Electronically Delivered

April 19, 2024

Licensee
Fairway View Assisted Living
215 Lundell Avenue
Ortonville, MN 56278

RE: Project Number(s) SL30337015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

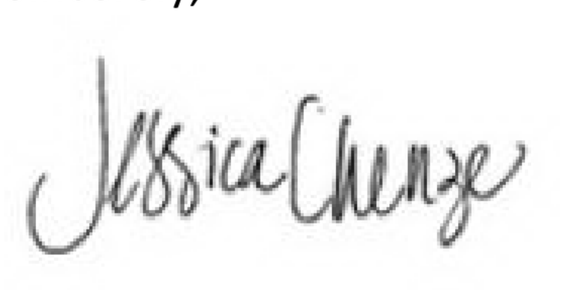
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30337015 On April 1, 2024, through April 3, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 22 residents; all of whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility license, including provisional and renewal	0 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 130	Continued From page 1 applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater and that specifies their relationship with the	0 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 130	Continued From page 2 licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or 1001.201;	0 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 130	Continued From page 3 (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked under a private or state-controlled receivership,	0 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 130	Continued From page 4 or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the licensee only provided assisted living services in the facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 1, 2024, at 10:00 a.m., the surveyor entered the facility and staff directed the surveyor to set up equipment in the community room on the second floor. During the entrance conference on April 1, 2024, at 10:20 a.m., campus director/licensed assisted living director (CD/LALD)-A stated CD/LALD-A was the temporary LALD for the licensee while the other LALD was on leave. On April 1, 2024, from 11:56 a.m. through 12:21 p.m., the surveyor toured the facility with CD/LALD-A and clinical nurse supervisor (CNS)-B. The entrance of the building had two	0 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 130	Continued From page 5 separate glass doors to enter. CD/LALD-A stated the licensee's address was numbered 215 to enter the assisted living building and the "independent" living address was 217. There was a wall separating the assisted living and independent living that went approximately ¾ of the way up to the ceiling and then was open to the ceiling. On the first floor of the assisted living a door was propped open labeled trash room. Upon entering the trash room another door was propped open and led to the independent living side where the nurse's office of the assisted living was located. The second floor of the assisted living facility contained a swinging door to access the independent living side and led to the community room where the surveyor was set up. The assisted living facility had a capacity of 24 residents. There were 22 residents residing on the assisted living side and an unknown number of people residing on the independent side. On April 1, 2024, at 1:15 p.m., unlicensed personnel (ULP)-D stated staff do not provide any services to people living in the independent building. On April 1, 2024, at 1:40 p.m., CNS-B stated the independent living was part of the campus, no services were offered to people that lived there, and the assisted living was not associated with the independent living. On April 2, 2024, at 1:05 p.m., CD/LALD-A stated the assisted living and independent living were connected and could be accessed to either side via the swinging door or through the trash room. On April 3, 2024, at 12:24 p.m., Minnesota Department of Health engineers stated there was	0 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 130	Continued From page 6 not a full fire wall between the independent building and the assisted living building, the swinging door on the second floor was not a fire rated door, and the two doors in the trash room were rated for a one-hour fire barrier. This indicated the assisted living and the independent living building were contained in one structure. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 130		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 480	Continued From page 7 (FBEIR) dated April 1, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents.	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 485	Continued From page 8 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 1, 2024, at 10:28 a.m., campus director/licensed assisted living director (CD/LALD)-A stated the licensee provided residents three meals per day and was written in the contract. On page four, section six: meal plans of the (facility name) Resident Agreement (assisted living contract) indicated you (resident) are not required to select a meal plan to live at the community. The cost of your meal plan, should you select one, is not included in your Monthly Base Fee [sic]. Meal plans are available for additional fees listed on Attachment B. Attachment B listed the following options: -Option 1: Three Meals a Day with snacks for a monthly cost; -Option 2: Second Occupant in Apartment offered three meals per day with snacks for a monthly cost; -Option 3: Modified Textures in addition to option 1 for a monthly cost; and -Option 4: No Meal Plan. Resident assisted living contracts lacked an option for residents to opt out of payment for one or two meals residents would not want.	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 485	Continued From page 9 On April 2, 2024, at 1:16 p.m., clinical nurse supervisor (CNS)-B stated assisted living contracts and attachments were the same for all residents. CNS-B further stated residents were not normally offered to opt out of one or two meal plans. CD/LALD-A stated there was one resident that was offered a reduced meal plan rate who only received one or two meals per day. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas to include posting the 911 emergency number in common areas at the assisted living. This had the potential to affect all residents, staff, and visitors.	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 640	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 1, 2024, from 11:56 a.m. through 12:21 p.m., during the facility tour, the evaluator did not observe 911 emergency number posted in any common areas at the assisted living. On April 1, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated the licensee did not post 911 signage in any common areas of the assisted living and was not aware 911 needed to be posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 650	Continued From page 11 and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for three of three employees (unlicensed personnel (ULP)-E, ULP-D, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 1, 2024, at 10:40 a.m., campus director/licensed assisted living director (CD/LALD)-A stated the licensee was aware of the required contents of employee records.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 650	Continued From page 12 COMPETENCY TRAINING AND TESTING ULP-E was hired on March 12, 2024, to provide direct assisted living services. On April 2, 2024, at 9:57 a.m., the surveyor observed ULP-E put on R6's Farrow Wraps (to treat lymphedema-swelling) to both lower extremities. ULP-E stated ULP-E was trained and competency tested by clinical nurse supervisor (CNS)-B on how to apply R6's Farrow Wraps. ULP-E's record lacked training and a competency evaluation for Farrow Wraps. On April 3, 2024, at 12:45 p.m., CNS-B stated CNS-B completed training and competency evaluations for R6's Farrow Wraps for all ULPs, however, did not document the training or competency evaluations in the employee's records. UNPLANNED TIME AWAY ULP-D was hired December 14, 2023, to provide direct assisted living services. On April 1, 2024, at 1:15 p.m., ULP-D stated CNS-B provided ULP-D's training and competency testing on medication administration. On April 2, 2024, at 7:02 a.m., the surveyor observed ULP-D provide scheduled morning medication to R4. ULP-D's record lacked training and competency testing for resident's unplanned time away. ON April 2, 2024, at 1:36 p.m., CNS-B stated unplanned time away training and competency testing is covered with medication administration, however, was unable to locate the	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 650	Continued From page 13 documentation. ORIENTATION TO ASSISTED LIVING ULP-C was hired as temporary agency staff on February 19, 2024, to provide direct assisted living services. ULP-C's record lacked the following required orientation content: -overview of 144G; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -consumer advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On April 2, 2024, at 2:24 p.m., CNS-B stated ULP-C was trained upon hire for orientation to assisted living, however, CNS-B was unable to locate the orientation sheet for ULP-C. The licensee's Personnel Records policy dated February 19, 2021, indicated personnel records will include record of all required training for ULPs, competency determinations, and home care orientation [sic]. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 810	Continued From page 14	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 810	Continued From page 15 Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During an interview on April 03, 2024, at 12:05 p.m., campus director/licensed assisted living director (CD/LALD)-A and safety officer (SO)-G provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the facility fire safety plan did not provide complete actions for employees and residents to take in the event of a fire or similar emergency. This plan also lacked the complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement of evacuation. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed evacuation drills	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 810	Continued From page 16 being done on a quarterly basis. CD/LALD-A and SO-G verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 970	Continued From page 17 The findings include: During the entrance conference on April 1, 2024, at 10:50 a.m., the surveyor asked for a copy of the licensee's assisted living contract. The assisted living contract was provided and later reviewed by the surveyor. The (facility name) Resident Agreement (assisted living contract) included a clause that resident would waive the facility's liability for health, safety, or personal property of the resident. Page 11, section 30: Miscellaneous Provisions. A. Liability: Your Personal Property: No Liability of (facility name). We (licensee) have no responsibility to you or ...for any personal property placed on the premises by you or the owner of such personal property. We (licensee) are not responsible to you ... for loss of any personal property by theft or any other cause. No Liability of (facility name) for Losses or Damages. You (resident) acknowledge familiarity with the apartment, the premises and services of (facility name) and therefore are willing to assume all risks associated with occupancy [sic]. You (resident) further acknowledge that we (licensee) are not an insurer of your safety. (Facility name), its employees, and its agents are not liable to You [sic] (resident) or to any other person for any loss or inconvenience of any kind, including personal injuries sustained by You [sic] (resident) or any other person, or any loss or damage to property, unless directly caused by Us (licensee) as a result of intentional or negligent acts in violation of applicable standards of care. We (licensee) are not responsible for the actions of, or for any damages, injury or harm caused by, third parties (such as residents, guests, intruders, or trespassers) who are not under our control [sic].	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
0 970	Continued From page 18 On April 2, 2024, at 1:13 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided the same assisted living contract to all residents and a waiver of liability was written in the assisted living contract. CNS-B further stated the licensee was not aware a waiver of liability could not be included in a resident contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter with the correct affiliation healthcare facility	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01290	Continued From page 19 identification number (HFID) for the assisted living facility for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 1, 2024, at 10:40 a.m., campus director/licensed assisted living director (CD/LALD)-A stated the licensee was aware of the required content for an employee record. ULP-D was hired December 14, 2023, to provide assisted living services. On April 2, 2024, at 7:02 a.m., the surveyor observed ULP-D provide scheduled morning medication to R4. ULP-D's background study dated December 15, 2023, indicated ULP-D was cleared, however, the background study was affiliated with HFID 23148 for the facility campus, and not the assisted living HFID 30337. On April 2, 2024, at 1:26 p.m., CD/LALD-A stated ULP-D's background study was affiliated to the facility campus HFID and not the assisted living HFID. CD/LALD-A further stated the facility campus had a human resource department	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01290	Continued From page 20 responsible for completing background studies on employees. On April 3, 2024, at 9:40 a.m., CD/LALD-A provided a cleared background study for ULP-D with the correct affiliation HFID 30337. CD/LALD-A stated the affiliation date for HFID 30337 was dated for April 2, 2024, after the surveyor requested ULP-D's background study with the HFID of the assisted living. The licensee's Background Screen Inv [sic] policy dated April 4, 2022, indicated the Personnel/Human Resources Director, or other designee, will conduct background checks, and criminal conviction checks (including fingerprinting as may be required by stat law) on all potential employees who meet the criteria for direct access employee. The licensee's Personnel Records policy dated February 19, 2021, indicated the personnel record for each person would include documentation of a completed criminal background study. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01370	Continued From page 21 to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP-D) to include all	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01370	Continued From page 22 required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on December 14, 2023, to provide direct care services to the facility's residents. On April 2, 2024, at 7:02 a.m., the surveyor observed ULP-D provide scheduled morning medication to R4. ULP-D's employee record did not include documentation of training and competency for the following: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aides; and - medication, exercise, and treatment reminders. On April 2, 2024, at 1:33 p.m., clinical nurse supervisor (CNS)-B stated ULP-D or any other ULPs had not completed training or competency evaluations as noted above. CNS-B further stated CNS-B does not complete the above noted training or competency evaluations unless the licensee had a resident that required assistance in the above noted areas and the licensee was not aware it was required as part of the core training.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01370	Continued From page 23 The licensee's Unlicensed Personnel Training Competency policy dated February 12, 2021, indicated required training topics with notation regarding the type of competency evaluation included the following: -Hair care and bathing (practical skills test required); -care of teeth, gums, and oral prosthetic devices (practical skills test required); -Care and use of hearing aids (practical skills test required); and -Medication, exercise and treatment reminders (written or oral test required). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01380	Continued From page 24 required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP-D) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on December 14, 2023, to provide direct care services to the facility's residents. On April 2, 2024, at 7:02 a.m., the surveyor observed ULP-D provide scheduled morning medication to R4. ULP-D's employee record did not include documentation of training and competency for range of motion and positioning. On April 2, 2024, at 1:33 p.m., clinical nurse supervisor (CNS)-B stated ULP-D or any other ULPs had not completed training or competency evaluations for range of motion and positioning. CNS-B further stated CNS-B does not complete range of motion and positioning training or	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01380	Continued From page 25 competency evaluations for ULPs unless the licensee had a resident that needed assistance with range of motion or positioning, and the licensee was not aware it was required as part of the core training. The licensee's Unlicensed Personnel Training Competency policy dated February 12, 2021, indicated required training topics with notation regarding the type of competency evaluation included range of motioning [sic] and positioning (practical skills test required). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01760	Continued From page 26 review, the licensee failed to ensure medications were administered per prescriber orders for one of one resident (R5) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 1, 2024, at 10:26 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R5's diagnoses included hypertension (HTN-high blood pressure), congestive heart failure (CHF) and weakness. R5's service plan dated January 1, 2024, indicated R5 received medication administration daily. R5's prescriber orders dated January 16, 2024, included an order for albuterol inhaler 90 micrograms (mcg) take two puffs every morning and every four hours as needed for wheezing. R5's medication administration records (MAR) dated March 2024, and April 2024, respectively, indicated albuterol inhaler 90 mcg take two puffs every morning and four hours as needed for wheezing.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01760	Continued From page 27 On April 2, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-E conduct a medication pass for R5, which included administration of the albuterol inhaler 90 mcg. ULP-E compared the prescription label with R5's MAR and then handed R5 the albuterol inhaler for self-administration. R5 shook the albuterol inhaler, inhaled three puffs with deep breaths, and handed the albuterol inhaler back to ULP-E. Immediately following the observation, ULP-E stated R5 inhaled three puffs from the albuterol inhaler and should have only taken two puffs. ULP-E then documented on R5's April MAR albuterol inhaler 90 mcg two puffs had been administered to R5. On April 2, 2024, at 1:42 p.m., CNS-B stated R5 was assessed to self-administer R5's albuterol inhaler and was surprised R5 inhaled three puffs instead of two puffs. CNS-B further stated it would be the expectation of ULP-E to notify CNS-B of the medication error and to complete a medication error report. The licensee's admin oral meds [sic] policy dated February 12, 2021, indicated staff will follow the instructions for that client (resident) for medication administration. In addition, if staff discovers a mistake that has resulted in a mediation error, the staff person that made the error or that discovered the error will report to the RN (registered nurse) immediately. The licensee's med errors [sic] policy dated February 26, 2021, indicated whenever a medication occurs the person will contact the nursing supervisor immediately and explain the situation with details including the client's (resident's) name, the medication name, dosage and amount and other relevant information [sic].	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01760	Continued From page 28 The RN will investigate and determine the potential harm and significance of the medication error. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed at the time of setup and included all the required content for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 1, 2024,	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01770	Continued From page 29 at 10:26 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R4's diagnoses included hypertension (HTN-high blood pressure), tremors (involuntary movement), and gastroesophageal reflux disease (GERD-acid reflux). R4's Service plan dated January 1, 2024, indicated R4 received weekly medication set ups by a registered nurse (RN) or licensed practical nurse (LPN). R4's prescriber orders dated January 5, 2024, included an order for coumadin 5 milligrams (mg) take ½ tablet every day but Thursday take one full tab. On April 2, 2024, at 8:54 a.m., the surveyor observed unlicensed personnel (ULP)-D complete scheduled morning medication administration for R4. ULP-D removed a weekly medication planner (a medication box with designated compartments for days and times) that contained R4's coumadin 5 mg tablets. All days except Thursday contained ½ tablet of coumadin 5 mg and Thursday's compartment contained one full tablet of coumadin 5 mg. ULP-D stated CNS-B sets up R4's coumadin in the medication planner every week. R4's medication administration record (MAR) dated March 2024, contained a line that had written Weekly RN (registered nurse) Med. (medication) Setup, check for PRN (as needed) meds (medications), side effects and compliance. On March 4, 2024, an unidentified RN's initials were written and CNS-B initialed March 11, 2024, March 18, 2024, and March 25, 2024,	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01770	Continued From page 30 respectively. R4's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of person completing the medication setup. On April 3, 2024, at 12:46 p.m., CNS-B stated CNS-B considered documentation of the medication set up to be sufficient with marking CNS-B initials in the weekly RN med., check for PRN meds, side effects and compliance box once per week on the MAR and all medication set ups for residents were documented that way. CNS-B further stated CNS-B should have documented all required content for the medication set up as CNS-B previously did while working in licensee's sister home care department. The licensee's MAR Dosage Box policy dated February 26, 2021, indicated the MAR would include the medication name and strength, storage, dosage to be administered, day and time of administration, route of administration, drug classification and special precautions, and any specific instructions for administer the medication to the client (resident). In addition, when the RN or LPN has completed setting up the medications into the Dosage Box [sic], the nurse will document medication that has been set up on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01910	Continued From page 31	01910		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01910	Continued From page 32 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 1, 2024, at 10:26 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. The licensee's Discharged or Deceased Resident Roster dated March 14, 2024, indicated R1 was admitted to the facility on November 13, 2023, and discharged on November 28, 2023. R1's diagnoses included hypertension (HTN-high blood pressure) and dementia. R1's service plan dated November 13, 2023, indicated R1 received medication administration services. R1's Medication Administration Record (MAR) dated November 2023, indicated R1 received the following medications: -multivitamin (supplement) one tablet daily -aspirin (heart health) 81 milligrams (mg) daily -Systane eye drops (for dry eyes) one drop to each eye daily -lasix (to treat edema) 20 mg daily -Tamoxifen (to treat breast cancer) 20 mg daily -metoptolol [sic] (for HTN) 50 mg daily -vitamin E (supplement) 180 mg daily -vitamin C (supplement) 500 mg daily R1's prescriber orders dated November 14, 2023, included the above noted medications. R1's Transfer form dated November 27, 2023, indicated R1 was transferred to a skilled nursing	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
01910	Continued From page 33 facility. R1's Medication sent [sic] Release Form dated November 27, 2023, listed the above noted medications, however, lacked the metoprolol strength and all prescription numbers for any applicable medications. On April 2, 2024, at 1:47 p.m., CNS-B stated CNS-B must have missed documenting R1's metoprolol strength. CNS-B further stated the licensee was not aware prescription numbers were required to be documented if applicable. The licensee's disposition _meds [sic] policy dated April 9, 2021, indicated staff will document in the client's (resident's) record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
02310	Continued From page 34 services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with a consumer bedrail. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3's diagnoses included hypertension (HTN-high blood pressure), arthritis (painful inflammation and stiffness of the joints), and hypothyroidism (underactive thyroid). On April 2, 2024, at 7:05 a.m., the surveyor observed an upper consumer bedrail on the right side of R3's bed. The consumer bedrail was a white upside-down U shape with one horizontal bar in the center. R3's Service Plan dated March 1, 2024, indicated R3 required assistance with medication administration, bathing, grooming, dressing, and laundry. R3's Bed Rail Assessment dated November 20, 2023, indicated the risk and benefits were discussed with R3, R3 used the bedrail to get off the bed, the bedrail had been checked for recalls, the bedrail was installed according to manufacturers guidelines, the bedrail was securely attached, and a copy of the manufacturers guidelines was in the resident	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
02310	Continued From page 35 chart. R3's Resident Assessment dated January 19, 2024, indicated R3 had a cane (bed) rail to get in and out of bed, the bedrail met measurements according to guidelines, and R3 was given information of the risks and benefits of the bedrails. R3's record lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bedrail recall information at least every 90 days with the requirement included in the uniform assessment tool for assessing assistive devices. On April 2, 2024, at 10:47 a.m., clinical nurse supervisor (CNS)-B stated CNS-B checked the CSPC website when a new consumer bed rail is installed for a resident and had checked recalls a few weeks ago, however, was not aware bedrail recalls should be checked at least every 90 days. The licensee's Bed rail assessment [sic] policy dated August 2023, indicated an assessment will be done with the resident to see if they (resident) are appropriate for a bedrail and if the bedrail is deemed appropriate, rail (bedrail) measurements will be done to make sure the rail (bedrail) is safe for the resident. The policy did not address the frequency of a bedrail assessment. The licensee's Initial and On-going Nursing Assessment of Clients Under the Comprehensive Licensed Agency policy dated April 9, 2021, indicated the registered nurse (RN) will re-assess each client (resident) with the frequency between assessments not to exceed 90 days from the last date of assessment. The policy did not address using the uniform assessment tool.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
02310	Continued From page 36 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated August 7, 2023, indicated licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices. Minnesota Rules - Assisted Living Facilities 4659.0150 Uniform Assessment Tool, subdivision 2 indicated each facility must develop a uniform assessment tool. The facility may use an acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
02320	Continued From page 37 review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 1, 2024, at 10:26 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. On April 2, 2024, at 7:02 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. ULP-D compared the prescription label with the medication administration record (MAR), placed the medications into a paper cup, documented on the MAR medications were administered, and then observed the medications being taking by R4. On April 2, 2024, at 7:10 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R3. ULP-D compared the prescription label with the MAR, placed the medications into a paper cup, documented on the MAR medications were administered, and then observed the medications being taking by R3.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
02320	Continued From page 38 On April 2, 2024, at 8:54 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R4. ULP-D compared the prescription label with the MAR, placed the medications into a paper cup, documented on the MAR medications were administered, and then observed the medications being taking by R4. Immediately following the observation, ULP-D stated the registered nurse (RN) trained ULP-D to write ULP-D's initials after placing medications into the paper cups. On April 2, 2024, at 1:39 p.m., CNS-B stated medications should be administered to residents and then document on the MAR the medications were taken. CNS-B further stated ULPs were trained to document after medications were administered to residents. The licensee's documentation meds (medications) [sic] policy dated February 26, 2021, indicated staff will document each instance of medication administration or medication reminder on the client's medication record or MAR immediately after that task has been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
03090	Continued From page 39 record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour at the front entrance of the licensee on April 1, 2024, at 12:06 p.m., with campus director/licensed assisted living director (CD/LALD)-A and clinical nurse supervisor (CNS)-B, the surveyor did not observe signage to disclose electronic monitoring activity. On April 1, 2024, at 12:08 p.m., CNS-B stated the licensee use to have a sign posted at the entry way regarding the required regulatory language of electronic monitoring, however, the sign was no longer posted. The licensee's Electronic Monitoring Policy and	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30337	A. BUILDING: _____ B. WING _____	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW ASSISTED LIVING	215 LUNDELL AVENUE ORTONVILLE, MN 56278

(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
03090	Continued From page 40 Procedure dated November 24, 2021, indicated the licensee will post a sing [sic] at each facility entrance accessible to visitors that states, Electronic monitoring devices, including security camera and audio devices, may be present to record persons and activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *04/01/24*
Time: 13:59:57
Report: 7935241005

Food and Beverage Establishment Inspection Report

Location:

Fairway View Assisted Living
215 Lundell Avenue
Ortonville, MN56278
Big Stone County, 06

Establishment Info:

ID #: 0038391
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3204874398
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COOLER WAS 41.9 DEGREES F. DIAL TURNED TO "COLDEST" SETTING.

Comply By: 04/02/24

3-500D Microbial Control: disposition of food

3-501.18A ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

DISCARD MILK DATED 3/26.

Comply By: 04/02/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41.9 Degrees Fahrenheit - Location: Cooler
Violation Issued: Yes

Type: Full
Date: *04/01/24*
Time: 13:59:57
Report: 7935241005
Fairway View Assisted Living

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	0	0

Kitchen is a serving kitchen only. All food is catered from the nursing home kitchen.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 7935241005 of 04/01/24.

Certified Food Protection Manager: Pamela Streich

Certification Number: 3361 Expires: 05/12/27

Signed: _____

pamela.streich@fairwayview.us

Signed: _____

Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us