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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WEMD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245545**

2.STATE VENDOR OR MEDICAID NO.
(L2) **804740500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIR MEADOW NURSING HOME**
(L4) **BOX 8 300 GARFIELD AVENUE SOUTHEAST**
(L5) **FERTILE, MN** (L6) **56540**

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 **09/04/2017** (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)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (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
	42			
(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 :
Lyla Burkman, Unit Supervisor 09/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 09/08/2017 (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
02/01/1991
(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
09/08/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245545 September 8, 2017

Ms. Angela Leiting, Administrator
Fair Meadow Nursing Home
Box 8 300 Garfield Avenue Southeast
Fertile, MN 56540

Dear Ms. Leiting:

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 August 21, 2017 the above facility is recommended for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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 Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697
cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 8, 2017

Ms. Angela Leiting, Administrator
Fair Meadow Nursing Home
Box 8 300 Garfield Avenue Southeast
Fertile, MN 56540

RE: Project Number S5545026

Dear Ms. Leiting:

On August 1, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 13, 2017. 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 September 4, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 24, 2017 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 July 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 21, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 13, 2017, effective August 21, 2017 and therefore remedies outlined in our letter to you dated August 1, 2017, 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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WEMD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00460

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(L1) **245545**

2.STATE VENDOR OR MEDICAID NO.
(L2) **804740500**

3. NAME AND ADDRESS OF FACILITY
(L3) **FAIR MEADOW NURSING HOME**
(L4) **BOX 8 300 GARFIELD AVENUE SOUTHEAST**
(L5) **FERTILE, MN** (L6) **56540**

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 **07/13/2017** (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)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(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 :
Vienna Andresen, HFE - NE II 08/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 09/07/2017 (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
02/01/1991
(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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 1, 2017

Ms. Angela Leiting, Administrator
Fair Meadow Nursing Home
Box 8 300 Garfield Avenue Southeast
Fertile, MN 56540

RE: Project Number S5545026

Dear Ms. Leiting:

On July 13, 2017, 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 electronically delivered CMS-2567, whereby corrections are required.

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 a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 August 22, 2017, 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 August 22, 2017 the following remedy will be imposed:

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

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.

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 October 13, 2017 (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 January 13, 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 electronic 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 related to this letter.

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	**BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On July, 10, 11, 12 and 13, 2017, 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. 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 (electronic plan of correction), your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect,	F 225		8/15/17

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

Electronically Signed | 08/09/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	**BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of potential abuse/mistreatment to the State Agency (SA) and administrator for 2 of 4 residents (R3, R4) reviewed for potential allegations of abuse not reported to the SA and administrator timely. Findings include: The facility submitted an Incident Report to the Office of Health Facility Complaints (OHFC) on 2/14/17, which indicated on 2/11/17, staff were pushing R40 past R3 when R40 grabbed onto R3's shirt by the collar and started hitting R3. The Resident Abuse Investigation form indicated incident occurred on 2/11/17, however the SA and administrator were not notified until 2/14/17. The facility submitted an Incident Report to the OHFC on 1/26/17, which indicated on 1/25/17, nursing assistant (NA)-B and NA-C were assisting R4 to get ready for the day. NA-C entered the room due to R4 yelling during cares.	F 225	Nursing supervisor meeting held on 08/08/2017. Charge staff were re-educated on reporting any incidents of abuse to an RN or the social worker within 2 hours for determination of need to file. Administrator to be notified immediately. If deemed reportable Social Worker or RN will file a vulnerable adult report to the state. VA policy and procedures were reviewed. New definitions were explained. CNA meeting scheduled for 08/15/2017 to re-educate staff on reporting any incidents of abuse immediately to the charge staff. VA policy, procedures and definitions will be reviewed. Upon hire, all staff are trained regarding VA policies and procedures. Upon hire, facility verifies all employees with a background check to ensure no history of abuse or mistreatment. DON and Social Worker will perform daily audits for compliance for 3 months, then twice weekly for 2 months, then random audits once compliant. All VA investigations and results will be brought to the QAA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245545	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIR MEADOW NURSING HOME	**BOX 8 300 GARFIELD AVENUE SOUTHEAST FERTILE, MN 56540**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 NA-C was assisting R4 to put on an undershirt. While R4 was yelling, NA-C put R4's undershirt in her mouth and told her to bite on that. R4 continued to yell so NA-C put her hand over R4's mouth and told her to shut up. NA-B did not report the incident until 5:50 p.m. that day when NA-B called registered nurse (RN)-A at home. RN-A instructed NA-B to put her observations in writing and turn it in to the director of nursing (DON) in the morning on 1/26/17. RN-A reported to the licensed social worker (LSW) and the DON the evening of 1/25/17. The incident occurred the morning of 1/25/17, however the administrator was not notified until 6:00 p.m. and the SA was not notified until 1/26/17. On 7/13/17, at 9:18 a.m. the LSW confirmed the incident involving R3 occurred on 2/11/17 which was a Saturday, however the administrator and SA were not notified until the following Tuesday, 2/14/17. LSW confirmed the incident should have been reported immediately. LSW also confirmed the incident involving R4 occurred on the morning of 1/25/17, was not reported to the administrator until 6 p.m. and the SA was not notified until 1/26/17, and the incident should have been reported immediately. On 7/13/17 at 1:22 p.m. the DON confirmed allegations of abuse/mistreatment should have been reported immediately, as directed by the facility policy. The Vulnerable Adult Abuse Prohibition Plan dated 11/28/16, directed each employee who has reason to believe a vulnerable adult is being or	F 225	Completion August 15, 2017.	

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F 225	Continued From page 4 has been maltreated shall immediately report to his/her immediate supervisor. The supervisor in turn must immediately report all suspected maltreatment to the DON or the LSW and the administrator. Reports must be filed immediately by the person in charge to protect the vulnerable adult from further maltreatment. The employee must report to the Minnesota Department of Health (MDH) OHFC.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 226		8/15/17

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F 226	Continued From page 5 (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse policy and procedure related to the immediate reporting to the administrator and State Agency (SA) allegations of potential abuse/mistreatment for 2 of 4 residents (R3, R4) reviewed for potential allegations of abuse/mistreatment. Findings include: The Vulnerable Adult Abuse Prohibition Plan dated 11/28/16, directed each employee who has reason to believe a vulnerable adult is being or has been maltreated shall immediately report to his/her immediate supervisor. The supervisor in turn must immediately report all suspected maltreatment to the director of nursing (DON)or the licensed social worker (LSW) and the administrator. Reports must be filed immediately by the person in charge to protect the vulnerable adult from further maltreatment. The employee must report to the Minnesota Department of Health (MDH) OHFC. The facility submitted an Incident Report to the OHFC on 2/14/17, which indicated on 2/11/17, staff were pushing R40 past R3 when R40 grabbed onto R3's shirt by the collar and started	F 226	Nursing supervisor meeting held on 08/08/2017. Charge staff were re-educated on reporting any incidents of abuse to an RN or the social worker within 2 hours for determination of need to file. Administrator to be notified immediately. If deemed reportable Social Worker or RN will file a vulnerable adult report to the state. VA policy and procedures were reviewed. New definitions were explained. CNA meeting scheduled for 08/15/2017 to re-educate staff on reporting any incidents of abuse immediately to the charge staff. VA policy, procedures and definitions will be reviewed. Upon hire, all staff are trained regarding VA policies and procedures. Upon hire, facility verifies all employees with a background check to ensure no history of abuse or mistreatment. DON and Social Worker will perform daily audits for compliance for 3 months, then twice weekly for 2 months, then random audits once compliant. All VA investigations and results will be brought to the QAA Committee. Completion date 08/15/2017.	

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F 226	Continued From page 6	F 226		

hitting R3. The Resident Abuse Investigation form indicated incident occurred on 2/11/17, however the SA and administrator were not notified until 2/14/17.

The facility submitted an Incident Report to the OHFC on 1/26/17, which indicated on 1/25/17, nursing assistant (NA)-B and NA-C were assisting R4 to get ready for the day. NA-C entered the room due to R4 yelling during cares. NA-C was assisting R4 to put on an undershirt. While R4 was yelling, NA-C put R4's undershirt in her mouth and told her to bite on that. R4 continued to yell so NA-C put her hand over R4's mouth and told her to shut up. NA-B did not report the incident until 5:50 p.m. that day when NA-B called registered nurse (RN)-A at home. RN-A instructed NA-B to put her observations in writing and turn it in to the director of nursing (DON) in the morning on 1/26/17. RN-A reported to the licensed social worker (LSW) and the DON the evening of 1/25/17. The incident occurred the morning of 1/25/17, however the administrator was not notified until 6:00 p.m. and the SA was not notified until 1/26/17.

On 7/13/17, at 9:18 a.m. the LSW confirmed the incident involving R3 occurred on 2/11/17 which was a Saturday, however the administrator and SA were not notified until the following Tuesday, 2/14/17. LSW confirmed the incident should have been reported immediately. LSW also confirmed the incident involving R4 occurred on the morning of 1/25/17, was not reported to the administrator until 6 p.m. and the SA was not notified until 1/26/17, and the incident should have been reported immediately.

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F 226	Continued From page 7 On 7/13/17 at 1:22 p.m. the DON confirmed allegations of abuse/mistreatment should have been reported immediately, as directed by the facility policy.	F 226		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that	F 309		7/20/17

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F 309	Continued From page 8 residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facilty failed to ensure coordination between a urologist and medical power of attorney (POA) in order to determine an ongoing plan of care for nephrostomy tubes for 1 of 1 resident (R44) reviewed with nephrostomy tubes. Findings include: R44's Diagnosis report dated 7/13/17, included diagnoses of ureter stricture, history of acute renal failure, calculus in bladder (kidney stone), stage 3 chronic kidney disease, and malignant neoplasm of prostate (prostate cancer). R44's significant change Minimum Data Set (MDS) dated 5/31/17, indicated R44 had moderate cognitive impairment and had a urinary catheter. The Care Area Assessment (CAA) for indwelling catheter dated 6/7/17, indicated R44 had nephrostomy tubes (the surgical formation of an opening between the kidney and the outside of the body that allows urine to drain directly from the kidneys via catheter or "tubes") for both kidneys. The CAA further indicated R44 had a large kidney stone in the bladder that was blocking the ureters.	F 309	On 07/13/2017 the designated POA was made the primary contact for this resident vs. the stepdaughter that was listed. All calls for resident care will go to POA and other family members as directed by POA. Education provided to charge staff at shift change related to POA contact update for one week. POA was contacted on 07/29/2017 regarding procedure for resident. The POA declined the procedure. The individual had his tubes changed on 08/02/2017. Care will continue unchanged. LSW to continue to receive POA and healthcare directive information from resident and/or family upon admission. POA and healthcare directive information is reviewed quarterly at care conferences with family to obtain any changes. Social worker will make appropriate changes as necessary. Correction to be reported to QAA committee at next quarterly meeting. Completion date 07/20/2017	

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F 309	Continued From page 9	F 309		

R44's Health Care Directive signed and dated on 2/11/16, indicated R44 lacked decision making capacity and appointed family member (FM)-C as the health care agent or POA. The directive included the agent had the power to make any health care decisions, however, R44 desired to be fully informed about and allowed to participate in any and all decision making processes. R44's electronic medical record identified family member (FM)-C as R44's medical POA.

R44 was seen by the urologist on 5/30/17. The visit note indicated R44 was seen for a follow-up visit for the ongoing plan for the nephroureteral catheters. The note indicated R44 was brought to the appointment by FM-A, who "unfortunately" did not have power of attorney, however, provided most of the medical history. The note explained, last year bilateral nephroureteral tubes were placed because R44 had not been a surgical candidate at the time to remove a large stone in the bladder which still measured 6.0 centimeters (cm) by 5.0 cm. The note indicated the facility had increased difficulties and issues managing his nephroureteral tubes (clogging, falling out or pulled out by R44). The note explained the urologist spoke with the son and reviewed risks, goals, complications, and side effects of surgical interventions of removing the stone from the bladder and stent placement. The note indicated R44's son would discuss the options with R44's durable POA and then get in touch with the urologist.

R44's written physician's orders dated 5/30/17, directed staff to update the POA to determine desire to proceed with surgical intervention. The

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	245545	A. BUILDING _____ B. WING _____	07/13/2017

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F 309	Continued From page 10	F 309		

order was "noted" by a nurse on 5/31/17. However, R44's medical record lacked documentation which indicated follow up with R44's POA had been completed.

Review of R44's medical record from 5/30/17, to 7/12/17, revealed the following:

--on 5/30/17, progress note indicated facility staff spoke with FM-B related to the urology appointment. The note indicated the family planned to meet to discuss the options and would inform the facility of their decision.
--on 5/31/17, progress note indicated the registered nurse (RN) was notified of R44's urology appointment and would be discussing with the family.
--on 6/7/17, care conference note indicated no family members had been in attendance and the RN would update the family later. The note identified the recent appointment with urology and the possibility of surgical intervention.
--on 6/8/17, progress note indicated care conference notes were reviewed with FM-B.
The record lacked evidence of notification or discussion with R44's POA had occurred or a decision pertaining to the nephrostomy tubes had been made.

On 7/12/17, at 10:02 a.m. R44 stated he didn't remember having any problems with the nephrostomy tubes, stated the tubes were there because there was a problem and that's how they fixed the problem. R44 explained he was not sure what the ongoing plan for the nephrostomy tubes was, but wished he didn't have to have them if he didn't need them.

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F 309	Continued From page 11	F 309		

On 7/13/17, at 10:21 a.m. nursing assistant (NA)-A emptied the urine collection bags that were held in place by elastic straps on R44's thighs. NA-A pulled up R44's shirt exposing the nephrostomy tubes partially covered by clean dressings on both sides of R44's lower back.

On 7/12/17, at 1:45 p.m. RN-A indicated she was the person responsible to communicate and coordinate care for R44 with POA and family members. RN-A indicated she had relied on family to communicate the information from R44's urology visit and confirmed she had not updated or made attempts to update FM-C.

-At 10:50 a.m. licensed social worker (LSW) confirmed the facility should have contacted the assigned medical POA to inform and discuss the urologist's findings and recommendations.

-at 12:40 p.m., the director of nursing (DON) verified R44's record lacked evidence the physician's order written on 5/30/17, to update the POA was followed and completed. The DON stated FM-C was the assigned POA and did not live in the area. DON explained, the assigned POA should have been directly contacted to inform, discuss, and develop an ongoing plan of care based on the urologist's findings and possible procedures and documentation of the conversation noted in the medical record.

A policy regarding care coordination with resident's power of attorney was requested but not provided

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	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM 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 YOU 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, Fair Meadow Nursing Home 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 and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2017**

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us and Angela.kappenman@ state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Fair Meadow Nursing Home is a 1-story building, without a basement, and constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1972 the south wing was added to the original building and was determined to be of Type II (111) construction. The south wing is separated with at least a 2 hour fire barrier from an apartment building. The facility is divided into 4 separate smoke zones by 30 minute fire barriers. The facility has a fire alarm system with smoke detection throughout the corridor system and in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition with automatic fire department notification. The building is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the	K 000		

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	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2017**

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K 000	Continued From page 2 Installation of Automatic Sprinkler Systems with quick response heads. Hazardous areas have automatic fire detection that is on the fire alarm system. The facility also has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 42 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		7/25/17

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	245545	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2017**

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K 321	Continued From page 3 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to construct 1 storage room in accordance with the 2012 Life Safety Code, (NFPA 101) section 19.3.2.1.3. This deficient practice could allow for smoke or fire to enter the corridor making it untenable for exiting, affecting 10 of the 41 residents and an undetermined amount of staff and visitors. Findings include: At 11:25 am on 07/12/2017 observations revealed storage room 194 in the south wing did not have a closer. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 321	In Room 194 on the South Wing a closer was installed to the door by Maintenance Assistant on Tuesday, July 25, 2017.	
K 341 SS=F	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment.	K 341		8/21/17

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K 341	Continued From page 4 Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect all 41 residents and an undetermined amount of patients, staff and visitors. Findings include: At 11:55 am on 07/12/2017 observations revealed there was no smoke detector within 5 feet of the fire alarm panel. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 341	Maintenance ordered a smoke detector from Simplex Grinnell on July 25, 2017, which will be installed once it arrives in the room where the fire alarm control panel is located. Completion date August 21, 2017.	
K 362 SS=E	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above	K 362		7/21/17

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K 362	Continued From page 5 the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the fire resistance of corridor walls in accordance with the Life Safety Code (NFPA 101) 2012 edition section 19.3.6.2.2. This deficient practice could create additional fuel load in a fire event, creating a more hazardous situation and reduce the time for evacuation. This would affect 5 of the 41 residents and an undetermined amount of staff and visitors. Findings include: At 12:10 pm on 07/12/2017 observations revealed the wall surface of the social services office was oriented strand board (OSB) on the corridor side. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 362	Maintenance called Kronschnabel Construction. They removed the OSB board and installed fire barrier sheetrock on the Social Service Office at the end of the West Wing. Completed July 21, 2017.	
K 363 SS=E	NFPA 101 Corridor - Doors	K 363		7/13/17

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K 363	Continued From page 6 Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide one corridor door with a means suitable to resist the passage of smoke in accordance with the 2012 Life Safety Code	K 363	Maintenance installed smoke gasket on door and door jam for room South 36. Completed July 13, 2017.	

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K 363	Continued From page 7 (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 16 of the 41 residents and an undetermined amount of staff and visitors. Findings include: At 11:20 am on 07/12/2017 observations revealed the door on resident room 36 did not fit tight in the frame. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 363		
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain two of three smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer	K 372	Maintenance filled the penetrations with 3M fire barrier rated foam FIP 1-Step above the ceiling line at the cross corridor doors of the West and East Wing, filled the 3 inch by 6 inch penetration with 3M	7/21/17

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K 372	Continued From page 8 from one smoke compartment to another affecting the exiting of 32 of the 41 residents and an undetermined amount of staff and visitors. Findings include: At 10:40 and 10:46 am on 07/12/2017 observations revealed smoke barrier penetrations: 1. A 3"x6" above the ceiling line at the cross corridor doors of the west wing. 2. A 3"x6" above the ceiling line at the cross corridor doors of the east wing. This deficient condition was confirmed by the Facility Administrator and the Director of Environmental Services.	K 372	fire barrier rated foam FIP 1-Step. Completed July 21, 2017.	