DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4MZT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29463

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245622**
2.STATE VENDOR OR MEDICAID NO.
(L2) **658925200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOWS ON FAIRVIEW**
(L4) **25565 FAIRVIEW AVENUE**
(L5) **WYOMING, MN** (L6) **55092**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/08/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **14** (L18)
13.Total Certified Beds **14** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	14			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Teresa Ament, HFE NEII 04/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist 05/20/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/23/2014
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00010 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
04/11/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245622

May 19, 2016

Ms. Erin Hilligan, Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, Minnesota 55092

Dear Ms. Hilligan:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 15, 2016 the above facility is certified for:

14 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 14 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 20, 2016

Ms. Kari Wilson, Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, Minnesota 55092

RE: Project Number S5622001

Dear Ms. Wilson:

On March 8, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 24, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On April 8, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 1, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 24, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 17, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 24, 2016, effective March 17, 2016 and therefore remedies outlined in our letter to you dated March 8, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245622		4/8/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0334 Reg. # 483.25(n) LSC	Correction Completed 03/17/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	CC/mm	04/20/2016	13922	04/08/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/24/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245622 Y1	A. Building 01 - MEADOWS FAIRVIEW B. Wing Y2	4/1/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	03/01/2016	LSC K0022	02/29/2016	LSC K0029	02/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0046	02/29/2016	LSC K0050	02/25/2016	LSC K0052	02/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0054	03/01/2016	LSC K0076	03/03/2016	LSC K0211	02/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	04/20/2016	27200	04/01/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/23/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4MZT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 29463

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245622**

2.STATE VENDOR OR MEDICAID NO.
(L2) **658925200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOWS ON FAIRVIEW**
(L4) **25565 FAIRVIEW AVENUE**
(L5) **WYOMING, MN** (L6) **55092**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/24/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **14** (L18)

13.Total Certified Beds **14** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	14			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 04/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 04/08/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/23/2014
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00010
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 3060

March 8, 2016

Ms. Kari Wilson, Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, Minnesota 55092

RE: Project Number S5622001

Dear Ms. Wilson:

On February 24, 2016, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: chris.campbell@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 4, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

If an acceptable PoC 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 May 24, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 24, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(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
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the	F 334	F 334 Pneumococcal Vaccine Policy and Procedure have been reviewed. 2/25/16 Resident number 68 has discharged from facility. Resident 41 currently still resides in the facility. Per conversation with daughter of resident 41, she believes resident was given pneumococcal vaccine in either January 2015 or September of 2015 while at an outside hospital. (He did have pneumovax (PPSV23) back on 11/27/1997.) She is working on getting vaccination records. Did give consent to give pneumococcal vaccine if indicated. Vaccine conversation was documented in resident's medical record.	

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

Administrator 3-17-16

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C.C. 4-7-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(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
F 334	Continued From page 1 Influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334	RN Nurse Manager audited current resident charts for compliance on 3/10/16. The Nurse Manager will be responsible for compliance with Pneumococcal Vaccine Policy. All Nursing Staff have been educated on Pneumococcal Vaccine Policy and Procedure. DON and RN Nurse Manager will conduct monthly chart audits on Pneumococcal Vaccine and facility compliance with Policy. After two months in a row of 100% compliance it will go to a quarterly spot audit and results will be shared at monthly QA. Completion: 3/17/16	

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F 334	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to confirm pneumococcal vaccination status and administration if indicated for 2 of 5 residents (R41, R68) reviewed for infection control. Findings include: R41's Admission Record dated 1/15/16, identified R41's diagnoses to include congestive heart failure, respiratory failure with hypoxia, hypertension (high blood pressure), myocardial infarction and anxiety. R41's admission Minimum Data Set (MDS) dated 1/22/16, indicated R41's pneumococcal vaccination was not up to date. R41's Immunization Report indicated R41 received the influenza vaccination on 1/6/15, however lacked documentation of if/when R41 had received the pneumococcal vaccination. R68's Admission Record dated 2/20/16, identified R68's diagnoses to include presence of left artificial hip joint, rheumatoid arthritis, muscle weakness and edema. R68's Immunization Report indicated R68 received the influenza vaccination on 2/19/16, however lacked documentation of if/when R68 had received the pneumococcal vaccination. On 2/23/16, at 11:23 a.m. registered nurse (RN)-A confirmed all vaccinations given to R41	F 334		

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	245622	A. BUILDING _____ B. WING _____	02/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 334	Continued From page 3 and R68 would be documented in the Immunization Report. RN-A stated the pneumococcal vaccinations were not being administered as residents on the unit were short term stay. RN-A reported when staff request an order to give the pneumococcal vaccination from a physician, they are told the resident can obtain the vaccination at their regular clinic at a later date. On 2/24/16, at 4:10 p.m. the director of nursing (DON) confirmed R41 and R68's medical record lacked documentation of pneumococcal vaccination history or refusal of vaccination. The DON confirmed R41 and R68 should have been offered the pneumococcal vaccination. The DON stated staff was expected to document in the medical record any prior vaccinations or refusals of vaccinations. Further, the DON confirmed all residents less than 65 years of age should also be offered the pneumococcal vaccination. The facility's Standing House Orders dated 1/27/15, indicated the orders were applicable for all residents admitted to the facility and directed staff to administer the pneumococcal vaccination if not contraindicated. The facility's Resident Pneumococcal Vaccine policy dated 9/13, indicated each resident would be offered the vaccine unless medically contraindicated, refusal or already immunized.	F 334		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5622001

PRINTED: 03/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING 01 - MEADOWS FAIRVIEW B. WING _____	02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	26565 FAIRVIEW AVENUE WYOMING, MN 55092

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K 000	INITIAL COMMENTS FIRE SAFETY 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 REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Meadows on Fairview was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	APPROVED By Tom Linhoff at 1:34 pm, Mar 30, 2016 RECEIVED MAR 21 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3-18-16

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MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Meadows on Fairview is one wing of an assisted living facility that was constructed in 2004 and converted to nursing home in 2014. The building construction type has been determined to be Type V(111)). It is properly separated from the original building constructed in 2004 by 2 hour fire resistive construction, with 1.5 hour rated doors. The building is fully sprinklered throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The facility has a capacity of 14 beds and had a census of 12 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 485.623 (d) is NOT MET.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA Life Safety Code 101 (2000 edition), section 18.3.6.3.2. This deficient practice could affect 12 of 12 residents, staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/23/2016, it was observed revealed the following deficient conditions: 1. Resident room 2 has a corridor door that did not close and latch into the frame. 2. The corridor doors to the oxygen storage room consisted of two by-fold doors that did not close and latch into a door frame.	K 018	**K018** 1. **Resident room 2 has a corridor door that did not close and latch into the frame.** Latch on room 2 has been fixed on 2-29-16. Environmental Services Director will audit doors monthly for compliance. 2. **Corridor doors to the oxygen storage room consisted of two by fold doors that did not latch into the door frame.** This room will no longer be used for oxygen storage effective 3/1/16. Oxygen moved outside into storage sheds. Administrator will audit storage closet with by-fold doors to unsure staff are not storing oxygen in storage closet.	

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K 018	Continued From page 3 This deficient condition was verified by the Maintenance Supervisor.	K 018		
K 022 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 1 of several non-required exit doors leading to the exterior that do not lead to the public way in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.1.7 and 7.10.8.1 These deficient practices could negatively affect 8 of 12 residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/23/2016, observations revealed that the doors leading to the enclosed three seasons porch is not marked as "NO EXIT". These doors are not part of a required exits for the facility and need to display a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO".	K 022	K 022 No exit sign was placed on door going to porch on 2-29-16 by Environmental Services Director.	

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K 022	Continued From page 4 This deficient condition was verified by the Maintenance Supervisor.	K 022		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition), section 18.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 12 of 12 residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/23/2016, observation revealed, that the corridor door of the soiled utility room did not fully close and positively latch into the frame. This deficient condition was verified by the Maintenance Supervisor.	K 029	K 029 Soiled Utility room door was fixed so it fully closed on 2-29-16 by environmental services director. Door will be audited monthly by Environmental Services Director or designee.	

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K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA Life Safety Code 101 (2000 edition), section 7.9.3, and 18.2.9.1. This deficient practice could affect 4 of 12 residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/23/2016, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Supervisor revealed the that the facility did not annotate the annual 90 minute and 30 second monthly testing of the battery back-up emergency lights. This deficient condition was verified by a Maintenance Supervisor.	K 046	**K 046** Annual testing of emergency lights completed on 2/29/16 by Administrator. Procedure and spreadsheet reviewed with Environmental Services Director. Monthly testing and annual testing to be completed by Environmental Services Director and documented on Battery operated emergency lights test log located in Life Safety Code Documentation Book.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership.	K 050		

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K 050	Continued From page 6 Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101 (2000 edition), section 18.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of 12 of 12 residents. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/23/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had he following deficient conditions were found affecting the facility's fire drills: 1. the facility could not provide documentation for a overnight shift fire drill in the 1st calendar quarter. 2. the facility could not provide documentation for a day shift fire drill in the 2nd calendar quarter. 3. the facility could not provide documentation for a evening shift fire drill in the 3rd calendar quarter. This deficient condition was verified by a Maintenance Supervisor.	K 050	**K050** Fire Drill Policy and Procedure reviewed by Administrator and Environmental Services Director. Fire drills will be conducted in accordance with NFPA Life Safety Code 101 (2000 Edition), section 18.7.1.2, starting with February 25, 2016 fire Drill completed on 2nd shift. January 2016 Fire Drill was completed on 1st shift. Administrator will audit Fire Drills monthly for compliance.	
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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K 052 SS=D	Continued From page 7 A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to Install and maintain the fire alarm system in accordance with the requirements of NFPA Life Safety Code 101 (2000 edition), sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/23/2016, during a documentation review of the available fire drill reports and fire alarm testing documentation for the last 12 months and interview with the Maintenance Supervisor, it was revealed that the facility failed to conduct 8 of 12 monthly tests of the fire alarm DACT system. This deficient condition was verified by a Maintenance Supervisor.	K 052	**K052** DACT System was tested on Fired Drill dated 2/25/16 by Environmental Services Director. Will continue to test DACT system monthly upon Fire Drill. Administrator will audit Fire drill reports monthly to ensure compliance.	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those	K 054		

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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
K 054	Continued From page 8 activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff of the facility. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/23/2016, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 054	K054 Sensitivity Testing was completed on smoke detectors on 3/01/16 by Olson Fire. Environmental Services Director will have Sensitivity testing completed on a bi-annual basis.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	K 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING 01 - MEADOWS FAIRVIEW B. WING	02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(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
K 076	Continued From page 9 (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Observations revealed that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities (1999 edition) section 4-3.5.2.2. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively 12 of 12 residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/23/2016, it was observed that the number of gaseous oxygen cylinders located in the oxygen storage room have a volume that is less than 3000 cubic feet. At the time of the inspection the cylinders that were located in the storage room were not separated and labeled as full or empty, and there are combustibles being stored within 5 feet of the oxygen cylinders. This deficient condition was verified by a Maintenance Supervisor.	K 076	**K 076** Oxygen has been moved to storage units outside of the building. Two storage units have been purchased. One for full cylinders and one for empty cylinders. Both have been labeled appropriately and staff has been in-serviced on the new storage of oxygen. Locks have been placed on both units. Only oxygen is stored in these new storage units. Nurse Manager will audit weekly for compliance. Completion date: 3/3/16	
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)	K 211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245622	A. BUILDING 01 - MEADOWS FAIRVIEW B. WING _____	02/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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K 211	Continued From page 10 o The dispensers shall have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the alcohol based hand sanitizer dispensers installed in the facility are not in accordance with CFR 483.70 Alcohol Based Hand Rubs and the Minnesota State Fire Code (2007 edition). This deficient practice could allow the ignition of the waterless flammable hand sanitizer causing a fire that would negatively impact 12 of 12 residents, staff and visitors within the room that the dispensers are located in. Findings include: On facility tour between 10:30 AM to 3:30 PM on 02/23/2016, observations revealed that the alcohol based hand sanitizers that are mounted in all of the resident sleeping rooms are directly above electrical outlets This deficient condition was verified by a Maintenance Supervisor.	K 211	K 211 The hand sanitizers in resident sleeping rooms have been removed by Environmental Services on 2-29-16.	