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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RML1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00259

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245170**

2.STATE VENDOR OR MEDICAID NO.
(L2) **616845105**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRVIEW UNIVERSITY TRANS SERV**
(L4) **2450 RIVERSIDE AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55454**

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 **11/17/2014** (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 **36** (L18)

13.Total Certified Beds **36** (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: * Code: **A*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(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 :
Gloria Derfus, Supervisor 10/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/11/1969
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/06/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5170

November 18, 2014

Ms. Caroline Portoghese, Administrator
Fairview University Transitional Services
2450 Riverside Avenue South
Minneapolis, Minnesota 55454

Dear Ms. Portoghese:

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 October 8, 2014 the above facility is certified for:

36 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 17, 2014

Ms. Caroline Portoghese, Administrator
Fairview University Transitional Services
2450 Riverside Avenue South
Minneapolis, Minnesota 55454

RE: Project Number S5170024

Dear Ms. Portoghese:

On October 13, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 2, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 17, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 4, 2014 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 October 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 8, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 2, 2014, effective October 8, 2014 and therefore remedies outlined in our letter to you dated October 13, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245170	A. Building B. Wing	11/17/2014

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**10/03/2014**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	**10/08/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GD/AK	Date: 11/17/2014	Signature of Surveyor: 18623	Date: 11/17/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/2/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245170	A. Building 01 - MAIN BUILDING 01 B. Wing	11/4/2014

Name of Facility	Street Address, City, State, Zip Code
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0020	10/02/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 11/17/2014	Signature of Surveyor: 28120	Date: 11/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/2/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RML1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00259

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(L1) **245170**

2.STATE VENDOR OR MEDICAID NO.
(L2) **616845105**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIRVIEW UNIVERSITY TRANS SERV**
(L4) **2450 RIVERSIDE AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55454**

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 **10/02/2014** (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 **36** (L18)

13.Total Certified Beds **36** (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: * Code: **B** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(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 :
Kathy Sass, HPR-Dietary Specialist 10/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/06/2014 (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
07/11/1969
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4820

October 13, 2014

Ms. Linda Gustafson, Administrator
Fairview University Transitional Services
2450 Riverside Avenue South
Minneapolis, Minnesota 55454

RE: Project Number S5170023

Dear Ms. Gustafson:

On October 2, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

<u>Remedies</u> - 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;

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 November 11, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 11, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 2, 2015 (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 April 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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
	245170	A. BLDG. _____ B. WING _____	10/2/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55455

(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
F000	INITIAL COMMENTS On 9/29/14, through 10/2/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program: PO Box 64900, Saint Paul, MN 55164-0900		FAIRVIEW UNIVERSITY TRANSITIONAL SERVICES Please accept this initial filing by Fairview University Transitional Services, as timely and one, which demonstrates that the deficiencies cited in the Statement of Deficiencies dated October 13, 2014 from a survey of completed on October 2, 2014 by the Minnesota Department of Health for the Centers for Medicare and Medicaid Services (CMS). Fairview University Transitional Services has provided credible evidence of correction of such asserted deficiencies noted in Tag F356, and F456.	10/24/14
F356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name o The current date o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: o Registered nurses o Licensed practical nurses or licensed vocational nurses (as defined under State law) o Certified nurse aides o Resident census The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format o In a prominent place readily accessible to residents and visitors The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F356	The following information will be posted on a daily basis: • Facility Name • Current Date • The total number and actual hours worked by Registered Nurses and Certified Nursing Assistants responsible for resident care. • Resident Census. Staffing information will be posted in public area accessible for residents and visitors across from main nursing station desk *(Attachment A)*. To ensure staffing information is posted at the beginning of each day, the responsibility for completion and posting of information has been delegated to night shift RN. Staff have been advised of their role and expectation via email Posted staffing data will be retained by the facility administrator for a minimum of 18 months.	10/3/14 10/3/14 10/3/14 10/3/14

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

Acting Administrator TCU 10/23/14 — Interim Administrator at time

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.

Signed 10/23/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BLDG. _____ B. WING _____	10/2/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE, MINNEAPOLIS, MN 55455

(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
F356	Continued From page 1 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the staff posting was updated on a daily basis. This had the potential to affect all 11 residents and family/visitors. Findings include: On 9/29/14 at 11:50 a.m. during an initial tour of the facility, the staff posting dated 9/29/14, was located on the wall across from the nursing station, in a clear acrylic wall holder. For each shift, the staff posting listed the census of the unit, registered nurses (RN's)on duty and nursing assistants (NA's) on duty. The staff posting dated 9/29/14, indicated the 7:00 a.m. to 3:30 p.m. shift had a patient census of 11, with three RN's and one NA working. On 9/30/14 at 8:00 a.m. the staff posting had not been changed and indicated the date of 9/29/14, the 7:00 a.m. to 3:30 p.m. shift had a patient census of 11, with three RN's and one NA working. The evening shift did not have a census and listed three RN's and one NA scheduled. The night shift did not have a census and listed two RN's and one NA scheduled. On 9/30/14 at 12:10 p.m. the director of nursing (DON) verified the staff posting was still dated for 9/29/14, and had not been updated for the evening and night shift census. The DON stated the HUC was floated today and that was probably why it was not updated.	F356	Bi-monthly the facility administrator will monitor compliance. The administrator will also conduct 10 random daily audits per month for 3 months, audit records will be retained for 18 months. Acceptable deviation will be less than 5%, if greater than 5% facility administrator will work with Director of Nursing to assure compliance.	10/3/14 - ~~1/3/2015~~ ongoing PMC W834 @ 11:54am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BUILDING _____ B. WING _____	10/2/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE MINNEAPOLIS, MN 55455

(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
	Continued From page 2			
F356	The regulation requirements were reviewed with the DON, and included the staff posting should be updated at the start of every shift. -At 12:30 p.m. the DON provided the staff posting for 9/30/14, which indicated the day shift had a census of 11 with three RN;s for 24 hours, two NA's for 16 hours. The evening shift had a census listed of 12 with three RN's for 24 hours, and two NA's for 15 hours. The night shift had a census listed of 12 with two RN's for 15 hours and one NA for eight hours. The DON verified an admission was expected to raise the census to 12.			
F456 SS=E	483.709(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 2 blanket warmers were maintained in a fully functional manner, which had the ability to affect 1 of 2 residents, (R46) reviewed who utilized the blanket warmer on the unit. However, this had the potential to affect 6 of the 11 residents. Findings Include: On 9/29/14, at 11:44 a.m. in the clean utility room the blanket warmer in West clean supply room (425) was set at 155 degrees Fahrenheit(F), the digital display read 156F.	F456	A work order was created for Facilities to provide maintenance and repair on both blanket warmers on the unit. Blanket warmers were both repaired and temperature settings locked at 130F.	9/30/14 9/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BLDG. _____ B. WING _____	10/2/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE MINNEAPOLIS, MN 55455

(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
	Continued From page 3			
F456	A sign posted on the face of the blanket warmer stated, "This blanket warmer can be used only for blankets. Maximum temperature is 130 F. If the temperature is set higher than 130F reset to 130F." The blanket warmer was opened; the temperature of the blankets to touch was minimally warm, but not hot. -At 12:00 p.m. nursing assistant (NA)-A entered the clean utility room, NA-A verified the digital display on the blanket warmer read 154F. NA-A then took a Blanket to room 426 fro R46. NA-A then returned to the clean supply room. -At 1:30 p.m. the director of nursing (DON) observed the blanket warmer in the West clean utility room blanket warmer had been set down to 130F, the digital display indicated 130F, when checked with the electronic thermometer the temperature registered 117F. On 9/29/14 at 1:55 p.m. the regulatory compliance specialist for the University of Minnesota Medical Center (RC) stated there have not been any I-Cares (incident and accident reports) for burns from the blanket warmers. The RC provided the work orders related to the individual blanket warmers. A general work order dated 3/21/14, was reviewed for the blanket warmer in West clean utility room (425). The work order lacked notation of the equipment ID number, and identified issue: "Blanket warmer is too hot, at 160F, supposed to be at 130F." The report was called into security office at 5:04 p.m. with a priority of 5 non-emergency/general work. The work order indicated the work was completed at 9:00 p.m. but the work order did not identify what the problem was or what was done to correct the problem.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BLDG _____ B. WING _____	10/2/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE MINNEAPOLIS, MN 55455

(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
F456	Continued From page 4 A general work order dated 4/2/13, at 12:47 p.m. and sent to facilities indicated "Blanket warmer in East clean utility room was not warming, priority 5 non-emergency general work." At 3:55 p.m. the problem code identified repair replace, with no further description or what was done to correct the problem. On 9/30/14 at 8:30 a.m. R46 was interviewed and stated the warm blankets are just barely warm, and have not caused any issues or discomfort for him. R46 indicated he was recovering from kidney surgery. R46 was alert and oriented at the time of the interview. On 9/30/14 at 9:28 a.m. a Preventative Maintenance (PM) work order indicated priority non-emergency patient care, completed 9/30/14, indicated blanket warmer Amsco asset #002902 (new red bar coded sticker) and Amsco asset #0029303 (new red bar coded sticker) indicated procedures "blanket warmer annual: check operation, check temp, check for proper signage, make sure set point is locked, check all working parts (lights/doors hinges/latches/gaskets)." On 9/30/14, at 2:08 p.m. the director of facilities (FD), with the RC and administrator were given a summary of the observations on 9/29/14, for the blanket warmer(s) findings. The FD stated the equipment was checked when brought into the system and then things like blanket warmers were tabled exempt and only looked at when called to check repair them. The FD verified during a review of the work orders, the work orders laced documentation of the equipment ID number, or a description of the service provided to repair the blanket warmer(s). The FD stated "They should be documenting what they did to repair it on		Both blanket warmers located in Transitional Services have been entered into the equipment inventory. Preventative maintenance (PM) will be completed according to manufacturer's standards. Director of Facilities and the facility administrator will monitor the completion of pm on the blanket warmers annually. Facility Director discussed the following items at a staff meeting: PM documentation expectations and identification of equipment not on PM cycles.	9/30/14 9/30/14-ongoing 10/8/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BLDG. _____ B. WING _____	10/2/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE MINNEAPOLIS, MN 55455

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F456	Continued From page 5 the work order sheets." "The Blanket warmers were put back into the PM cycle today, calibrated and given new bar code stickers that say UMMC-W (for west bank)." The FD further stated, as equipment was located it was being brought back into the PM cycle, these (blanket warmers) were never part of an alternative maintenance program, they were tabled exempt, with the thought that surveyors would see exempt and walk past. The FD stated the staff meeting would be that week, identifying equipment not in the cycle and documenting work done would be addressed. The Medical Equipment Maintenance Schedule – UMMC revised 1/11 noted, "To ensure that the equipment maintenance schedule is implemented and completed as required by the Clinical Risk Assessment Plan...the PM technician and other technicians assigned to work PM's are responsible for closing PM work orders, they are also responsible for any editing of the St. Croix Systems database with regard to their assigned PM's for the month. This includes looking for duplicate pieces of equipment and requesting a 'merge' from the 'Change Manager' if needed, switching from B numbers to F numbers, filling in missing serial numbers, changing department owner and location information, adding new equipment to the database, and verifying manufacturer/ model numbers of devices...when closing PM and safety inspection work orders, all template blanks must be filled in. If an edit needs to occur to the PM template, send a request to the "Change Manager."			

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	245170	A. BLDG. _____ B. WING _____	10/2/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE MINNEAPOLIS, MN 55455

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	Continued From page 6			
F456	On 10/2/14, at 9:15 a.m. registered nurse (RN)-A, stated that "usually 60 to 70% of the patients are using warmed blankets at any time, although not 100% because some have orders not to use them (warmed blankets), depending on what has been done. We usually sue them for transport to other services (through the tunnel system on campus)." The Amsco Blanket warmer manufacturer's recommendations, provided by the facility, (section 5) indicated, "Each warming cabinet must be testing and inspected. A visual inspection of the cabinet and doors. A functional temperature checks should calibrate within 5 degree F."			

F5170024

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE SOUTH MINNEAPOLIS, MN 55454

(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	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, UMMC Fairview Transitional Services was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 5-story building was determined to be of	K 000	POC for K20 W/FSES ft 10-29-14 TS RECEIVED OCT 28 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Acting Administrator TCU 10/28/14 — Acting Administrator at time of survey — 10/28/14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BLDG. _____ B. WING _____	10/2/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE MINNEAPOLIS, MN 55455

(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
K000	Continued From page 1 This 5-story building was determined to be of Type II (222) construction. It has a full basement and 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. The facility ahs a capacity of 36 beds and had a census of 10 at the time of the survey. Only the 4th floor is occupied as a skilled nursing facility. The 3rd and 5th are also surveyed as a condition of the facility FSES. The requirement at 42CFR, Subpart 483.70(a) NOT MET as evidenced by:			
K020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.285.6 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain vertical openings as required by LSC(00) Section 19.3.11. This deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 12:30 PM on 10/2/2014, observation revealed that the resident room ventilation system is served by a vertical riser duct shaft with horizontal ductwork.	K020	FSES *(Attachments B1-B14)*	10/2/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245170	A. BUILDING _____ B. WING _____	02/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW UNIVERSITY TRANS SERV	2450 RIVERSIDE AVENUE, SUITE C 2300 MINNEAPOLIS, MN 55455

(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
K020	Continued From page 2 leading from the penthouse to the resident rooms. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.			