DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 11, 2024

Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, MN 55092

RE: CCN: 245622
Cycle Start Date: July 24, 2024

Dear Administrator:

On September 11, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 6, 2024

Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, MN 55092

RE: CCN: 245622
Cycle Start Date: July 24, 2024

Dear Administrator:

On July 24, 2024, 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 [Cycle Start + 3 Months()] (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 [Cycle Start + 6 Months()] (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

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,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	C 07/24/2024

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
E 000	Initial Comments On 7/22/24 through 7/24/24 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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.	E 000		
F 000	INITIAL COMMENTS On 7/22/24 through 7/24/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H56225798C (MN00095611), H56226020C (MN00094146) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/14/2024

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 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.

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		8/20/24

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F 623	Continued From page 2 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623		

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F 623	Continued From page 3 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to ensure a written notification of transfer was sent to the office of the Ombudsman for long term care for 2 of 2 residents (R1, R13) with the potential to affect all residents transferred to the hospital. Findings include: R1's face sheet dated 7/24/24 listed the following diagnoses: chronic respiratory failure with hypoxia (long term breathing issues with low blood oxygen), chronic obstructive pulmonary disease (long term narrowing of the breathing passages), diabetes, obesity, congestive heart failure (the heart was unable to pump efficiently), dysphagia (difficulty swallowing), atrial fibrillation (top two chamber of the heart beat erratically), coronary	F 623	FOOO Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. F623 - Notice Requirements Before Transfer/Discharge	

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F 623	Continued From page 4 artery disease (narrowing of the veins/arteries in the heart), dependence on supplemental oxygen, obstructive sleep apnea (stops breathing for spells of time while sleeping), and peripheral vascular disease (the body struggles to return blood from its extremities). Progress notes indicated R1 was hospitalized twice on the following dates: 4/10/24 through 4/12/24 5/14/24 through 5/28/24 and went to the emergency department of 6/5/24, and R1's medical record lacked evidence a written notification of transfer was sent to the Ombudsman for long term care. R13's face sheet dated 7/24/2024, listed the following diagnoses: hypertension (high blood pressure), unspecified dislocation of right hip (right hip our of hip socket), restless leg syndrome (restless legs), presence of right artificial joint (surgical joint replacement) and major depressive disorder (Feeling sad). Progress notes indicated R13 went to an emergency department on 4/29/24 and was hospitalized on 4/29/24. R13's medical record lacked evidence a written notification of transfer was sent to the ombudsman for long term care. Facility provided document, referred to as, Hospital Transfer List, indicated list of resident transfers over the last six months, and included R1 and R13. During an interview on 7/23/24 at 1:06 p.m.,	F 623	1. Corrective Action: R1 and R13 Notices of Transfer/Discharge were sent to the ombudsman on 8/20/24. The facility will send a list of residents who have been discharged and transferred out of the facility to the ombudsman monthly. 2. Date of Completion: 08/20/24 3. Recurrence will be prevented by: An ombudsman reporting audit has been created that will take place monthly. After six months of consecutive successful audits, we will discontinue further audits, as compliance standards have been consistently met. 4. The Correction will be monitored by: Campus Administrator	

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F 623	Continued From page 5 director of nursing (DON) stated the facility transfer list document included the residents R1 and R13. DON stated she did not believe the ombudsman had been notified of R1 and R13's transfer to the hospital and she was reviewing the facility policy. During an interview on 7/23/24 at 2:04 p.m., DON stated the notice of transfer to ombudsman for R1 and R13 had not been done but should have During an interview on 7/23/24 at 2:25 p.m., licenses social worker (LSW) stated she had not notified the ombudsman for the transfer and hospitalization of R1 and R13. LSW stated the transfers should have been sent to the ombudsman upon review of the facility policy. Facility provided document, titled, Transfer and Discharge from the facility indicated, copies of notices for emergency transfer must also be sent to the ombudsman, and can be done monthly.	F 623		

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	245622	A. BUILDING **01 - MEADOWS FAIRVIEW** B. WING _____	**07/23/2024**

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 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/23/2024. At the time of this survey, Meadows On Fairview 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.	K 000		

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

Electronically Signed | 08/14/2024

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 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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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. Meadows on Fairview is one wing of an assisted living facility that was constructed in 2004 and converted to a 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	K 000		

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K 000	Continued From page 2 the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 14 beds and had a census of 13 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		8/16/24

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1, 19.3.2.5.3 (9)(C) and 19.3.2.5.4and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. These deficient findings could have an widespread impact on the residents within the facility. Findings include: 1. On 07/23/2024 between 08:45 AM and 11:00 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a kitchen hood inspection within six months. Inspections were completed on 09/23/2023 and 06/13/2024 making the inspections 9 months apart. 2. On 07/23/2024 between 08:45 AM and 11:00 AM, it was revealed by observation that the lockout for the neighborhood stove did not include a timer of a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 324	K324- Cooking Facilities 1. Corrective Action: Kitchen hood inspection is scheduled for 8/16/24. Summit will conduct inspections every 6 months going forward. Plug lockout box purchased and installed for TCU range, eliminating the need for a 120-minute timer. 2. Date of Completion: 8/16/24 3. Reoccurrence will be prevented by: EVS Director has created a template to monitor due dates for inspections, maintenance, and testing schedules. 4. The Correction will be monitored by: EVS Director	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		9/6/24

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	245622	A. BUILDING **01 - MEADOWS FAIRVIEW** B. WING _____	**07/23/2024**

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K 345	Continued From page 4 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, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.1, 14.4.5.3.2, and 14.4.5.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/23/2024 between 08:45 AM and 11:00 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the Annual Fire Alarm Test has not been tested since 05/11/2023. 2. On 07/23/2024 between 08:45 AM and 11:00 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the sensitivity of the smoke detectors in the facility have been tested since 06/05/2023. An interview with the Director of Environmental Services verified these deficient findings at the	K 345	K345 - Fire Alarm System -Testing and Maintenance 1. Corrective Action: Smoke sensitivity test and Annual Fire Alarm Test are scheduled for 9/6/24. 2. Date of Completion: 9/6/24 3. Reoccurrence will be prevented by: EVS Director has created a template to monitor due dates for inspections, maintenance, and testing schedules. 4. The Correction will be monitored by: EVS Director	

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K 345	Continued From page 5 time of discovery.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 353	K353 -Sprinkler System - Maintenance and Testing 1. Corrective Action: 5-year internal pipe inspection scheduled for 8/19/24 and gauges on the fire sprinkler riser are set to be replaced on 8/16/24 by Summit. 2. Date of Completion: 8/19/24 3. Reoccurrence will be prevented by: EVS Director has created a template to monitor due dates for inspections, maintenance, and testing schedules. 4. The Correction will be monitored by: EVS Director	8/19/24

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K 353	Continued From page 6 1. On 07/23/2024 between 08:45 AM and 11:00 AM, it was revealed by observation that the five-year internal pipe inspection was not completed for the riser. The last five-year inspection was completed on 06/13/2018 and the facility could not provide documentation showing that it had been completed at the time of the survey. 2. On 07/23/2024 between 08:45 AM and 11:00 AM, it was revealed by observation that the gauge on the fire sprinkler riser was dated 6/13/2023. An interview with the Director of Environmental Services verified these deficient findings at the time of discovery.	K 353		
K 712 SS=F	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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. These deficient findings could have a widespread impact on the	K 712	K712 - Fire Drills 1. Corrective Action: Education completed for EVS Director on proper fire drill timing. 2. Date of Completion: 8/14/24 3. Reoccurrence will be prevented by;	8/14/24

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K 712	Continued From page 7 residents within the facility. Findings include: 1. On 07/23/2024/2024 between 08:45 AM and 11:00 AM, it was revealed by a review of available documentation that the fire drills that were conducted during the first shift were not conducted during varied times. 2. On 07/23/2024/2024 between 08:45 AM and 11:00 AM, it was revealed by a review of available documentation that the fire drills that were conducted during the second shift were not conducted during varied times. 3. On 07/23/2024/2024 between 08:45 AM and 11:00 AM, it was revealed by a review of available documentation and interview with the Director of Enviromental Services and the Administrator. According to my interview, they stated the times for the third shift was between 10:00 and 10:30 PM., all drills were conducted in the 9 o'clock hour for the third shift, making then second shift drills and were not conducted during varied times. An interview with the Director of Environmental Services and the Administrator verified these deficient findings at the time of discovery.	K 712	An-audit of monthly fire drills has been created. After six months of consecutive successful audits, we will discontinue further audits, as compliance standards have been consistently met. 4. The Correction will be monitored by: Campus Administrator	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient	K 761		8/14/24

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K 761	Continued From page 8 rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/23/2024 at 10:00 AM, it was revealed by a review of available documentation at the time of the survey the facility the facilities door inspection report was dated with the year only. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 761	K761- Maintenance, Inspection, and Testing - Doors 1. Corrective Action: Education for EVS Director on proper documentation standards has been completed. 2. Date of Completion: 8/14/24 3. Reoccurrence will be prevented by: Monthly Life Safety book reviews. 4. The Correction will be monitored by: Campus Administrator	
K 918 SS=F	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	K 918		8/1/24

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K 918	Continued From page 9 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 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators 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 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could	K 918	K918 - Electrical Systems - Essential Electric System 1. Corrective Action: 4-hour load bank test was completed on 8/1/24. 2. Date of Completion: 8/1/24 3. Reoccurrence will be prevented by: EVS Director has created a template to monitor	

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K 918	Continued From page 10 have a widespread impact on the patients within the facility. Findings include: On 07/23/2024 at 10:20 AM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 918	due dates for inspections, maintenance, and testing schedules. 4. The Correction will be monitored by: EVS Director	