



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 30, 2026

Administrator
FAIRWAY VIEW NEIGHBORHOODS
201 MARK DRIVE
ORTONVILLE, MN 56278

RE: CCN:245451

Cycle Start Date: July 22, 2026

Dear Administrator:

On July 22, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 22, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 22, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245451		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/22/2026		
NAME OF PROVIDER OR SUPPLIER FAIRWAY VIEW NEIGHBORHOODS				STREET ADDRESS, CITY, STATE, ZIP CODE 201 MARK DRIVE , ORTONVILLE, Minnesota, 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) COMPLETION DATE	
E0000	Initial Comments On 7/20/26 to 7/22/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			07/30/2026	
F0000	INITIAL COMMENTS On 7/20/26 to 7/22/26, a standard recertification survey (S#5451040-0) was conducted at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000				07/30/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:			F0732				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0732 SS = C	Continued from page 1 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			F0732	Continued from page 1 participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. On July 20, 2026, the Daily Nursing Staffing Posting was immediately corrected to include the resident census. Although no residents were directly harmed by the deficient practice, the facility corrected the posting to ensure accurate staffing information was available to residents, visitors, and staff. The corrected posting was reviewed by the Director of Nursing (DON) to verify compliance with federal requirements. To determine whether the deficient practice existed beyond the identified occurrence, the DON or designee audited all Daily Nurse Staffing Postings completed during the prior thirty (30) days to ensure that the census was listed. The audit verified that each posting included the facility name, date, staffing hours by nursing category and shift, and resident census. Any posting found to be incomplete was immediately corrected. This review was completed to ensure compliance and identify any additional occurrences of the deficient practice. To ensure systemic changes are sustained, the facility reviewed its Daily Nurse Staffing Posting policy and process to require verification of the resident census before the posting is displayed. Licensed nursing staff responsible for completing the staffing posting received education on 7/20/2026 regarding federal nurse staffing posting requirements under §483.35(g), including the requirement to include the resident census on each daily posting. All nurses will receive this education by 8/3/26. To ensure compliance is maintained, the DON or designee will conduct audits of the Daily Nurse Staffing Posting five (5) times per week for four (4) weeks starting 7/20/2026 and weekly thereafter for four (4) additional weeks. Audits will verify that all required information, including resident census, is accurately documented and posted. Audit findings will be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will be addressed through corrective action and additional education as needed. Monitoring will continue until sustained compliance is demonstrated.		08/03/2026

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F0732 SS = C	Continued from page 2 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to include the resident censuses on the facility nurse staff posting. This deficient practice had the potential to affect all 49 who resided in the facility and any visitors who may have wished to view the information. During an observation on 7/20/26 at 3:46 p.m., nurse staff posting dated 7/20/26, was observed on a bulletin board by the director of nursing (DON) office. The staff posting included the total number of nursing staff hours, broken down into sections of day shift, evening shift, and overnight shift, with spaces in each section for registered nurse (RN), licensed practical nurse (LPN), trained medication aide (TMA), and certified nursing assistant (NA). The posting lacked information on the resident census. During an interview on 7/20/26 at 4:00 p.m., DON indicated that the process was for the night shift to post the nurse staff posting. DON verified that the census area was blank and should have been included in the posting. DON indicated that it is important to list the censuses and staffing in order to have the information available to residents and visitors. Facility policy titled Posting Direct Care Daily Staffing dated 9/27/22, identified the information recorded on the form shall include the name of the facility, the date for which the information is posted, the resident census at the beginning of the shift for which the information is posted. The direct care daily staffing lacked the census information.			F0732	Continued from page 2 The facility will achieve compliance on August 3, 2026.		08/03/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/23/2026. At the time of this survey, Fairway View Neighborhoods was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			07/31/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Fairway View Neighborhoods was built in 2016 under the LSC 2000 regulations and is one story in height without a basement. It is fully fire sprinkled and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility is divided into 4 smoke compartments by two-2 hour fire barriers and 2 smoke barriers. The facility has a capacity of 51 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.			K0000			07/31/2026

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K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on review of available documentation and staff interview, the facility failed to maintain emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.9.3.1, and 7.9.3.1.1(3). This deficient finding could have a widespread impact on residents within the facility. Findings include: On 07/23/2026 at 11:14 AM, it was revealed by review of available documentation that the 90-minute annual test for the emergency lighting system had not been completed in the last 12 months. An interview with the Maintenance Director and Director of Nursing verified this deficient finding at the time of discovery.			K0291	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. K0291 – Emergency Lighting The facility will complete the required 90-minute annual emergency lighting test and document the results on 8/20/26. During this inspection, all emergency lighting units will be inspected to verify proper operation and battery function. Any deficiencies identified during testing will be corrected immediately. The Maintenance Team was educated on the annual emergency lighting testing and its requirements. A preventative maintenance schedule has been updated to include the annual emergency lighting testing requirements and will be maintained by the Maintenance Manager. The Maintenance Manager or designee will perform audits weekly x 4 monthly x 2. The Maintenance Manager will maintain and review testing logs annually. Annual testing and audit results will be reviewed during the facility's QAPI meeting. Any identified concerns will be addressed through corrective action and additional education as needed. Maintenance Manager is responsible for corrective actions and ongoing monitoring.		08/20/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance,			K0345	K0345 – Fire Alarm System Testing and Maintenance The facility has scheduled a semi-annual fire alarm inspection by the Maintenance Team to occur on 8/13/26. All inspection reports will be maintained in the Life Safety Code compliance files. The Maintenance Manager will maintain a fire alarm testing schedule that includes all required semi-annual and annual		08/13/2026

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K0345 SS = F Bldg. 01	Continued from page 3 maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.3.1, 14.6.2.1, and 14.6.2.4. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 07/23/2026 at 11:32 AM, it was revealed by review of available documentation that the facility did not have documentation showing that a semi-annual fire alarm system inspection had taken place. An interview with the Maintenance Director and Director of Nursing verified this deficient finding at the time of discovery.			K0345	Continued from page 3 inspections. Service dates will be tracked on the facility's preventative maintenance calendar. The Maintenance Manager or designee will perform audits weekly x 4 monthly x 2. Semi-annual and annual testing results and audits will be reviewed during the facility's QAPI meeting. Any identified concerns will be addressed through corrective action and additional education as needed.		08/13/2026
K0363 SS = F Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are			K0363	K0363 – Corridor Doors The corridor doors for Resident Rooms 303, 308, and 313, along with the Activity Storage Room near the Therapy area, were inspected and repaired on 7/23/26 to ensure positive latching when closed on. After repairs were completed, door functionality was verified by maintenance staff. The facility will audit all corridor doors to verify proper latching and closure by 8/18/26. The Maintenance Manager or designee will perform audits weekly x 4 monthly x 2. On 8/6/26, staff were educated to report any doors that do not latch properly. Corridor door inspection and audit results will be reviewed during the facility's QAPI meeting. Any identified concerns will be addressed through corrective action and additional education as needed. Maintenance Manager and all caregivers are responsible for corrective actions and ongoing monitoring.		08/18/2026

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K0363 SS = F Bldg. 01	Continued from page 4 allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3, and 19.3.6.3.5. These deficient findings could have a widespread impact on residents within the facility. Findings include: On 07/23/2026 at 12:09 PM, it was revealed by observation that the door for Resident Rooms 303, 308, and 313 did not latch when the door was closed. On 07/23/2026 at 12:18 PM, it was revealed by observation that the door for the Activity Storage Room near the Therapy area did not latch when the door was closed. An interview with the Maintenance Director and Director of Nursing verified these deficient findings at the time of discovery.			K0363			08/18/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on review of available documentation and			K0712	K0712 – Fire Drills A fire drill was conducted on the 3rd shift on August 6th. The facility reviewed fire drill documentation and will conduct fire drills on all shifts, including the third shift, with the appropriate varying time going forward. Education was provided to department managers and all caregivers regarding fire drill requirements and ensuring participation in fire drills. Department Managers were also educated and are responsible for obtaining participant signatures for their respective department during these fire drills. Maintenance Manager or designee will conduct audits weekly x 4 monthly x 2. Maintenance Manager is responsible for scheduling and conducting drills for the year to ensure compliance.		08/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245451		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
NAME OF PROVIDER OR SUPPLIER FAIRWAY VIEW NEIGHBORHOODS				STREET ADDRESS, CITY, STATE, ZIP CODE 201 MARK DRIVE , ORTONVILLE, Minnesota, 56278			
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K0712 SS = F Bldg. 01	Continued from page 5 staff interview, the facility failed to conduct and document fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4, and 19.7.1.6. These deficient findings could have a widespread impact on residents within the facility. Findings include: On 07/23/2026 at 10:58 AM, it was revealed by review of available documentation that fire drills were not conducted on the 3rd shift in the 3rd and 4th Quarters of 2025. On 07/23/2026 at 10:58 AM, it was revealed by review of available documentation that the 2nd shift drill from the 3rd Quarter of 2025 that took place on 09/25/2025 at 3:00 PM, did not show that the fire alarm signal was tested and verified. The documentation for this drill was also missing signatures from staff members who participated in the drill. An interview with the Maintenance Director and Director of Nursing verified these deficient findings at the time of discovery.			K0712	Continued from page 5 Fire Drill results and audits will be reviewed during the facility's QAPI meeting. Any identified concerns will be addressed through corrective action and additional education as needed. Monitoring will continue until sustained compliance is demonstrated.		08/06/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily			K0918	K0918 – Electrical Systems: Essential Electric System (Generator) The facility arranged for diesel fuel quality testing in accordance with ASTM standards for the emergency generator on 7/30/26. The facility modified the contract with Cummins to include diesel fuel quality testing annually. The diesel fuel quality test has been added to the preventative maintenance schedule and compliance calendar to ensure completion at least annually. The facility is waiting for the test results, and any recommendations resulting from the fuel analysis will be implemented promptly. Maintenance Manager or designee will conduct audits weekly x 4 monthly x 2. Diesel Fuel Testing and audit results will be reviewed during the facility's QAPI meeting. Any identified concerns will be addressed through corrective action and additional education as needed. Monitoring will continue until sustained compliance is demonstrated. The Maintenance Manager will maintain testing documentation and review the generator testing schedule to ensure compliance.		07/30/2026

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NAME OF PROVIDER OR SUPPLIER FAIRWAY VIEW NEIGHBORHOODS				STREET ADDRESS, CITY, STATE, ZIP CODE 201 MARK DRIVE , ORTONVILLE, Minnesota, 56278			
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K0918 SS = F Bldg. 01	Continued from page 6 available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), section 8.3.8. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 07/23/2026 at 10:22 AM, it was revealed by a review of available documentation that the facility has not completed a diesel fuel quality test per ASTM standards for the emergency generator in the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0918	Continued from page 6 Maintenance Manager is responsible for scheduling and documenting testing.		07/30/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenance CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period			K0921	K0921 – Electrical Equipment Testing and Maintenance (PCREE) The facility will complete an inventory of all patient care related electrical equipment (PCREE) and test equipment by 9/30/26. Policies and procedures were developed to address testing requirements, intervals, documentation standards, and equipment maintenance. All identified PCREE will be tested according to NFPA 99 requirements, and complete records will be maintained. The facility established a comprehensive equipment management program that includes an equipment inventory, testing schedule, and documentation requirements. Staff responsible for equipment maintenance have been educated on the program requirements. The Maintenance Manager or designee will conduct audits weekly x 4 monthly x 2 to verify the equipment inventory, testing records, and documentation ensure ongoing compliance. PCREE testing results will be reviewed during the facility's QAPI meeting. Any identified concerns will be		09/30/2026

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K0921 SS = F Bldg. 01	Continued from page 7 of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain patient care related electrical equipment (PCREE) per NFPA 99 (2012 edition), sections 10.3, 10.5.2.1.1, 10.5.2.1.2, 10.5.3.1, 10.5.6, and 10.5.8. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 07/23/2026 at 11:29 AM, it was revealed by a review of available documentation and staff interview that the facility has not tested all patient care related electrical equipment (PCREE) within the facility, the facility has not established policies or procedures for testing PCREE, and the documentation provided at the time of the survey was incomplete for PCREE that had been tested. An interview with the Maintenance Director and Director of Nursing verified this deficient finding at the time of discovery.			K0921	Continued from page 7 addressed through corrective action and additional education as needed. Monitoring will continue until sustained compliance is demonstrated. Maintenance Manager is responsible for implementation and monitoring. Director of Nursing will assist with identifying patient care equipment.		09/30/2026