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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5U98

## 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 **07/26/2018** (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, Unit Supervisor 07/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 07/31/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

CMS Certification Number (CCN): 245622 July 30, 2018

Ms. Amy Koehnen, Administrator
Meadows on Fairview
25565 Fairview Avenue
Wyoming, MN 55092

Dear Ms. Koehnen:

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 June 21, 2018 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.

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered July 30, 2018

Ms. Amy Koehnen, Administrator
Meadows on Fairview
25565 Fairview Avenue
Wyoming, MN 55092

RE: Project Number S5622003

Dear Ms. Koehnen:

On June 11, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 31, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 26, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 25, 2018 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 May 31, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 21, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 31, 2018, effective June 21, 2018 and therefore remedies outlined in our letter to you dated June 11, 2018, 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.

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

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

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(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 **05/31/2018** (L34)

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2 AOA 3 Other

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| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
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**12/31**

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Compliance Based On:
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**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:
Kimberly Settergren, HFE NE II 06/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 07/30/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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3. Both of the Above :
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**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
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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

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
June 11, 2018

Ms. Amy Koehnen, Administrator
Meadows On Fairview
25565 Fairview Avenue
Wyoming, MN 55092

RE: Project Number S5622003

Dear Ms.. Koehnen:

On May 31, 2018, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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;

Electronic 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@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 July 10, 2018 the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- 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 ePoC 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 ePoC 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 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, 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 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.

## 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 August 31, 2018 (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 December 1, 2018 (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
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:

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:

Mr. 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
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

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 _____ | 05/31/2018 |

| 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<br><br>A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 5/29/18, through 5/31/18, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| E 018 SS=C | Procedures for Tracking of Staff and Patients<br>CFR(s): 483.73(b)(2)<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]<br><br>(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.<br><br>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. | E 018 | | 6/21/18 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 06/21/2018 |

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.

| 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 _____ | 05/31/2018 |

| 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 018 | Continued From page 1<br><br>*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.<br>(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.<br>(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.<br><br>*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.<br><br>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.<br><br>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. | E 018 | | |

| 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 _____ | 05/31/2018 |

| 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 |
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| E 018 | Continued From page 2<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the emergency preparedness plan addressed tracking of on-duty staff during an emergency. This had the potential to affect all 12 residents residing in the facility.<br><br>Findings include:<br><br>The facility emergency preparedness action plan for 2017, lacked direction for tracking of on-duty staff during an emergency or evacuation.<br><br>On 5/31/18, at 11:08 a.m. the administrator stated there should be a clipboard in the van for tracking staff, but verified she could not find it in the facility plan. The administrator verified the facility plan was developed in 11/17. | E 018 | Emergency Preparedness Action Plan has been updated with a Policy and Procedure addressing on-duty staff tracking during and emergency or evacuation. Staff have been trained via memo on this policy/procedure.<br><br>Policy and Procedure has been sent to MDH for review and is listed below.<br><br>POLICY: In case of an emergency or disaster or the need to evacuate, the following procedures will be used.<br><br>PURPOSE: To assure the continued quality of care for residents.<br><br>PROCEDURE:<br>In the event of an emergency staff will “defend in place” and stay at the facility as directed by the ED/Administrator/designee. Facility staff will do their best to prepare for the emergencies and may have available roll-away cots, guest rooms, etc for staff to stay.<br><br>1. Seek advice from Executive Director/Administrator/DON or designee/Incident Commander.<br><br>2. If staff are unable to be contacted the person in charge during an emergency has the authority to make decisions regarding operation of the facility.<br>• Assess resident needs and assign available staff accordingly without regard | |

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| E 018 | Continued From page 3 | E 018 | to department but with each employees' abilities in mind.<br>• Provide instructions as to essential functions (nursing and dietary) and what functions can be postponed until more staff are available.<br>• Employees may be requested to stay beyond their normal working hours.<br>• Provide rest areas and meals for employees unable to leave at assigned times.<br>• Off-duty employees may be called in.<br><br>In case of an Evacuation the Incident Commander will use the "Staff/Volunteer Tracking Slip" located in the Emergency Red Binder for identifying all staff on duty that are participating in the evacuation, noting their assignment, and tracking their whereabouts. Staff will be assigned their task per the incident commander (see the Red Evacuation Books) and the Incident Commander will either track staff his/herself or assign the duty to another. (See Staff/Volunteer Tracking Form) | |
| E 024 SS=C | Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)<br><br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] | E 024 | | 6/21/18 |

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| E 024 | Continued From page 4<br><br>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the emergency preparedness plan addressed the use of volunteers. This had the potential to affect all 12 residents residing in the facility.<br><br>Findings include:<br><br>The facility emergency preparedness action plan for 2017, lacked direction for the use of volunteers during an emergency.<br><br>On 5/31/18, at 11:08 a.m. the administrator stated they would not use volunteers in any capacity, and verified the facility plan did not address the use of volunteers. The administrator verified the facility plan was developed in 11/17. | E 024 | The Facilities Emergency Preparedness Action Plan has been updated to include Policy and Procedure regarding the use and tracking of volunteers during an emergency or evacuation. Staff have been trained via memo on this new Policy and Procedure.<br><br>Policy and Procedure has been sent to MDH for review and is below:<br><br>POLICY:<br><br>In case of an emergency or disaster or the need to evacuate, the following procedures will be used if any volunteers are present.<br><br>PURPOSE:<br>To assure the continued quality of care for residents.<br><br>PROCEDURE: | |

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| E 024 | Continued From page 5 | E 024 | Generally, Meadows on Fairview SNF/TCU does not use any outside volunteers. The only volunteers that regularly come to the SNF/TCU are internal residents from our campus that are located under the same roof/internal walkway. In the event of an emergency no volunteers will be scheduled or used.<br>In the event of an evacuation no volunteers will be scheduled. If a volunteer happens to be in the building at the time of the evacuation(internal/campus volunteers, family members, guests/visitors) they will be utilized and tracked using the same system as the employees and the following guidelines:<br><br>1. Seek advice from Executive Director/Administrator or designee/Incident Commander.<br>2. Assist in carrying out the functions of the Role the Incident Commander has assigned to the volunteer.<br>3. Volunteers should partner with a staff member.<br>4. Volunteers will be tracked for up to 24 hours.<br>5. Tracking Sheets will be in the Red Evacuation Binders and also in the Van.<br><br>In case of an Evacuation the Incident Commander will use the “Staff/Volunteer Tracking Slip” located in the Emergency Red Binder for identifying all staff on duty that are participating in the evacuation, noting their assignment, and tracking their whereabouts.<br>See Attached Staff/Volunteer Tracking | |

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| E 024 | Continued From page 6 | E 024 | Sheet. | |
| F 000 | INITIAL COMMENTS<br><br>On 5/29/18, through 5/31/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at | F 880 | | 6/21/18 |

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| F 880 | Continued From page 7<br>a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. | F 880 | | |

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| F 880 | Continued From page 8<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use during glucometer checks for 1 of 1 resident (R3) reviewed for glucometer checks, and 1 of 1 residents (R1) reviewed for wound care.<br><br>Findings include:<br><br>R3's Admission Record printed 5/31/18, indicated R3's diagnoses included diabetes mellitus type 2.<br><br>R3's Order Summary Report dated 5/31/18, directed nursing to monitor R3's blood glucose before meals and at bedtime.<br><br>On 5/29/18, at 3:48 p.m. licensed practical nurse (LPN)-A was observed in the process of doing a glucometer check (to monitor blood glucose levels) for R3. LPN-A was not wearing gloves while poking R3's finger with the lancet and obtaining the blood sample in the sample strip in the glucometer. LPN-A returned to the medication cart, disposed of the lancet in the sharps | F 880 | BLOOD GLUCOSE INFECTION CONTROL:<br>R3 Received no injuries/consequences from LPN-A not using gloves during blood glucose monitoring on 5/29/18.<br>Re-education was done with LPN-A immediately after the surveyor observed the incident and LPN-A expressed understanding and willingness to comply.<br>LPN-A had 5 residents with blood glucose monitoring that day. LPN - A was noted to be wearing gloves when performing blood glucose checks on all four of her remaining residents that day.<br><br>All licensed staff have been re-educated on wearing gloves when performing blood glucose checks and proper hand hygiene and have received a copy of the Policy and Procedure regarding the same.<br>Monitoring of blood glucose checks has been on-going with audits being performed three times a week for three weeks (6/10 - 7/1) and if no concerns two | |

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| F 880 | Continued From page 9<br>container, sanitized her hands, opened the medication cart, wrapped the glucometer in a Sani-cloth, and sanitized her hands. At that time, LPN-A stated she usually wears gloves, but hadn't that time.<br><br>On 5/31/18, at 2:34 p.m. registered nurse (RN)-A verified staff should be wearing gloves when doing a glucometer check, and should sanitize hands after glove removal, and before touching clean items.<br><br>R1's Admission Record printed 5/31/18, indicated R1's diagnoses included diabetes mellitus with a foot ulcer.<br><br>R1's care plan initiated 5/17/18, indicated R1 had a Methicillin-resistant Staphylococcus aureus (MRSA) bacterium causing an infection in the left foot. R1's care plan directed staff to use contact precautions, wear gowns and masks during changing of contaminated linens, and use standard or universal precautions (avoiding contact with bodily fluids, by means of the wearing of nonporous articles such as medical gloves, goggles, and face shields). The care plan also directed staff observe for signs and symptoms of infection, and wash hands immediately after activities of daily living, care tasks and activities.<br><br>R1's Order Summary Report dated 5/31/18, included orders for left foot wound, treatment for a coccyx and buttocks wound, and intravenous antibiotic orders for the left foot wound infection.<br><br>R1's progress notes for antibiotic treatment dated 5/31/18, indicated R1's left foot wound dressing was changed every other day, no drainage noted | F 880 | times a week for two weeks (7/2 - 7/15) and then once a week if no concerns (7/16 - Quarterly QAPI mtg). Decision will be made at 7/17 quarterly QAPI meeting on how often to continue regular auditing of blood glucose checks.<br><br>WOUND CARE INFECTION CONTROL:<br><br>R1 received no injuries/consequences from LPN-B not following proper hand hygiene during the dressing change on 5/31/18. No s/s of increased infection have been noted. No other residents under LPN-B's care received wound care that day. LPN-B was aware of, and received re-education on proper hand hygiene during donning/doffing gloves during wound care that same day. She expressed understanding and willingness to comply.<br><br>All licensed staff have been re-educated on proper hand hygiene during wound cares and given a copy of the policy/procedure. Monitoring has been on-going with audits being performed on wound care three times a week for three weeks (6/10 - 7/1) and if no concerns two times a week for two weeks (7/2 - 7/15) and then once a week if no concerns (7/16 - Quarterly QAPI mtg). Decision will be made at 7/17 quarterly QAPI meeting on how often to continue regular auditing of wound care.<br><br>All nursing staff is currently being re-educated and audited on general | |

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| F 880 | Continued From page 10<br>through the dressing, R1 was without a fever, and was seen by infectious disease. R1's antibiotic therapy had been continued for another 30 days due to suspected osteomyelitis (infection of the bone) beneath the wound.<br><br>R1's progress notes for antibiotic treatment dated 5/29/18, indicated R1's left foot wound had a small amount of brown and purulent drainage (containing pus; a sign of infection).<br><br>On 5/30/18, at 3:09 p.m. LPN-B was observed to prepare to do a dressing change on R1's left foot wound. LPN-B sanitized her hands and put on a gown, mask and gloves. LPN-B entered R1's room, and took out a bin of supplies. LPN-B removed R1's left stocking and Tubigrip (elastic tubular support), and stated there was no dressing was in place. R1's wound had yellow slough (dead tissue) on approximately 90% of the wound base, and 10% pink granulation (new tissue growth). LPN-B sprayed the wound cleanser and cleansed R1's foot wound with wound cleanser and gauze, opened dressings, opened a tube of Iodosorb gel (cleans wound by absorbing fluids, removing exudate, slough and debris and forming a gel over the wound surface) and squeezed it into the inside of the gauze pad wrapping. LPN-B opened the gauze packing, removed her soiled gloves, and put on clean gloves without performing hand hygiene. LPN-B put the Iodosorb on the wound base with a cotton-tip applicator, put the Nugauze packing (fine dressing that absorbs fluids) over the wound base after moistening it with sterile water, and opened a packet of skin prep and applied it to the skin around the wound. LPN-B then put an Primapore dressing (conformable adhesive dressing consisting of a breathable non-woven | F 880 | proper hand hygiene techniques. Annual education has been updated for all staff regarding hand hygiene. Random audits will continue throughout the year. | |

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| F 880 | Continued From page 11 | F 880 | | |

top layer and a low-adherent absorbent pad) over the wound, removed her soiled gloves, and put on clean gloves without performing hand hygiene. LPN-B threw away the old Tubigrip that was previously over the wound, then looked at R1's healed wounds on his arms and put Aquaphor (skin protectant ointment that moisturizes, nourishes and protect the skin to aid in healing) on R1's left lower extremity. LPN-B then removed her soiled gloves, and put clean gloves on without performing hand hygiene. LPN-B cut a clean piece of Tubigrip, put it on over R1's left foot, dressing and up the leg, and put R1's stocking and shoe on. LPN-B removed the protective pad from under R1's leg, threw it in the garbage, removed her soiled gloves, applied clean gloves, and did not perform hand hygiene. LPN-B closed up the top of the garbage bag, tied it, and put it in the biohazard bag. LPN-B removed her soiled gloves, and without performing hand hygiene, wiped the scissor blade with an alcohol swab, put away the treatment supplies in the bin, and took a garbage bag out of the cabinet in R1's room. LPN-B removed her gown, gloves, and mask and disposed of them in the biohazard bag. LPN-B then washed her hands.

On 5/30/18, at 3:39 p.m. LPN-B verified she should have sanitized or washed her hands between glove changes, especially from dirty to clean. LPN-B stated she tried to be very careful not to touch dirty things and contaminate her gloves, but acknowledged she could have contaminated R1's supplies if her gloves were soiled. LPN-B stated R1's wound did not have yellow slough yesterday, but she cleaned it all out of the wound today, when she cleansed it.

On 5/31/18, at 2:34 p.m. registered nurse (RN)-A

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| F 880 | Continued From page 12<br>verified staff should wash or sanitize hands when entering a room, doing wound care, before leaving the room, and after removal of gloves following removal of a soiled dressing. Staff should then don new gloves, do clean tasks, and then wash or sanitize after removing gloves. RN-A verified staff should not touch wound care supplies after removing a dressing or when gloves were soiled, and verified there could be cross contamination of organisms.<br><br>The facility policy and procedure for Blood Glucose Disinfection revised 3/17, directed staff to disinfect the glucometer after using it, while wearing gloves.<br><br>The facility policy and procedure for Hand Hygiene revised 9/17, directed staff to wash hands after removing gloves, and to change gloves before touching a residents non-intact skin or open wound, and change gloves if moving from a contaminated body site to a clean body site, and remove gloves after contact with a resident and medical equipment. | F 880 | | |

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| K 000 | INITIAL COMMENTS | K 000 | | |

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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS 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 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) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

EPOC

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 06/21/2018 |

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.

| 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 _____ | **05/30/2018** |

| 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 000 | Continued From page 1<br>St Paul, MN 55101-5145, or<br><br>By email to:<br>Marian.Whitney@state.mn.us and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br>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.<br><br>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.<br><br>The facility has a capacity of 14 beds and had a census of 14 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is | K 000 | | |

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| K 000 | Continued From page 2<br>NOT MET as evidenced by: | K 000 | | |
| K 354 SS=C | Sprinkler System - Out of Service<br>CFR(s): NFPA 101<br><br>Sprinkler System - Out of Service<br>Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service.<br>18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code (19.3.5.1, 9.7.5, 15.5.2 (NFPA 25))<br>This deficient practice could affect the safety of all (14) the residents, staff and visitors within the smoke compartment.<br>Findings Include:<br>On facility tour between 09:30:00 AM and 11:30 PM on 5/31/18, observation and documentation reviewed revealed the following:<br>The Facility does not have a current out of service policy.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 354 | Facility has a current Sprinkler Out of Service Policy. Staff have been trained via memo on this updated policy. | 6/21/18 |
| K 711 SS=C | Evacuation and Relocation Plan<br>CFR(s): NFPA 101 | K 711 | | 6/21/18 |

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| K 711 | Continued From page 3<br><br>Evacuation and Relocation Plan<br>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.<br>Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.<br>18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code (19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3)<br>This deficient practice could affect the safety of all (14) the residents, staff and visitors within the smoke compartment.<br>Findings Include:<br>On facility tour between 09:30 AM and 11:30 PM on 5/31/18, observation and documentation reviewed revealed the following:<br>Facility does not have a current fire drill policy with new code years.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 711 | Facility has a current Fire Drill Policy that has the updated code years. Staff have been trained via memo on the new Policy. | |
| K 781 SS=C | Portable Space Heaters<br>CFR(s): NFPA 101<br><br>Portable Space Heaters<br>Portable space heating devices shall be prohibited in all health care occupancies, except, | K 781 | | 6/21/18 |

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| K 781 | Continued From page 4<br>unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 19.7.8)<br>This deficient practice could affect the safety of all (14) the residents, staff and visitors within the smoke compartment.<br>Findings Include:<br>On facility tour between 09:30 AM and 11:30 PM on 5/31/18 observation and documentation reviewed revealed the following:<br>Facility does not have a current space heater policy.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 781 | Facility has a current Space Heater Policy. Staff have been trained via memo on this new policy. | |