STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245333	A. BUILDING _____ B. WING _____	03/05/2020

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

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)
E 0041 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Implement emergency and standby power systems.** Based on the fire marshals record review and staff interview, the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 Section 8.3.4 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of 26 of 26 residents and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: During the documentation review and interview between 9:00 am to 1:00 p.m. on [DATE], documentation review revealed, monthly generator logs were not filled in correctly. This deficient condition was confirmed by the Environmental Service Director.
F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on observation, interview, and document review, the facility failed to act to ensure resident concerns identified at resident council meetings were addressed in a timely manner. This had the potential to affect any of the seven residents (R3, R12, R7, R9, R4, R14, R13) identified to have attended the meetings where dim lighting in the dining room was discussed. Findings include: During observation of dining on 3/2/20, at 5:41 p.m., surveyor noted dim lighting in the dining area. The dining area had vaulted ceilings with pendant light fixtures of white globes of various sizes. It was noted that one light was out, one light was dim and cast a yellowish hue, and lights in other globes were not very bright. Review of the past 12 months of resident council minutes, from March 2019 through February 2020, indicated for months of September and October 2019, dim lighting in the dining room was raised as a concern. The meetings minutes indicated the council meetings were facilitated by the activities director (AD)-A who also wrote the minutes. Resident council meeting minutes from 9/26/19, and attended by R3, R12, R7, R9 and R4 indicated: --Old business: lights in lobby and dining room still out. --Suggestions or Concerns: listed under maintenance was lights still out in DR (dining room) by kitchen and over by birds. --No Resident Council Departmental Response Form was completed for this concern as was for other concerns identified that month. This form idenfied the specific resident council issue; was given to the appropriate department who would follow up in writing to the resident council with an explanation, response or action taken. Resident council meeting minutes from 10/2[DATE]9, and attended by R12, R14, R7, R9, R13 and R4 indicated: --Old business: lights are still out -- will check with environmental supervisor (ES)-A. --No Resident Council Departmental Response Form was completed for this concern as was for other concerns identified in other meeting minutes. During resident council interview on 3/3/20, at 11:17 a.m. attendees (R4, R7, R14, R20 and R17) talked about the burnt out bulbs/lights in the dining room. According to R4 they talk about replacing them, but it hasn't happened. R4 stated this concern had been raised several times in the past and stated the lights are very dim in the dining room and some of the bulbs are still out.have been for a while. During interview on 3/5/20, at 8:49 a.m. AD-A stated she facilitates resident council meetings and takes minutes. Following a meeting, a copy of the resident council minutes is given to the administrator. AD-A stated she reports concerns raised by resident council in person to the appropriate department leader. AD-A indicated department leaders of the facility do not routinely attend resident council meetings except at times as a guest speaker. AD-A reported the burnt out bulbs in the dining room to environmental supervisor ES-A but did not recall when. AD-A stated there was an electrical problem and it was fixed over by the puzzle area. (Puzzle area was observed in the lobby/great room and not dining room). Standing in the dining area, AD-A looked up at the lights and stated, I see that light is out, I was going to mention it to ES-A. During interview on 3/5/20, at 9:25 a.m., when asked about lighting in the dining room, ES-A took surveyor to the lobby/great room and stated the pendant lights in that room was updated to LED bulbs about two months ago and indicated can really see the difference. ES-A further stated they are waiting for the owner to approve replacing bulbs in the dining area. Despite concerns being identified and documented at resident council meetings six and seven months ago, there had been no response back to resident council that any action was being taken regarding their concerns about dim lighting in the dining room.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the current status and needs for 1 of 2 residents (R13) reviewed for hospice, and 1 of 3 residents (R9) reviewed for abuse. Findings include: Review of R13's medical record identified the resident was admitted on hospice care on 1/3/20. The significant change Minimum Data Set (MDS) assessment dated [DATE], identified R13 had a prognosis of 6 months or less to live. The MDS did not identify the resident received hospice care while in the facility. When interviewed on 3/4/20, at 12:20 p.m. the registered nurse MDS coordinator (RN)-B confirmed R13 went on hospice on 1/3/20, and a significant change MDS was completed. RN-B confirmed hospice was not checked on the MDS, and further stated that must have been why it hadn't shown up on the facility matrix. Review of R9's care plan indicated the resident had a WanderGuard elopement bracelet attached to her wheelchair on 3/29/19. The quarterly MDS dated [DATE], section P - Wander guard/elopement alarm documented that a wander guard was not in use. During observation on 3/05/20, at 8:56 a.m. of R9's wheelchair revealed a WanderGuard elopement bracelet attached to the right armrest. On 3/05/20, at 10:56 a.m. the director of nursing stated RN-B will have to correct and resubmit the MDS. It is wrong, R9 has a wander guard on her wheelchair.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a baseline care plan was developed and implemented within 24 hours of admission to address the individualized safety needs for 1 of 2 residents (R19) reviewed for falls. Findings include: R19' Admission Record printed on 3/5/20, indicated [DIAGNOSES REDACTED]. R19's admission minimum date set (MDS) assessment dated [DATE], identified moderate cognitive impairment. Additionally, R19 required extensive assistance with activities of daily living (ADL) and walking, and had difficulty with balance and turning while standing. The facilities Individual Resident Care Plan (initiate within twenty-four hours of admission) form was obtained that was not dated or signed off by nursing staff. The Individual Resident Care Plan,did not identify fall risk or inlcude fall interventions. R19's care plan initiated on 2/7/20, identified high risk for falls due to activity intolerance, impaired

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

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) balance and confusion related to TBI and senile degeneration of the brain. Morse Fall Scale score of 90 (high risk for falls) The interventions initiated on 2/10/20, directed: Anticipate and meet the residents needs, Be sure the resident call light is within reach and encourage the resident to use it for assistance as needed, Ensure the resident is wearing appropriate foot wear when ambulating or moibilizing in wheelchair, Follow facility fall protocol, PT (physical therapy) evaluate and treat as ordered or PRN (as needed), The resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare free light, a working and reachable call light, personal items within reach. An incident note dated 1/30/20, at 12:26 a.m. indicated resident was found sitting on foot rests of wheelchair. The resident stated he did not have any injuries or pain. R19 stated he tried to get up to go to bed, but didn't make it very far. An incident note dated 2/4/20, at 1:37 p.m. indicated a (unknown) nursing assistant walked by R19's room and observed the resident on his knees by recliner and end table. R19 had been lying in bed, got up and fell . R19 stated he crawled to recliner. The resident denied pain but the left elbow was red. An incident note dated 2/4/20, at 8:11 p.m. indicated R19 had put on his call light and when the (unknown) staff member arrived at his room the resident was found on his knees in front of his recliner. The resident denied pain. The resident stated, I thought I could make it by myself but my knees gave out and I crawled the rest of the way. A physician progress notes [REDACTED]. No fall prevention interventions were ordered or identified. The hospital discharge documentation dated 1/24/20, at 12:00 p.m. identified R19 is at high risk for falls and to implement high risk fall prevention interventions. During observation on 3/4/20, at 9:01 a.m R19 was observed walking independently in his room without using his four wheel walker. When the resident saw he was being observed by surveyor, walked to the door, almost completely shut it, and walked to the bathroom. On 3/04/20, at 9:42 a.m. an interview with R19 was attempted but the resident refused and stated, go away. During an interview on 3/4/20, at 9:48 a.m. nursing assistant (NA)-B stated R19's call light is answered quickly because he will get up and he could fall. NA-B stated do two hour rounding on him because he falls when he gets up to go to the bathroom. NA-B indicated R19 is receptive to cares but he won't use his call light. During an interview on 3/4/20, at 12:55 p.m. the director of nursing (DON) stated, I see there isn't a date or signature of when the Individual Resident Care Plan form was completed upon admission to the facility. The DON further indicated the fall care planning assessment wasn't completed. The DON stated don't know what happened here. We had the Morse Fall Risk assessment done but it doesn't have interventions. The facilities Care Planning Interdisciplinary Team policy dated 9/2013, directed the baseline plan of care to meet the residnets immediate needs shall be developed within forty-eight hours of admission.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide adequate supervision, interventions, and update the care plan following unsafe wandering for 1 of 2 residents (R9) reviewed for accidents. Findings include: R9's admission record dated 12/24/18, indicated diagnosis's of dementia with behavioral disturbance (anxiety [MEDICAL CONDITION], agitation, and aggression), [MEDICAL CONDITION] (decreased cognitive reasoning, judgement and decision making), and [MEDICAL CONDITION] (mental confusion and emotional disruption). R9's current care plan updated 7/3/19, indicated R9 was able to ambulate for short distances and uses a four wheel walker. The care plan indicated able to self-propel self in wheelchair. R9 was identified as a wanderer on 3/29/19. She is noted to wander throughout the facility and a WanderGuard alarm was placed on her wheelchair. R9's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified R9 scored 2 of 15 on the brief interview for mental status, indicating severe cogitative impairment and required extensive assistance in activites of daily living(AD). The MDS incorrectly identified for wandering presence/frequency R9 had not shown symptoms of wandering. The facility incident report #241 Elopement dated 2/23/20, at 6:50 a.m. indicated staff were at the 200 Wing unit when they heard a faint WanderGuard alarm sounding. They looked down the 100 Unit hallway and the assisted living - nursing home door was closed. Upon further investigation the staff noticed R9 was missing. A search of Countryview Estates found R9. Key factors in her elopement were identified as impaired memory and wanderer. The facility electronic medical record progress note dated 2/20/20, at 1:35 p.m. by the director of nursing (DON) did not include further interventions for wandering.
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep all essential equipment working safely.** Based on observation, interview and document review, the facility failed to ensure 1 of 2 bathtubs were kept in good repair to prevent injury to residents and cleaned according to manufacturer instructions to prevent infection to residents. This had the potential to affect the 11 residents residing on the [LOC] who used the bathtub and those from the [LOC] who preferred this tub. Findings include: During preparation for resident council interview, minutes from resident council for the past 12 months were reviewed. Minutes dated [DATE], indicated the the [LOC] tub was out of order frequently. The tub on the [LOC] was not a desired alternative. During resident council interview on 3/3/20, at 11:15 a.m. R20 who lived on the [LOC], stated the [LOC] had the better tub. Other residents at the meeting agreed they liked the design of the tub on the [LOC] better. On 3/3/20, at 1:01 p.m. the bathtub on the [LOC] was viewed. The tub was a MasterCare Patient Equipment Incorporated brand; serial number 03, which according to the manufacturer, indicated it was made in 2003. The tub was fiberglass, deep, with a door at the foot of the tub where a chair on rails slides in and out with a resident on it. The seat was a large, white metal seat with a oval hole in the center and small holes on either side. Over this seat was a black foam cushion about 1/2 inch thick. The cushion had a large oval hole in the center and smaller holes on either side that aligned with the holes in the metal seat. The smaller holes had straps that secured the cushion to the metal seat. It was observed that the metal seat had a significant amount of corrosion and rust on the surface. The jagged, corroded metal had the potential to scratch a residents skin due to the rough edges of the oval hole in the metal seat not protected by the cushion. Another black cushion was secured to the backrest of the seat. On the undercarriage of the seat, the left and right railings were noted to be rusty and pitted. During interview on 3/5/20, at 11:44 a.m. tub was reviewed with environmental supervisor (ES)-A who had no comment when the black cushion was lifted to expose the corrosion and rusting on the seat. ES-A stated she ordered the black cushions from the tub manufacturer and was not sure how staff cleaned the tub or the cushions. The manufacturer information for the cushions was reviewed, and included cleaning and disinfecting instructions for the tub. During interview on 3/5/20, at 11:49 a.m. tub was reviewed with the director of nursing (DON). When black cushion was lifted from seat, DON stated hmmmm and stated she was unaware of the condition of the seat. DON stated she had talked to ES-A about replacing the tub recently because they have had trouble with getting the water warm but that had been fixed. DON stated the tub is really old, it would be nice to have a new one. Stated this is the favorite tub of the residents. During interview on 3/5/20, at 1:40 p.m. (NA)-A when asked about the corrosion on the seat, NA-A didn't reply. NA-A stated to clean the tub in between residents, they spray the inside of the tub with a disinfectant, let it sit for 5 or 10 minutes, then rinsed it off with water using the sprayer. When asked if the black cushions were removed for cleaning, NA-A stated they were not, but they were sprayed with disinfectant and rinsed also. This cleaning process did not provide for disinfection of the surface of the metal seat nor all surfaces of the cushions where a residents bare bottom rested. Manufacturer recommendations titled Integrity Bath With Reservoir, System Operation Procedure, dated 12/31/02 indicated: --Cleaning And Disinfecting The Tub and Chair: Turn on BathAire. Return the carrier with the empty chair to the tub. Engage the carrier with the tub. Disengage the chair and roll it inside the tub. Remove the pads from the chair and lay them in the well of the tub. Rinse the chair and insides of the tub down with clean hot water before disinfecting. Close the drain. Grasp the Disinfectant Wand and hold it so the nozzle is pointed inside the tub. Turn the Disinfectant On/Off Valve counter clockwise until fully on. Spray the insides of the tub, all surfaces of the chair and as well as those of the pads. Scrub all areas with the long handled brush provided with the tub. After all areas are thoroughly scrubbed, turn off the Disinfectant On/Off Valve by rotating it in a clockwise direction until it is fully off. --Rinsing The Residual Cleaner Disinfectant Off Of The Tub: Open the drain. After sufficient contact time, use the Shower Wand to rinse thoroughly all areas that were in contact with the disinfectant cleaner. If bathing another patient, dry the chair and pads with a towel. Replace the pads on the chair, return and lock it to the carrier. Disengage the carrier and you are ready to pick up the next resident for bathing. If it is the end of the day and you will not be bathing another individual on your shift, stick the pads to the inside vertical surfaces of the tub to drip dry. Turn off BathAire.