff to change gloves after perineal care to prevent cross-contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/10/24 at 11:00 a.m., infection preventionist (IP) stated hand hygiene was important after removing gloves to prevent the spread of infection. IP stated her expectation was that staff always performed hand hygiene after removing gloves. In addition, IP stated staff were expected to remove gloves, perform hand hygiene and apply clean gloves after performing perineal cares to prevent cross-contamination.</p> <p>During an interview on 7/10/24 at 11:05 a.m., IP indicated the facility implemented the EBP process in April 2024, and confirmed R16 should have been on EBP due to wound care and a PICC in place. IP stated staff were educated last week about R16 being on EBP. IP indicated she was not aware R16 did not have any PPE inside or outside of R16's room. IP stated she would expect staff to follow EBP guidelines when they completed high-contact care with residents who were in EBP.</p> <p>During an interview on 7/10/24 at 11:14 a.m., director of nursing (DON) stated her expectation would be for staff to change gloves after removing dirty briefs and to change gloves after perineal care. DON stated she would have expected staff to perform hand hygiene before oral cares and hair care were completed to prevent cross-contamination.</p> <p>During an interview on 7/10/24 at 11:32 a.m., DON stated her expectation was staff would have washed their hands after removing gloves and before assisting any other residents.</p> <p>During an interview on 7/10/24 at 11:43 a.m., DON confirmed the above findings and stated her expectations were staff were to follow the EBP guidelines. DON stated staff were to have gowns/gloves on and were to sanitize/wash their hands before and after cares.</p> <p>Facility policy titled Wound Care revised date 3/14/24, the following equipment and supplies would be necessary when performing this procedure: personal protective equipment (e.g. gowns, gloves, mask, etc., as needed).</p> <p>Facility policy titled Enhance Barrier Protection revised 4/19/24, Fairway View - Long Term Care to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms. An order would be obtained for residents with any of the following: wounds and/or indwelling medical devices including central lines. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. High contact care activities include: device care or use and wound care.</p> <p>Requested a policy on PICC care and dressing change, however one was not provided.</p> <p>A policy titled Hand Hygiene-Ortonville dated 2/13/24 revealed when to perform hand hygiene moving from contaminated body site to clean body site during patient care, after removing gloves. Change gloves when moving from a dirty to a clean site during patient care and perform hand hygiene after glove removal.</p>