DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 13, 2026

Administrator
Parkview Home
102 COUNTY STATE AID HIGHWAY 9
BELVIEW, MN 56214

RE: CCN:245475
Cycle Start Date: May 6, 2026

Dear Administrator:

On May 6, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and

Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by August 6, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 6, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245475	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Home	**102 COUNTY STATE AID HIGHWAY 9 , BELVIEW, Minnesota, 56214**

(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
E0000	Initial Comments On 5/4/26 through 5/6/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 5/4/26 through 5/6/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the	F0628		

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 reverse for further 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.

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

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F0628 SS = D	Continued from page 1 facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F0628		

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F0628 SS = D	Continued from page 2 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F0628		

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F0628 SS = D	Continued from page 3 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the	F0628		

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F0628 SS = D	Continued from page 4 time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to obtain a bed hold for 1 of 4 sampled residents (R24) reviewed for hospitalization Findings include: R24's 4/16/26, accepted discharge with return anticipated Minnimum Data Set (MDS) assessment identified R24 had an unplanned short-term general hospital stay beginning on 4/2/26. Additionally, the 4/6/26, accepted quarterly MDS assessment identified R24's cognition was intact. He was independent with set-up assistance from staff for Activities of Daily Living (ADLS), except dressing of lower body, which required some assistance from staff. He was able to ambulate independently and used no assistive devices. R24 had diagnoses including emphysema, heart disease with high blood pressure, congestive heart failure, diabetes, difficulty swallowing, and chronic kidney disease. R24's progress notes identified on 4/2/26 at 10:30 a.m. R24 was increasingly fatigued this morning and continued to be weak and was taken to the clinic by	F0628		

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F0628 SS = D	Continued from page 5 his family. At 3:06 p.m. facility received a phone call that R24 had been admitted to acute care for Pneumonia. On 4/3/26 a 3:29 p.m., R24 remained hospitalized and was discharged from the facility with a return anticipated. Interview on 5/5/26 at 12:51 p.m. with nursing consultant (NC)-A and the interim director of nursing (IDON) confirmed a bed hold should have been completed when the facility was notified R24 had been admitted to the hospital and there was no indication a bed hold had been completed either verbally or in writing. Review of the February 2024 Bed Hold Responsibilities policy identified all residents leaving the facility due to hospitalization or a therapeutic leave and chose to return were to complete a Bed Hold. The policy identified charges that would be incurred with a Bed Hold but failed to identify the process for completion of a bed hold.	F0628		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or	F0657		

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F0657 SS = D	Continued from page 6 as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 2 of 12 sampled resident (R15 and R18) reviewed. Findings include: R15 R15's 4/6/26, accepted quarterly Minimum Date Set (MDS) assessment identified R15's cognition was severely impaired. R15 was independent with her dressing, toileting and ambulation using a walker. R15 had occasional pain and took an antidepressant, diuretic, antiplatelet, and opioid medication. R15's current Diagnosis Report identified Alzheimer's disease, dementia, muscle weakness, long term use of pain medication, hallucinations, anxiety disorder, and high blood pressure. Observation and interview on 5/4/26 at 1:09 p.m., with R15 identified the facility took her scissors away from her and she cannot use her scissors anymore. She reported she was not endangering anyone, she had her knitting stuff but no scissors to cut the string. Observed was a bag next to her recliner with a large ball of yarn on the floor next to the bag with string from the ball of yarn draped into the bag. The bag was open at the top and other balls of yarn were inside the bag. She was unsure when the facility took her scissors. R15's 4/15/26, progress note identified housekeeping staff reported R15 had been cutting her clothes and R15 had cut her hair. Social service spoke to R15 about safety concern with scissors of cutting hair and cutting her clothing while on her. Plan will be to implement supervised scissor use and offer a hair appointment. The facility will provide time for staff and activity staff to utilize scissors when needed with yarn or other material items that are appropriate to cut.	F0657		

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F0657 SS = D	Continued from page 7 R15's undated, care plan identified self-directed leisure profile centered on her pastimes. Activities included that R15 enjoyed interactions with others and would continue with one-to-one interactions. R15 enjoyed music, being outside, going for walks, and putting together jigsaw puzzles. The facility staff were to respect R15's right to decline one-to-one interaction or other activities. There was no mention in the care plan that R15 would be offered supervised assistance with use of scissors for safety reasons. Interview on 5/5/26 at 9:34 a.m., with activity director (AD)-A identified she was unaware of any residents who needed supervision using some scissors. She reported that if a resident was identified to be unsafe using scissors the facility would ask the family to take the scissors home and set up a one-to-one with the resident to use the scissors in the activity room. Interview on 5/5/26 at 9:41 a.m., with interim director of nursing (IDON)-A identified she determined if someone was safe to use a scissors by looking at the residents cognitive level and any actions they may have taken. She would visit with the resident's family and try to allow the resident opportunities to continue to use a scissors with supervision if needed. She confirmed that R15 had been cutting her clothing and her hair with her scissors and was determined not to be safe with the scissors. R15 just needed to ask staff for her scissors and staff will assist or supervise her using her scissors. She confirmed that R15's care plan should reflect that she was unsafe to use her scissors unsupervised. R18 R18's 5/6/26, accepted quarterly MDS assessment identified to have a Brief Interview for Mental Status (BIMS) score of 13, as cognitively intact. R18 was independent with dressing, toileting, and ambulation using his walker. R18 was noted to wander 1-3 days during the 7-day assessment period. R18 used oxygen, took antipsychotic, antidepressant, hypnotic, anticonvulsant, pain, and antiplatelet medication. R18's current Diagnosis Report identified stroke, one sided weakness, emphysema, chronic obstructive pulmonary disease (COPD), high blood pressure, muscle weakness, insomnia, major	F0657		

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F0657 SS = D	Continued from page 8 depression disorder, and a history of falling. Interview on 5/4/26 at 2:00 p.m., with R18 identified he had an alarm on, and he wanted to go outside but could not. He reported “this was illegal” and he was “calling the police” and “telling the state people” and was waiting to see what they did (the facility). He said “this must be against the law to have this thing on” so he could not go outside. R18 then reported staff told him he needed someone to go outside with him but remarked there was never anyone that “had time”. When asked about going out into the enclosed courtyard, he reported he could go out there, but he did not want to. He wanted to sit out front and look around. R18’s current, care plan identified R18 had cognition focus related to diagnosis of dementia and cognitive deficits as evidenced by BIMS. Staff were to communicate with R18 and address his needs and support his capabilities. Staff were to cue, reorient and supervise as needed, monitor cognitive function and report changes. Staff were to provide information and allow R18 to make decisions independently. R18 had a wander guard based on elopement assessment. The care plan lacked identification that R18 was at risk for elopement and what the goal was. There were no interventions of what staff were to do if R18 attempted to leave, or interventions to help meet R18 needs when he wanted to go outside and sit or take a walk. R18’s 3/24/26 elopement evaluation identified he wanted to return home and was one time progress notes at 6:41 p.m., identified R18 had gone outside, staff observed R18 and went outside with him. R18 had said he was leaving and wanted to go home. Staff had walked with R18 to the assisted living apartment entrance. R18 entered the assisted living and began visiting with the staff at the assisted living. The assisted living staff assisted R18 later to the long-term care side of the building. A wander guard will be started. R18’s 4/16/26, Elopement Evaluation identified R18 did not have a history of elopement or an attempted elopement while at home. R18 did not express the desire to go home and/or pack his belongings to go home or stay by an exit door. R18 did not wander and had not been admitted recently within the last 30 days. The risk for wandering and/or elopement was left blank with no care plan focus, goal, or	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245475	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/06/2026

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F0657 SS = D	Continued from page 9 interventions identified. The assessment did not identify the prior history of elopement or attempts to leave the facility without informing staff or R18's desire to go home. Interview on 5/5/26 at 1:14 p.m., with activity director (AD)-A identified she assessed residents' likes and dislikes and reviewed things they enjoyed prior to coming to the facility. For residents who have a wander guard on, and they want to go outside she would attempt to take them out depending on the weather and staff availability. Interview on 5/5/26 at 1:24 p.m., with nursing assistant (NA)-A identified R18 liked to go outside and sit in front of the building. The activity staff did take him outside when they can. R18 did go to the doors and attempt to go out on his own, but he has a wander guard on, so the door alarmed when he did that. R18 did make comments about not being able to go outside by himself. If someone cannot take him out front, we remind R18 he can go out in the courtyard by himself if he wants too. Interview on 5/5/26 at 2:58 p.m., with registered nurse consultant (RNC)-A identified R18 went out of the building but did not leave the premises so according to the facility policy that was not considered an elopement. She confirmed an elopement assessment had been completed on 3/24/26 and a wander guard had been applied to R18. When NC-A was asked if the care plan should have been revised to identify R18 was at risk for elopement with interventions of what staff were to do when he attempted to go outside, she stated "I will not answer that". She then reported that the floor nurses do not update care plans as they have not been educated on updating care plans and at this time only NC-B and the interim director of nursing (IDON) updated care plans. Interview on 5/5/26 at 3:10 p.m., with RNC-B identified R18's care plan "met the minimum requirements" as RNC-B had put on R18's care plan that he had a wander guard per his elopement assessment. RNC-B agreed that the care plan could be more detailed and have identified interventions of what staff were to do if R18 was wanting to leave. Interview on 5/6/26 at 8:38 a.m., with licensed practical nurse (LPN)-B identified R18 asked to go	F0657		

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F0657 SS = D	Continued from page 10 outside all the time. R18 had moved from the attached assisted living to the nursing home a couple months ago. At that time while he was living in assisted living, he was free to walk around outside but he had declined, and it was just not safe for him to do that anymore. The ground was uneven, and she was not sure if he walked away from the facility, he would be able to find his way back. R18's cognition varies day by day, so it is hard for R18 to wait for someone to go outside with him. The staff try to take him outside when they can. Review of undated, Care Plan Revisions Upon Status Change policy identified when a resident experiences a change the facility will discuss the change and collaborate on intervention options. The team meeting would be documented in the resident medical record, and the care plan would be updated to reflect the change and new interventions. The nurse manager or designated staff member would communicate the changes to all staff involved with the resident's care.	F0657		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F0755		

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F0755 SS = D	Continued from page 11 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff had appropriately followed medication administration through to completion for 1 of 1 sampled resident (R4) with a nebulized (inhaled) medication by providing appropriate supervision and follow policy and procedure for the cleaning of the medication cup after administration was completed. Findings include: R4’s quarterly Minimum Data Set (MDS) assessment accepted on 4/6/26, identified her cognition was intact and had diagnoses of chronic obstructive pulmonary disease (COPD), respiratory failure with hypoxia (low oxygen levels), and was dependent on supplemental oxygen, sleep apnea. R4 required moderate assistance of 1 staff for transfers, dressing, and hygiene. Observation on 5/4/26 at 5:30 p.m., in R4’s room identified a handheld nebulizer was lying on her end table still connected to the nebulizer machine. The cup that holds the liquid medication still contained approximately half of the liquid medication. R4 was not in the room. Observation and interview on 5/4/26 at 5:45 p.m., with registered nurse (RN)-A identified she observed the nebulizer cup on the end table. She agreed there was a moderate amount of medication remaining in the cup. She identified nursing should have followed up with R4 to ensure the medication had been fully administered. In addition, she said the handheld nebulizer should have been disassembled and rinsed following the completion of the administration to prevent potential infection. She further identified the nebulizer treatment was scheduled to be administered at 2:00 p.m., confirming this treatment had occurred 3 hours and 45 minutes prior to this observation.	F0755		

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F0755 SS = D	Continued from page 12 R4's May 2026 medication administration record (MAR) identified on 5/4/26 documentation that R4 had received a nebulizer treatment of ipratropium/albuterol inhalation solution 0.5-2.5 milligrams (MG) per milliliter (ML) for acute respiratory failure with hypoxia at 2:00 p.m.. The documentation identified RN-B had signed off the completion of the nebulizer treatment. The MAR further identified R4 was able to self-administer oral medications and nebulizers after set- up. Observation on 5/5/26 at 8:34 a.m., of R4's room identified her hand-held nebulizer was again laying on her end table assembled with approximately 1/4th of the liquid medication remaining in the cup. R4 was lying in bed asleep. Interview on 5/5/26 at 8:37 a.m., with licensed practical nurse (LPN)-A identified R4 had not been administered any medication for morning medication pass. She confirmed the nebulizer was still lying on the end table and had a small amount of medication still in the cup. She reviewed the medication record and identified the last nebulizer treatment had been during the night at 1:20 a.m. R4's 4/13/26, self-administration of medication assessment, completed by RN Consultant (RNC-B), identified R4 was not capable of self-administering inhalants or use inhalers without supervision. The summary identified R4 was not safe to self-administer at that time. Interview on 5/5/26 at 12:35 p.m., with RNC-B identified he had completed the assessment when R4 returned following a hospital stay on 4/13/26. He identified the assessment was accurate and agreed he did not update R4's administration record to show she was no longer safe to self-administer nebulizer treatments. He agreed he should have updated the MAR immediately to ensure nursing staff were aware they would need to supervise R4 while she completed her nebulizer treatments. Interview on 5/5/26, at 1:00 p.m., with the interim director of nursing (IDON) identified it was her expectation that staff follow the facility policy for nebulizer treatments. She further identified they have noted in the orders if a resident is safe to self-administer and that all areas of the electronic medical record should have been updated	F0755		

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F0755 SS = D	Continued from page 13 immediately following the change with re-assessment. Review of the undated facility Nebulizer Therapy Policy identified staff were to verify the order, assemble the tubing and nebulizer cup, place the ordered medication solution into the nebulizer cup, remain with the resident during the procedure and monitor for any change in condition. When the medication is complete, staff were to disassemble, rinse the nebulizer with warm water and allow to air-dry.	F0755		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F0842		

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F0842 SS = D	Continued from page 14 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure documentation of 1 of 1 sampled resident’s (R4) ability to self-administer medication was consistent and	F0842		

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F0842 SS = D	Continued from page 15 accurate throughout the medical record. Findings include: R4's quarterly Minimum Data Set (MDS) assessment accepted on 4/6/26, identified her cognition was intact, she had diagnoses of heart failure, chronic obstructive pulmonary disease (COPD), respiratory failure with hypoxia, dependence on supplemental oxygen, sleep apnea, and atrial fibrillation. R4 requires moderate assistance of 1 staff for transfers, dressing, and hygiene. Observation on 5/4/26 at 5:30 p.m., in R4's room identified a handheld nebulizer was lying on her end table still connected to the nebulizer machine. The cup that holds the liquid medication still contained approximately half of the medication. R4 was not in the room. R4's May 2026 medication administration record (MAR) identified on 5/4/26 staff documented that R4 had received a nebulizer treatment of ipratropium/albuterol inhalation solution 0.5-2.5 milligrams (MG) per milliliter (ML) for acute respiratory failure with hypoxia at 2:00 p.m., the documentation identified RN-B had signed off the completion of the nebulizer treatment. The MAR further identified R4 was able to self-administer oral medications and nebulizers after set- up. R4's 4/13/26, self-administration of medication assessment, completed by RN Consultant (RNC-B), identified R4 was not capable of self-administering inhalants or use inhalers without supervision. The summary identified R4 was not safe to self-administer at that time. Interview on 5/5/26 at 12:35 p.m., with RNC-B identified he had completed the assessment when R4 returned following a hospital stay on 4/13/26. He identified the assessment was accurate and agreed he did not update R4's administration record to show she was no longer safe to self-administer nebulizer treatments. He agreed he should have updated the MAR immediately to ensure nursing staff were aware they would need to supervise R4 while she completed her nebulizer treatments. Interview on 5/5/26, at 1:00 p.m., with the interim	F0842		

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F0842 SS = D	Continued from page 16 director of nursing (IDON) identified it was her expectation that staff follow the facility policy for nebulizer treatments. She further identified they have it noted in the orders on the MAR if a resident is safe to self-administer and that should have been updated immediately following the change with re-assessment. Review of the undated facility Resident Self-Administration of Medication policy identified the interdisciplinary team (IDT) would complete the assessment to determine if the resident was clinically appropriate to self-administer medications. The results of the IDT assessment were to be recorded on the Medication Self-Administration Assessment form and added to the resident's medical record. The policy made no mention that staff were to update/revise the MAR to reflect the results of the assessment.	F0842		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880		

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F0880 SS = D	Continued from page 17 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 observed nebulizer (inhaled medication) medication cup was rinsed and left to air dry after each medication administration for 1 of 1 resident (R4) to prevent potential complication of infection.	F0880		

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F0880 SS = D	Continued from page 18 Findings include: R4's quarterly Minimum Data Set (MDS) assessment accepted on 4/6/26, identified her cognition was intact, she had diagnoses of heart failure, chronic obstructive pulmonary disease (COPD), respiratory failure with hypoxia, dependence on supplemental oxygen, sleep apnea, and atrial fibrillation. R4 requires moderate assistance of 1 staff for transfers, dressing, and hygiene. Observation on 5/4/26 at 5:30 p.m., in R4's room identified a handheld nebulizer was lying on her end table still connected to the nebulizer machine. The cup that holds the liquid medication still contained a approximately half of the medication. R4 was not in the room. Observation and interview on 5/4/26 at 5:45 p.m., with registered nurse (RN)-A observed the nebulizer cup on the end table. She agreed there was a moderate amount of medication remaining in the cup. She identified nursing should have followed up with R4 to ensure the medication had been fully administered, in addition she said the handheld nebulizer should have been disassembled and rinsed following the completion of the administration. She further identified the nebulizer treatment was scheduled to be administered at 2:00 p.m., confirming this treatment had occurred 3 hours and 45 minutes prior to this observation. R4's May 2026 medication administration record (MAR) identified on 5/4/26 staff documented that R4 had received a nebulizer treatment of ipratropium/albuterol inhalation solution 0.5-2.5 milligrams (MG) per milliliter (ML) for acute respiratory failure with hypoxia at 2:00 p.m. The documentation identified RN-B had signed off the completion of the nebulizer treatment. The MAR further identified R4 was able to self-administer oral medications and nebulizers after set- up. Observation on 5/5/26 at 8:34 a.m., of R4's room identified her hand-held nebulizer was again laying on her end table assembled with approximately 1/4th of the liquid medication remaining in the cup. R4 was lying in bed asleep. Interview on 5/5/26 at 8:37 a.m., with licensed	F0880		

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F0880 SS = D	Continued from page 19 practical nurse (LPN)-A identified R4 had not been administered any medication yet that morning. She confirmed the nebulizer was still lying on the end table and had a small amount of medication still in the cup. She reviewed the medication record and identified the last nebulizer treatment had been during the night at 1:20 a.m. R4's 4/13/26, self-administration of medication assessment, completed by RN Consultant (RNC-B), identified R4 was not capable of self-administering inhalants or use inhalers without supervision. The summary identified R4 was not safe to self-administer at that time. Interview on 5/5/26, at 1:00 p.m., with the interim director of nursing (IDON) identified it was her expectation that staff follow the facility policy for nebulizer treatments. She further identified she would expect staff to remain with the resident to ensure the entire dose of the medication was administered. She would expect it to be noted in the orders if a resident is safe to self-administer and that should have been updated immediately following the change with re-assessment. Review of the undated facility Nebulizer Therapy Policy identified staff were to verify the order, assemble the tubing and nebulizer cup, place the ordered medication solution into the nebulizer cup, remain with the resident during the procedure and monitor for any change in condition. When the medication is complete, staff were to disassemble, rinse the nebulizer with warm water and allow to air-dry.	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Care Center	200 PARK LANE , BUFFALO, Minnesota, 55313

(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
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/01/2026. At the time of this survey, Park View Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:	K0000		04/20/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

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K0000	Continued from page 1 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Park View Care Center is a 1-story building with a partial basement. The building was constructed at four different times. The original building was constructed in 1961 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the northeast and was determined to be of Type II(111) construction. In 1979, an addition was constructed to the northwest and was determined to be of Type II(111) construction. In 2007 an addition was added to the southeast of the facility and was determined to be of Type II(111) construction. All buildings have been surveyed as one. The facility has a capacity of 92 beds and had a census of 80 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		
K0930 SS = D Bldg. 01	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to safely store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility.	K0930	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. K0930 D The identified resident will have tubing reattached to their liquid oxygen tank to ensure it is not considered as being stored. The facility will complete a facility-wide audit to identify proper storage of oxygen tanks. The facility will educate nurse staff about attaching tubing to all in-use oxygen tanks.	05/11/2026

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K0930 SS = D Bldg. 01	Continued from page 2 Findings include: On 04/01/2026 at 12:32 PM, it was revealed by observation that in resident room 215 there was a liquid oxygen container being stored in the room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0930	Continued from page 2 The facility will monitor for compliance using a weekly audit for 5 weeks and escalate the results for review aby the QAPI committee. The date the deficiency will be correct will be May 11th, 2026	

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K0000 Bldg. 01	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1962 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: A two (2) story, 1962, Type II (111), protected noncombustible construction. The building had complete coverage by a supervised automatic (wet) sprinkler system and a total of 11 smoke compartments. The facility had two (2) story, 1969, 1979, and 2006 additions of the same construction type. A Comparative Federal Monitoring Survey was conducted on 4/14/26, following a State Agency Annual Survey on 4/1/26, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Park View Care Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.90 (a) et seq. (Life Safety from Fire).	K0000		05/01/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE	K0921	K0921 Electrical Equipment Testing and Maintenance The facility will complete and document electrical equipment testing and results on all Patient-Care Related Electrical Equipment (PCREE) per K0921. The facility will re-test all Patient-Care Related Electrical Equipment (PCREE) per K0921 on implementation and at least annually.	05/22/2026

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K0921 SS = F Bldg. 01	Continued from page 1 used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on observation, records review, and interview, the facility failed to complete and maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) at the facility. The deficient practice affected 11 of 11 smoke compartments, staff, and all residents. The facility had the capacity for 92 beds with a census of 83 on the day of the survey. The findings include: Observation during a tour of the building, on 4/14/26, from 10:00 a.m., to 2:00 p.m., revealed that PCREE such as electric patient beds, therapeutic air mattresses, suction machines, and other electrical medical equipment was present at the facility. Records review, on 4/14/26, at 2:44 p.m., revealed there was no documentation of initial testing of all PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. An interview, on 4/14/26, at 2:44 p.m., with the Maintenance Director revealed the facility was made aware of the requirement for PCREE testing during their recent state survey. The census of 83 was verified by the Social Work Director on 4/14/26, at 9:47 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on	K0921	Continued from page 1 The date of correction will be May 22nd, 2026.	05/22/2026

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K0921 SS = F Bldg. 01	Continued from page 2 4/14/26, at 3:00 p.m. Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012) 3.3.137 Patient-Care-Related Electrical Equipment. Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. 10.3 Testing Requirements - Fixed and Portable. 10.3.1 * Physical Integrity. The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection. 10.3.2 * Resistance. 10.3.2.1 For appliances that are used in the patient care vicinity, the resistance between the appliance chassis, or any exposed conductive surface of the appliance, and the ground pin of the attachment plug shall be less than 0.50 ohm under the following conditions: (1) The cord shall be flexed at its connection to the attachment plug or connector. (2) The cord shall be flexed at its connection to the strain relief on the chassis. 10.3.2.2 The requirement of 10.3.2.1 shall not apply to accessible metal parts that achieve separation from main parts by double insulation or metallic screening or that are unlikely to become energized (e.g., escutcheons or nameplates, small screws). 10.3.3 * Leakage Current Tests. 10.3.3.1 General. 10.3.3.1.1 The requirements in 10.3.3.2 through 10.3.3.4 shall apply to all tests. 10.3.3.1.2 Tests shall be performed with the power switch ON and OFF. 10.3.3.2 Resistance Test. The resistance tests of 10.3.3.3 shall be conducted before undertaking any leakage current measurements. 10.3.3.3 * Techniques of Measurement. The test shall not be made on the load side of an isolated power system or separable isolation transformer.	K0921		05/22/2026

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K0921 SS = F Bldg. 01	Continued from page 3 10.3.3.4 * Leakage Current Limits. The leakage current limits in 10.3.4 and 10.3.5 shall be followed. 10.3.4 Leakage Current - Fixed Equipment. 10.3.4.1 Permanently wired appliances in the patient care vicinity shall be tested prior to installation while the equipment is temporarily insulated from ground. 10.3.4.2 The leakage current flowing through the ground conductor of the power supply connection to ground of permanently wired appliances installed in general or critical care areas shall not exceed 10.0 mA (ac or dc) with all grounds lifted. 10.3.5 Touch Current - Portable Equipment. 10.3.5.1 * Touch Current Limits. The touch current for cord connected equipment shall not exceed 100 ?A with the ground wire intact (if a ground wire is provided) with normal polarity and shall not exceed 500 ?A with the ground wire disconnected. 10.3.5.2 If multiple devices are connected together and one power cord supplies power, the leakage current shall be measured as an assembly. 10.3.5.3 When multiple devices are connected together and more than one power cord supplies power, the devices shall be separated into groups according to their power supply cord, and the leakage current shall be measured independently for each group as an assembly. 10.3.5.4 Touch Leakage Test Procedure. Measurements shall be made using the circuit, as illustrated in Figure 10.3.5.4, with the appliance ground broken in two modes of appliance operation as follows: (1) Power plug connected normally with the appliance on (2) Power plug connected normally with the appliance off (if equipped with an on/off switch) 10.3.5.4.1 If the appliance has fixed redundant grounding (e.g., permanently fastened to the grounding system), the touch leakage current test shall be conducted with the redundant grounding intact. 10.3.5.4.2 Test shall be made with Switch A in Figure 10.3.5.4 closed.	K0921		05/22/2026

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K0921 SS = F Bldg. 01	Continued from page 4 10.3.6 * Lead Leakage Current Tests and Limits - Portable Equipment. 10.3.6.1 The leakage current between all patient leads connected together and ground shall be measured with the power plug connected normally and the device on. 10.3.6.2 An acceptable test configuration shall be as illustrated in Figure 10.3.5.4. 10.3.6.3 The leakage current shall not exceed 100 ?A for ground wire closed and 500 ?A ac for ground wire open. 10.5.2.1 Testing Intervals. 10.5.2.1.1 The facility shall establish policies and protocols for the type of test and intervals of testing for patient care-related electrical equipment. 10.5.2.1.2 All patient care-related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or modification that might have compromised electrical safety. 10.5.2.5 * System Demonstration. Any system consisting of several electric appliances shall be demonstrated to comply with this code as a complete system. 10.5.3 Servicing and Maintenance of Equipment. 10.5.3.1 The manufacturer of the appliance shall furnish documents containing at least a technical description, instructions for use, and a means of contacting the manufacturer. 10.5.3.1.1 The documents specified in 10.5.3.1 shall include the following, where applicable: (1) Illustrations that show the location of controls (2) Explanation of the function of each control (3) Illustrations of proper connection to the patient or other equipment, or both (4) Step-by-step procedures for testing and proper use of the appliance (5) Safety considerations in use and servicing of the appliance	K0921		05/22/2026

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K0921 SS = F Bldg. 01	Continued from page 5 (6) Precautions to be taken if the appliance is used on a patient simultaneously with other electric appliances (7) Schematics, wiring diagrams, mechanical layouts, parts lists, and other pertinent data for the appliance (8) Instructions for cleaning, disinfection, or sterilization (9) Utility supply requirements (electrical, gas, ventilation, heating, cooling, and so forth) (10) Explanation of figures, symbols, and abbreviations on the appliance (11) Technical performance specifications (12) Instructions for unpacking, inspection, installation, adjustment, and alignment (13) Preventive and corrective maintenance and repair procedures 10.5.3.1.2 Service manuals, instructions, and procedures provided by the manufacturer shall be considered in the development of a program for maintenance of equipment. 10.5.6 Record Keeping - Patient Care Appliances. 10.5.6.1 Instruction Manuals. 10.5.6.1.1 A permanent file of instruction and maintenance manuals shall be maintained and be accessible. 10.5.6.1.2 The file of manuals shall be in the custody of the engineering group responsible for the maintenance of the appliance. 10.5.6.1.3 Duplicate instruction and maintenance manuals shall be available to the user. 10.5.6.1.4 Any safety labels and condensed operating instructions on an appliance shall be maintained in legible condition. 10.5.6.2 * Documentation.	K0921		05/22/2026

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K0921 SS = F Bldg. 01	Continued from page 6 10.5.6.2.1 A record shall be maintained of the tests required by this chapter and associated repairs or modifications. 10.5.6.2.2 At a minimum, the record shall contain all of the following: (1) Date (2) Unique identification of the equipment tested (3) Indication of which items have met or have failed to meet the performance requirements of 10.5.6.2 10.5.6.3 Test Logs. A log of test results and repairs shall be maintained and kept for a period of time in accordance with a health care facility's record retention policy. 10.5.8 Qualification and Training of Personnel. 10.5.8.1 * Personnel concerned for the application or maintenance of electric appliances shall be trained on the risks associated with their use. 10.5.8.1.1 The health care facilities shall provide programs of continuing education for its personnel. 10.5.8.1.2 Continuing education programs shall include periodic review of manufacturers' safety guidelines and usage requirements for electrosurgical units and similar appliances. 10.5.8.2 Personnel involved in the use of energy-delivering devices including, but not limited to, electrosurgical, surgical laser, and fiberoptic devices shall receive periodic training in fire suppression. 10.5.8.3 Equipment shall be serviced by qualified personnel only.	K0921		05/22/2026
K0363 SS = E Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the	K0363	K0363 Corridor Doors The identified doors affected by the deficient practice were repaired on the same day as the survey. The facility will audit all other corridor doors for holes in the door and for compliance with K0363. The facility will audit annually for holes in the door	05/15/2026

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K0363 SS = E Bldg. 01	Continued from page 7 passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. 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 interview, the facility failed to maintain corridor doors to resist the passage of smoke. The deficient practice affected two (2) of 11 smoke compartments, staff, and 12 residents. The facility had a capacity for 92 beds with a census of 83 on the day of the survey. The findings include: A. Observation during a tour of the building, on 4/14/26, at 10:46 a.m., revealed that the door to the Memory Care dining room activities storage closet had a 1/2 inch diameter hole in the door just above the door handle. The hole in the door prevented the door from resisting the passage of smoke as required by section 19.3.6.3.2(2) of NFPA 101 Life Safety Code. An interview, on 4/14/26, at 10:46 a.m., with the Maintenance Director revealed the facility was not aware of the hole in the door.	K0363	Continued from page 7 and compliance with K0363. The date of correction is May 15th, 2026	05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Health Care Center	**200 PARK LANE , BUFFALO, Minnesota, 55313**

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K0363 SS = E Bldg. 01	Continued from page 8 B. Observation during a tour of the building, on 4/14/26, at 1:55 p.m., revealed that the IT closet had a 1 inch diameter hole in the door just above the door handle. The hole in the door prevented the door from resisting the passage of smoke as required by section 19.3.6.3.2(2) of NFPA 101 Life Safety Code. An interview, on 4/14/26, at 1:55 p.m., with the Maintenance Director revealed the facility was unaware of the hole in the door. The census of 83 was verified by the Social Work Director on 4/14/26, at 9:47 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 4/14/26, at 3:00 p.m. Actual NFPA Standard: NFPA 101, Life Safety Code (2012) 19.3.6.3 * Corridor Doors. 19.3.6.3.1 * Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1 3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes 19.3.6.3.2 The requirements of 19.3.6.3.1 shall not apply where otherwise permitted by either of the following: (1) Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall not be required to comply with 19.3.6.3.1. (2) In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7, the door construction materials requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.3 Compliance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, shall not be required. 19.3.6.3.4 A clearance between the bottom of the door and the floor covering not exceeding 1 in. (25 mm) shall be permitted for corridor doors. 19.3.6.3.4 A clearance between the bottom of the door and the floor covering not exceeding 1 in. (25 mm) shall be permitted for corridor doors. 19.3.6.3.5 * Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied	K0363		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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K0363 SS = E Bldg. 01	Continued from page 9 at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K0363		05/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/14/2026

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E0000	Initial Comments 42 CFR 483.73 K3 BUILDING: 0101 K6 PLAN APPROVAL: 1962 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: A two (2) story, 1962, Type II (111), protected noncombustible construction. The building had complete coverage by a supervised automatic (wet) sprinkler system and a total of 11 smoke compartments. The facility had two (2) story, 1969, 1979, and 2006 additions of the same construction type. A Comparative Federal Monitoring Survey was conducted on 4/14/26, following a State Agency Annual Survey on 4/1/26, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Park View Care Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E0000		05/01/2026

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 reverse for further 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.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 21, 2026

Administrator
PARKVIEW HOME
102 COUNTY STATE AID HIGHWAY 9
BELVIEW, MN 56214

RE: CCN: 245475
Cycle Start Date: May 6, 2026

Dear Administrator:

On May 6, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112