



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 24, 2026

Administrator
Waverly Gardens
5919 Centerville Road
North Oaks, MN 55127

RE: CCN: 245613

Cycle Start Date: August 19, 2026

Dear Administrator:

On August 19, 2026, a survey was completed at your facility by the Minnesota Departments 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 November 19, 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 February 19, 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,



Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245613		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HO... B. WING		(X3) DATE SURVEY COMPLETED 08/18/2026	
NAME OF PROVIDER OR SUPPLIER WAVERLY GARDENS				STREET ADDRESS, CITY, STATE, ZIP CODE 5919 CENTERVILLE ROAD , NORTH OAKS, Minnesota, 55127			
(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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/18/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Waverly Gardens 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			10/02/2026

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. Waverly Gardens is on the 1st floor (ground level) of a 3-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 2005 and was determined to be of Type II(111) construction. In 2008 a 3 story addition was constructed to the East and was determined to be of Type II(111) construction. The nursing home uses only the 1st floor and is fire separated from the other floors. The facility has a capacity of 60 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			10/02/2026
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting			K0291	This facility does comply with the NFPA 101 (2012 edition) 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.		10/02/2026

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K0291 SS = F Bldg. 01	Continued from page 2 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 a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/18/2026 at 10:40 AM, it was revealed by a review of available documentation that the facility did not have an emergency lighting inspection report showing that the emergency lights have been tested. An interview with the Engineer verified this deficient finding at the time of discovery.			K0291	Continued from page 2 This facility contracts HMCragg to perform both Minor & Major Pm's to include an annual load bank with a minimum of 2 hours annually with transfer test for all emergency testing. This load bank was completed as scheduled on 12/11/2025 to include the emergency lighting transfer test. This facility completes weekly visual inspections with monthly exercises to include a transfer test for all emergency testing to include emergency lighting requirements. The Environmental Services Director will reinspect the correction of the deficiency and verify compliance of NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. Waverly Gardens does have a Life Safety "Task" in our TELS work order system for annual testing and inspections. Completion date by 10/2/26.		10/02/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 08/18/2026 at 10:45 AM, it was revealed by a review of available documentation that the facility could not provide an updated fire damper inspection report that showed the location of the dampers in the facility.			K0521	This facility does comply with the NFPA 101 (2012 edition) Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.18.5.2.1, 19.5.2.1, 9.2 The facility will complete all required fire damper inspections in accordance with NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12 The Environmental Services Director will reinspect the correction of the deficiency and verify compliance of NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. The Environmental Services Director will provide the Tels work order task documentation with locations to be in compliance of NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12.		10/02/2026

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K0521 SS = F Bldg. 01	Continued from page 3 An interview with the Engineer verified this deficient finding at the time of discovery.			K0521	Continued from page 3 Completion date of 10/2/2026.		10/02/2026
K0901 SS = F Bldg. 01	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility Findings Include: On 08/18/2026 at 10:59 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a risk assessment of the facility being completed using chapters 5 through 11 of NFPA 99 (2012 edition), Health Care Facilities Code. An interview with the Engineer verified this deficient finding at the time of discovery.			K0901	The facility does comply with Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. The facility will be completing an in-house audit and inspection of all risks. The Environmental Services Director will provide the NFPA 99 Risk Assessment to include chapters 5 through 11 of NFPA 99 (2012 edition), Health Care Facilities Code. The Environmental Services Director will confirm this has been updated with any changes along with annual review. Completion date of 102/2026.		10/02/2026
K0911 SS = F Bldg. 01	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and			K0911	This facility does comply with the NFPA 101 (2012 edition) Emergency Lighting of at least 1-1/2-hour duration is provided automatically in accordance This facility contracts HMCragg to perform both Minor & Major Pm's to include an annual load bank with a minimum of 2 hours annually with transfer test for all emergency testing. This load bank was completed as scheduled on 12/11/2025 to include the emergency lighting transfer test. This facility completes weekly visual inspections with monthly exercises to include a transfer test for all emergency testing to include emergency lighting requirements.		10/02/2026

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K0911 SS = F Bldg. 01	Continued from page 4 staff interview, the facility failed to install emergency lighting in Emergency Power systems (EPS) equipment locations per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 7.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/18/2026 at 11:39 AM, it was revealed by observation that the facility did not have emergency lighting installed in the electrical room that contained the emergency generator transfer switch. An interview with the Engineer verified this deficient finding at the time of discovery.			K0911	Continued from page 4 The Environmental Services Director will reinspect the correction of the deficiency and verify compliance of NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. Waverly Gardens does have a Life Safety “Task” in our TELS work order system for annual testing and inspections. Completion date by 10/2/26		10/02/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc 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 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			K0921	This facility does comply with NFPA 101 Electrical Equipment - Testing and Maintenance as well as NFPA 99 (PCREE) 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 The Environmental service Director will provide policies and documentation to verify the requirements that will be met to include; The Environmental Services Director to audit all resident rooms and clinical areas to create a master inventory log of all Patient Care-Related Electrical Appliances and Equipment (PCREE) currently in use across the building. Qualified maintenance personnel (or contracted Biomedical Equipment Technicians) began performing physical safety inspections and electrical leakage testing on all identified PCREE. Any equipment that has not yet passed testing has been tagged "Out of Service" and temporarily removed from patient care areas until compliant inspection testing is completed and documented. Policy Update: The facility’s Electrical Safety and Preventive Maintenance (PM) policy was updated to explicitly require annual (or manufacturer-specified) electrical safety testing and documentation for all facility-owned and resident-owned PCREE.		10/02/2026

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K0921 SS = F Bldg. 01	Continued from page 5 staff interview, the facility failed to test and inspect patient care related electrical appliances and equipment (PCREE) per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2, 10.3, and 10.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 08/18/2026 at 10:30 AM, it was revealed by a review of the available documentation that at the time of the survey, the facility could not provide documentation showing that the patient care-related electrical appliances and equipment (PCREE) in the facility had been inspected or tested. An interview with the Engineer verified this deficient finding at the time of discovery.			K0921	Continued from page 5 Staff education for the Maintenance Director, Facilities Staff, regarding the requirement to log, test, and tag all PCREE before use. The Maintenance Director (or designee) will conduct annual audits of active PCREE to verify corresponding documentation is logged in the facility management system. Completion date of 10/2/2026		10/02/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms			K0321	The facility does comply with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. The Engineer adjusted and repaired the identified doors on 8/18/2026-8/19-2026. The Environmental Services Director will reinspect the correction of the deficiency and verify compliance of NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8. The Environmental Services Director will verify compliance. Waverly Gardens does have a Life Safety "Task" in our TELS work order system for annual testing and inspections. Completed Date 8/19/2026.		10/02/2026

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(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
K0321 SS = E Bldg. 01	Continued from page 6 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a patterned impact on the residents within the facility Findings Include: 1. On 08/18/2026 at 11:22 AM, it was revealed by observation the door to the storage room near the dining room did not latch when testing the self-closing device. 2. On 08/18/2026 at 11:26 AM, it was revealed by observation the door to the soiled utility room near room 41 room did not latch when testing the self-closing device. 3.On 08/18/2026 at 11:29 AM, it was revealed by observation the door to the dietary storage room in North Gables room did not latch when testing the self-closing device. An interview with the Engineer verified these deficient findings at the time of discovery.			K0321			10/02/2026
K0372 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			K0372	The facility does comply with NFPA 101 Subdivision of Building Services – Smoke Barrier Construction – 2012 -Existing requirements. The Engineer corrected and repaired the fire penetration in the smoke barrier near North Gables room 78 on 8/18/2026. The Environmental Services Director will reinspect the correction of the deficiency and verify compliance NFPA 101 Subdivision of Building Services – Smoke Barrier Construction – 2012 -Existing. The Environmental Services Director will verify compliance. Waverly Gardens does have a Life Safety “Task” in our TELS work order system for annual testing and inspections.		10/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245613		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HO... B. WING		(X3) DATE SURVEY COMPLETED 08/18/2026	
NAME OF PROVIDER OR SUPPLIER WAVERLY GARDENS				STREET ADDRESS, CITY, STATE, ZIP CODE 5919 CENTERVILLE ROAD , NORTH OAKS, Minnesota, 55127			
(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
K0372 SS = E Bldg. 01	Continued from page 7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Finding Include: On 08/18/2026 at 11:26 AM, it was revealed by observation that there was a penetration in the smoke barrier caused by low voltage wires above the ceiling in the North Gables near room 78. An interview with the Engineer verified this deficient finding at the time of discovery.			K0372	Continued from page 7 Completion date 8/18/2026		10/02/2026