DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 28, 2026

Administrator
PARKVIEW MANOR NURSING HOME
308 SHERMAN AVENUE
ELLSWORTH, MN 56129

RE: CCN:245553
Cycle Start Date: May 11, 2026

Dear Administrator:

On May 11, 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 11, 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 11, 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING B. WING	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE , ELLSWORTH, Minnesota, 56129

(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 5/10/26 through 5/12/26, 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		06/06/2026
F0000	INITIAL COMMENTS On 5/10/25 through 5/12/26, 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		06/06/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	F0812 The Dietary Manager (DM) has oversight responsibility for the proper storage, preparation and disposal of food items. The kitchen staff have been reeducated on the proper storage, preparation and disposal food items.	07/07/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245553	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

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F0812 SS = F	Continued from page 1 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure food was not outdated, foods were thawed in a safe and sanitary manner, and the walk-in freezer and the floors of the walk-in cooler were kept in a sanitary manner in 1 of 1 kitchen. This has the potential to affect all 30 residents. Findings include: Observation and interview on 5/10/26 at 11:02 a.m., with dietary cook (C)-A on initial tour of the kitchen identified in the refrigerator next to the prep area in the kitchen had a ½ gallon milk container with the lid off, and what looked like pancake batter on the outside of the container and inside. C-A stated “oh, I am throwing this” and reported it was butter milk, and the best used-by date was 4/6/26. Also, in the same refrigerator there were 5 bowls of undated pre-made salad, covered with plastic wrap with lettuce starting to turn brown. C-A confirmed the butter milk was expired and the salads should have been dated and proceeded to remove all items and dispose of them. As we entered the walk-in cooler there were 2 sheet pans on the bottom shelf of a wire rack the first one had a bag of turkey thawing with juice noted on the tray. The second tray had 2 items wrapped in tin foil and a 10-pound sleeve of ground beef sitting on the tray. All items were sitting in blood juice from one of the items. C-A moved the tray and one item wrapped in tin foil had label on it that identified prepared date 4/29/26, she thought that was turkey, but it did not say on the label, the	F0812	Continued from page 1 Stored food items will be labeled with the name of the item and dated with the date it was opened or prepared so they can be easily identified and it is known when they need to be disposed of. Meats will be placed in a pan for thawing so that drippings will remain in the pan and not drip onto the floor of the cooler. Each meat item will be thawed in its own separate pan so there is no cross contamination. Food items in the walk-in freezer will be stored in an organized manner and not in direct contact with the floor. Since the walk-in freezer is relatively small, the Administrator will discuss purchasing a chest freezer for additional storage with the facility Board of Directors. The policies requested were, in fact, emailed to the surveyor on 05/12/2026 by the DON. Beginning the week of 06/07/2026 the DM will: Audit stored food items to ensure proper labeling, dating, and timely disposal daily for two weeks, then three times per week for two weeks, then weekly on an on-going basis. Audit the walk-in cooler to ensure the proper thawing of food items and cleanliness daily for two weeks, then three times per week for two weeks, then weekly on an on-going basis. Audit the walk-in freezer to ensure food items are organized and not in direct contact with the floor daily for two weeks, then three times per week for two weeks, then weekly on an on-going basis. Results of audits will be brought to QAPI and reviewed for compliance or the need for further monitoring.	07/07/2026

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F0812 SS = F	Continued from page 2 other item wrapped in tin foil had label on it that identified it was ground beef, and dated 5/3/26. The 10-pound sleeve of ground beef had a hole in the plastic with a dark, hard looking, exposed ground beef. Continued observation on 5/10/26 beginning at 11:02 a.m., identified C-A then opened the walk-in freezer that was inside of the walk-in cooler. Once the door to the freezer was opened it was observed to be full of multiple boxes stacked on top of each other in the walk-through space. Some of the boxes were tipped over, some directly on the floor, and some on top of a plastic crate. The shelves within the walk-in freezer were full. One box tipped over directly on the floor was labeled “sea food”. The outside of the box identified 15 pieces of fish were left and dated it had been opened on 3/27/26. The box was not closed and the bag inside the box was not closed or secured. There was a plastic tote cover tipped upside down with 5 bags of thawed chicken sitting in the cover directly onto the floor. C-A stated she had just placed the remaining chicken in the freezer that she had not used for the noon meal. There was no room to place the chicken on the shelf, so she placed it on the plastic cover and just put it in the freezer on the floor. C-A confirmed there was no way to step into the walk-in freezer due to all the boxes in the walk-through space. Back inside the walk-in cooler it was observed to have a large amount of blood or brown juices spilled on the floor under both wire racks in the cooler. There were also a couple of butter packets mixed in with the dried meat juices and/or debris under one rack and a dirty plastic cup in the spilled juices under the other rack. C-A confirmed that the observed blood or brown dried areas was “probably juices from thawing meat spilled”. She identified there was no schedule for cleaning and no specific person oversaw cleaning; staff were just to clean as they needed. Interview and observation on 5/10/26 at 11:50 a.m., for follow up tour of kitchen with C-B identified inside the walk-in cooler remained the tray of 2 items wrapped in tin foil and the 10-pound sleeve of ground beef sitting in blood juices on the tray. Also noted was a large item wrapped in tin foil sitting on top of a box back towards the back on the bottom shelf. C-B pulled that out and it was labelled “ham” and dated 5/5/26. C-B stated, “the meat should each be on their own tray to thaw”. He then stated, “they should not be together (the ground beef and the turkey)”. He confirmed that all items were sitting	F0812		07/07/2026

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F0812 SS = F	Continued from page 3 in blood juices on the one tray. He removed the tray from the walk-in cooler, and he opened both items in tin foil. One was sliced turkey, and the other one was 10 pounds of ground beef. He confirmed there was a hole in the plastic of the 10-pound sleeve of ground beef and that the exposed area appeared “dried and crusty”. C-B then entered the walk-in freezer, and stated, “oh no! that should not be there” and pointed to the chicken sitting on the floor inside the plastic cover. He confirmed that you could not step into the walk-in freezer as it was full of boxes in the walk-through space, and confirmed the boxes were tipped over, some on the floor, and some on top of a plastic crate. Interview on 5/11/26 at 9:48 a.m., with the administrator identified, he has had multiple conversations in the past with the dietary manager and staff about keeping the kitchen neat, clean, and organized not only for infection control purposes, but also for ordering supplies. He revealed there had been some ongoing concerns with expired items and cleaning in the kitchen with newer staff. He had even done some “spot checks” in the kitchen related to the concern and had asked the dietary manager to make sure she was checking for expired items as well. He further revealed he had completed a check one time and found a 10-pound sleeve of ground beef sitting on the wire rack with no tray under it dripping onto the floor. He talked with the dietary manager and staff about thawing items in the walk-in cooler and making sure the item was on a tray. Items thawing in the walk-in refrigerator should be on a tray by itself and not with other food. He was unaware that the walk-in freezer had so many items on the floor that you could not step into the walk-in freezer or that the walk-in cooler had spilled drippings from thawing items on the floor. If the kitchen staff could not reach under the wire rack to clean that up, they should have asked for maintenance to assist. His expectation was that the kitchen monitored for expired items and removed those items, thawed foods appropriately, did not place items on the floor, and maintain a clean and sanitary kitchen. Interview on 5/11/26 at 5:09 p.m., with dietician identified she had been at the facility the week prior and discussed all the identified area's of concern with the dietary manager. She would expect the meat to be thawed on individual trays on the bottom shelf in the refrigerator, and any spills would be cleaned up, and the kitchen would be maintained in a sanitary manor. She revealed that having more than	F0812		07/07/2026

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F0812 SS = F	Continued from page 4 one type of meat thawing on the same tray was a concern for cross contamination. Nothing should be stored on the floor and the walkways inside the freezer and refrigerator should remain clean and items should be kept on the shelves. The facility should be monitoring for expired items on a regular basis. She revealed that the facility needed to have a better protocol for monitoring and cleaning of the kitchen with audits to ensure things were getting done. A policy on infection control in the kitchen was requested but not provided. A policy on safe food storage was requested but not provided.	F0812		07/07/2026
F0880 SS = F	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 infections before they can spread to other persons	F0880	F0880 The facility will ensure employees are documented as having been tested and illnesses monitored and tracked to identify potential or actual correlation between residents with known COVID and staff exposure and/or subsequent illness or indicate when an employee would be able to return to work after illness, according to the CDC guidelines. The Infection Preventionist (IP) will complete the Employee Illness Log to include the date, employee name, symptoms, the return to work date, and whether or not the employee had been tested for COVID after becoming symptomatic during a COVID outbreak. Beginning the week of 06/07/2026 the DON will audit the Employee Illness Log following each occurrence of employee illness for the next month and then randomly as needed to ensure it is filled out completely and the proper testing and return to work guidelines are being followed. Results of audits will be brought to QAPI and reviewed for compliance or the need for further monitoring.	07/07/2026

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F0880 SS = F	Continued from page 5 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 interview and document review, the facility failed to ensure employees were documented as having been tested and illnesses monitored and tracked to identify potential or actual correlation between residents with known COVID and staff exposure and/or subsequent illness, or indicate when an employee would be able to return to work (RTW) after illness, according to the Centers for Disease Control, for 7 of 9 staff (Nursing assistant	F0880		07/07/2026

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F0880 SS = F	Continued from page 6 (NA)-B, NA-C, NA-E, NA-F, NA-G, NA-H, and NA-I) with symptoms of COVID during an outbreak. This had the potential to affect 11 remaining residents who showed no documented signs and/or symptoms of COVID, but who may have been exposed to staff. Findings include: Review of the March 2025, Centers for Disease Control (CDC), Symptoms of COVID-19 article, located at https://www.cdc.gov/covid/signs-symptoms/index.html, identified the following list does not include all possible symptoms. Symptoms may change with new COVID-19 variants and can vary depending on vaccination status. Possible symptoms include: Fever or chills Cough Shortness of breath or difficulty breathing Sore throat Congestion or runny nose New loss of taste or smell Fatigue Muscle or body aches Headache Nausea or vomiting Diarrhea Review of the 3/18/24, CDC article, Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, located at https://www.cdc.gov/covid/hcp/infection-control/guidance-risk-assesment-hcp.html, identified: Health care personnel (HCP) with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays. When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the	F0880		07/07/2026

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F0880 SS = F	Continued from page 7 sample was collected. If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT. If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses. HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and At least 24 hours have passed since last fever without the use of fever-reducing medications, and Symptoms (e.g., cough, shortness of breath) have improved. *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later Review of the January 2026, Resident Infection Surveillance log identified 12 residents (R27, R11, R14, R4, R19, R6, R25, R33, R3, R34, R9, and R2) had been diagnosed with COVID during an outbreak and showed signs and symptoms of cough, runny nose, congestion and wheezing. 5 additional residents (R20, R1, R29, R26 and R4) also showed signs of potential COVID (loose stools and vomiting) however; it was unknown if those residents had been tested or had been found to be positive for COVID.	F0880		07/07/2026

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F0880 SS = F	Continued from page 8 Review of the January 2026 Employee Illness Log identified the following columns: Report date Employee name Vomiting Diarrhea Jaundice Fever Respiratory (cough, sore throat, runny nose) Comments or additional symptoms Date returned to work Diagnosed with a pathogen? If diagnosed, was local health agency contacted? None of the monthly employee illness logs were filled out completely and the date returned to work was left blank each time. There was also no indication staff had been tested for COVID after becoming symptomatic during a COVID outbreak. Review of January 2026, Monthly Employee Illness log identified on: 1/3/26, NA-E reported a sore throat, headache and congestion. 1/3/26, NA-I called in with a headache. 1/5/26, NA-F reported dizziness, lightheadedness, and a sore throat. 1/7/26, NA-I called in again and reported a headache. 1/21/26, NA-G called in with diarrhea. 1/22/26, NA-C reported vomiting. 1/22/26, NA-H reported diarrhea. 1/28/16, NA-B called in with sinus congestion and cough. 1/29/26, NA-B called in with vomiting and diarrhea.	F0880		07/07/2026

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F0880 SS = F	Continued from page 9 1/30/26, NA-C called in with vomiting and a fever. There was no indication on the forms, the above-mentioned staff had been tested for COVID, nor if they had been vetted before potentially returning to work according to CDC guidance. Interview on 5/11/26 at 8:30 a.m., with the infection preventionist (IP) identified that she had been in that position for less than a year. Her hours working in the IP role depended on current staffing levels and if she had to work on the floor as a charge nurse, however; she typically worked on infection control only 4-5 hours a week. She tracked staff call-ins on an absence report form that went to the business office first. If staff were sick, she would get a copy of the form from the business office and then transferred that information to the employee illness logs. Staff were to be off work for a minimum of 24 hours after symptoms were resolved for vomiting, fever, or diarrhea. She attempted to review the infection control information at least weekly, but that was dependent on staffing and if she had to work as a charge nurse on the floor. She confirmed the surveillance logs were not thoroughly completed and she had not really looked for trends or patterns since starting the infection preventionist role. The IP made no mention if she felt the 4-5 hours she was able to dedicate to her role was enough to provide appropriate oversight and vetting for employee RTW. Interview on 5/11/26 at 11:04 a.m., with the director of nursing (DON) identified she provided oversight of the infection control program by reviewing the IP's monthly data prior to the QAPI meeting. She had not been reviewing any of the surveillance logs since the new IP started. Review of the undated, Infection Control policy identified the program was to minimize the risk of infection between residents, staff, volunteers, and visitors. The facility would monitor, assess, identify, and manage infections through education and record keeping. Review of the undated, Surveillance for Infection policy identified surveillance of infections would be monitored for trends to guide appropriate interventions to slow or stop the spread of infections.	F0880		07/07/2026

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F0880 SS = F	Continued from page 10 Review of the undated, current Return to Work Policy for Infectious Illness identified it included guidance on RTW for suspected or confirmed cases of COVID. Staff were able to RTW at least 3 days after symptom onset, must be fever free for at least 24 hours, symptoms improving, and use source control upon RTW. There was no indication, this return to work followed the CDC guidance above.	F0880		07/07/2026
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP) had appropriate time allowed to dedicate to oversight of the infection control program. This had the potential to affect all 28 residents. Findings include: Review of the January 2026 Employee Illness Log identified the following columns: Report date Employee name Vomiting	F0882	F0882 The Facility Assessment was reviewed on 06/11/2026 and even though regulation does not mandate a specific number of hours for the IP to dedicate to oversight of the infection control program it has been determined that the IP will be allotted up to 4 hours per week for those tasks. Should that amount of time be insufficient any given week the IP will communicate to the DON additional time is needed to complete her tasks. The DON will then modify the nursing schedule to allow the IP the additional time necessary for her to complete her tasks. The DON will oversee the IP tasks are being completed each week. The Administrator will ensure the IP is being allotted the appropriate time each week to dedicate to oversight of the infection control program.	06/12/2026

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F0882 SS = F	Continued from page 11 Diarrhea Jaundice Fever Respiratory (cough, sore throat, runny nose) Comments or additional symptoms Date returned to work Diagnosed with a pathogen? If diagnosed, was local health agency contacted? None of the monthly employee illness logs were filled out completely and the date returned to work was left blank each time. There was also no indication staff had been tested for COVID after becoming symptomatic during a COVID outbreak. Review of January 2026, Monthly Employee Illness log identified on: 1/3/26, NA-E reported a sore throat, headache and congestion. 1/3/26, NA-I called in with a headache. 1/5/26, NA-F reported dizziness, lightheadedness, and a sore throat. 1/7/26, NA-I called in again and reported a headache. 1/21/26, NA-G called in with diarrhea. 1/22/26, NA-C reported vomiting. 1/22/26, NA-H reported diarrhea. 1/28/16, NA-B called in with sinus congestion and cough. 1/29/26, NA-B called in with vomiting and diarrhea. 1/30/26, NA-C called in with vomiting and a fever. There was no indication on the forms, the above-mentioned staff had been tested for COVID, nor if they had been vetted before potentially returning to work according to CDC guidance.	F0882		06/12/2026

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F0882 SS = F	Continued from page 12 Interview on 5/11/26 at 8:30 a.m., with the infection preventionist (IP) identified that she had been in that position for less than a year. Her hours working in the IP role depended on current staffing levels and if she had to work on the floor as a charge nurse, however; she typically worked on infection control only 4-5 hours a week. She tracked staff call-ins on an absence report form that went to the business office first. If staff were sick, she would get a copy of the form from the business office and then transferred that information to the employee illness logs. Staff were to be off work for a minimum of 24 hours after symptoms were resolved for vomiting, fever, or diarrhea. She attempted to review the infection control information at least weekly, but that was dependent on staffing and if she had to work as a charge nurse on the floor. She confirmed the surveillance logs were not thoroughly completed and she had not really looked for trends or patterns since starting the infection preventionist role. The IP made no mention if she felt the 4-5 hours she was able to dedicate to her role was enough to provide appropriate oversight and vetting for employee RTW. Interview on 5/11/26 at 11:04 a.m., with the director of nursing (DON) identified she provided oversight of the infection control program by reviewing the IP's monthly data prior to the QAPI meeting. She had not been reviewing any of the surveillance logs since the new IP started. Review of the undated, Infection Control policy identified the program was to minimize the risk of infection between residents, staff, volunteers, and visitors. The facility would monitor, assess, identify, and manage infections through education and record keeping. Review of the undated, Surveillance for Infection policy identified surveillance of infections would be monitored for trends to guide appropriate interventions to slow or stop the spread of infections. Review of the undated, current Return to Work Policy for Infectious Illness identified it included guidance on RTW for suspected or confirmed cases of COVID. Staff were able to RTW at least 3 days after symptom onset, must be fever free for at least 24 hours, symptoms improving, and use source control upon RTW. There was no indication, this	F0882		06/12/2026

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F0882 SS = F	Continued from page 13 return to work followed the CDC guidance above. Review of the 9/21/20, undated Infection Control Policy identified the facility was to ensure effective implementation of infection control. Records of IC activities were to be maintained. There was no mention in the policy how the IP was to perform her duties and have appropriate oversight. Review of the 6/10/25, Facility Assessment identified the assessment was to describe how the facility would evaluate if the IC program included effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents and staff that followed accepted national standards and referred to the Centers for Disease Control (CDC).	F0882		06/12/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F0580	F0580 The facility will make prompt notification of a significant change in a resident's condition to the resident's physician or facility Medical Director and the resident's family or representative. Documentation of the notification will be entered into the medical record. The DON will educate the nursing staff that a significant change of a resident's condition must be promptly brought to the attention of the charge nurse who will then make prompt notification to the resident's physician or facility Medical Director, the resident's family or representative, and the DON. The DON will ensure prompt notification has been made to the resident's physician or facility Medical Director and the resident's family or representative following each event of a significant change in a resident's condition.	06/05/2026

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F0580 SS = D	Continued from page 14 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to timely notify the physician for 1 of 1 sampled resident (R15) when she experienced worsening cough with no relief. Findings include: R15's quarterly Minimum Data Set (MDS) assessment, accepted on 3/20/26, identified her cognition was intact, and she had diagnosis of edema (swelling), heart failure, high blood pressure, premature contractions of the heart ventricles, and tricuspid regurgitation (a heart condition that can cause extreme tiredness, shortness of breath and swelling in the belly, legs, or neck veins). R15 required moderate assistance of one staff for transfers, dressing, and hygiene. Intermittent observations on 5/10/26 from 11:30 a.m., to 7:00 p.m., and again on 5/11/26 from 7:33 a.m., to 4:30 p.m., identified R15 remained in her room was seated in her recliner. She could be heard coughing continuously and the cough was worsening.	F0580		06/05/2026

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F0580 SS = D	Continued from page 15 Review of R15's nursing progress notes identified on 5/6/26, at 4:30 p.m., R15 returned from AN appointment with new orders to provide comfort cares only. Staff were advised to not hospitalize R15, stop metolazone, increase Lasix to 80 milligrams (MG) twice daily, and discontinue any labs per family request. R15's physician progress notes identified that she was seen at the clinic by MD-B on 5/6/26, for concerns of fluid retention in her legs. The physicians' progress note identified R15 had a history of heart failure and chronic fluid retention and was experiencing weight gain, generalized edema, and decreased strength. Although R15's diuretic medications had been increased previously, they were not seeing an improvement. R15's weight gain over the past month was significant despite the medication changes. R15's respiratory symptoms included occasional shortness of breath and persistent cough, though she generally reports her breathing as pretty good. MD-B identified after discussion of prognosis and limited benefit of further hospitalization; the family opted for comfort care. The plan was to include no further lab draws, do not hospitalize R15, continue morphine (pain medication) as needed for comfort at the facility and the family did not want hospice at this time. R15's undated, current care plan identified R15 was on diuretic therapy (medication is given to alleviate excess fluid buildup in the tissues) related to edema (swelling from excess fluid) and high blood pressure with a focus for R15 to be free of discomfort. Staff were to administer diuretic medication as ordered and monitor for their side effects and report pertinent lab results to the physician. The care plan made no mention that R15 was to be provided comfort care at the facility, should not be hospitalized, or that staff were to discontinue all lab draws. In addition, the care plan did not identify how the facility should maintain comfort if R15's overall condition were to change. Further review of R15's Nursing progress notes identified on: 5/7/26 at 1:52 p.m., R15's family member requested the nurse to arrange for R15 to receive the catholic "last rights". A call was place to the Catholic church.	F0580		06/05/2026

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F0580 SS = D	Continued from page 16 5/8/26 at 4:45 a.m., staff noted R15 was not resting well that night and had been coughing chronically since 10:45 p.m.. They administered as needed morphine 0.25 milliliters (ML) in attempts to alleviate her discomfort from chronic cough related to fluid overload. 5/8/26 at 5:28 a.m., staff noted the morphine was ineffective and R15 reported her pain scale was 8 of 10 which is considered severe. R15 did not appear to have any relief from her cough and discomfort. The nurse will continue to monitor. Interview on 5/11/26 at approximately 2:00 p.m., with registered nurse (RN)-A identified she was aware of R15's coughing. She presumed it was caused by fluid retention. She identified they had received an order from the physician to not send R15 to the hospital. Interview on 5/11/26, at 2:34 p.m., with the director of nursing (DON) identified she was aware of R15's cough. She had been seen at the clinic on 5/6/26 and had new orders for comfort care and was not to be transported to the hospital. She agreed comfort measures should have been added to the care plan. Additional review of R15's progress notes identified on 5/11/26 at 2:47 p.m., a nursing assistant reported R15 was coughing. Staff documented a nurse assessment identified R15 was not feeling well, was short of breath, and continued to cough. Nurse administered cough syrup and 0.25 milliliters (ML) of morphine and brought her some warm coffee. R15 experienced very little relief from these measures. Follow up interview on 5/11/26 at 3:32 p.m., with the director of nursing identified they had sent a fax to the physician earlier but had not received a response. She further identified they could not call the doctor during clinic hours and had been advised to fax. They could call the nurse triage line but were told calling that line would be no faster than sending a fax. She agreed R15's care plan should have been revised to identify what staff were to do to provide comfort for R15 if her condition worsened. Additional review of R15's progress notes identified on 5/11/26 at 2:47 p.m., a nursing assistant	F0580		06/05/2026

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F0580 SS = D	Continued from page 17 reported R15 was coughing. Staff documented a nurse assessment identified R15 was not feeling well, was short of breath, and continued to cough. Nurse administered cough syrup and 0.25 milliliters (ML) of morphine and brought her some warm coffee. R15 experienced very little relief from these measures. Follow up interview on 5/11/26 at 3:32 p.m., with the director of nursing identified they had sent a fax to the physician earlier that day on 5/11/26 but had not received a response. She further identified they could not call the doctor during clinic hours and had been advised to fax. They could call the nurse triage line but were told calling that line would be no faster than sending a fax. R15’S progress note review identified on: 5/11/26 at 5:00 p.m., the nurse noted communication with the family to ask if they would be in agreement with increasing R15’s morphine dose to help with her frequent coughing and to discuss a hospice referral. The family agreed. 5/11/26 at 6:43 p.m., a call was placed to the on-call physician (MD-C), who ordered staff to increase the frequency of as needed morphine to every 2 hours as needed for pain, shortness of breath, or cough and monitor if it was more effective for the cough. 5/11/26 at 8:05 p.m., staff documented following the morphine administration, they felt the cough was better this evening. 5/11/26 at 10:39 p.m., a fax was sent to the clinic to request an order for a hospice referral per the family’s request. Review of the facilities May 2017, Change in a Resident’s Condition or Status policy identified the nurse would notify the resident’s attending physician or physician on-call when there has been a significant change in the resident’s physical/emotional/mental condition, there is a need to transfer the resident to the hospital. A significant change of condition is a major decline or improvement in the resident’s status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. The policy made no mention of how the facility staff should contact the physician for	F0580		06/05/2026

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F0580 SS = D	Continued from page 18 guidance if a residents change of condition was not emergent but needed to be reviewed in a timelier manner.	F0580		06/05/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to accurately code medication on the Minimum Data Set (MDS) assessment for 1 of 1 resident (R5) who was reported to be receiving insulin. Findings include:	F0641	F0641 All resident MDS's have been reviewed by the MDS/Care Plan Coordinator to ensure they are accurate and up to date. Completion date of the review was 06/05/2006. The MDS/Care Plan Coordinator will ensure all resident MDS's are accurate and current. R5s MDS was revised on 05/11/2026 and resubmitted. The MDS for the one other resident receiving GLP1 was reviewed, revised and resubmitted on 06/08/2026.. Beginning the week of 06/07/2026 the DON will randomly select and audit for accuracy two MDS's per week for two weeks, then one MDS per week for two weeks, then randomly as she may feel to be necessary. Results of audits will be brought to QAPI and reviewed for compliance or the need for further monitoring. Compliance date: 07/07/2026	06/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245553	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE , ELLSWORTH, Minnesota, 56129

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F0641 SS = D	Continued from page 19 R5's, quarterly MDS assessment, accepted on 2/3/26 and 4/15/26. identified R5 received an INSULIN injection (1) time during the last 7 days. R5 had a diagnosis of diabetes, but her current physician orders identified no orders for insulin. R5'S current physician orders included an order dated 12/17/25, for Semaglutide (0.25 or 0.5 milligrams (mg/dose,) subcutaneous (SQ) 2 mg/3 milliliter (ml). staff were to inject R5 with 0.25 mg subcutaneously (SQ) in the morning, every Wednesday for diabetes with hyperglycemia for 4 Weeks, and then 0.5 mg sq every Wednesday morning. Interview on 5/10/26 at 2:30 p.m. with R5 identified she was diabetic and received an oral medication daily for her diabetes. She reported she did not receive insulin, but received a weekly injection of a GLP1 medication that was administered on Wednesdays. Interview on 5/11/26 at 8:14 a.m. with registered nurse (RN)-B confirmed she had incorrectly coded both the 1/16/26 and 4/10/26 quarterly MDS assessments as R5 received no insulin. She identified she would need to complete and submit a modification of the assessment. Interview on 5/12/26 at 11:28 a.m., with director of nursing (DON) identified she would expect the MDS to be accurate and reflect the status of each resident. There was no policy related to accuracy of the MDS provided by the end of survey.	F0641		06/10/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the	F0656	F0656 All residents will have accurate and complete Care Plans developed within 7 days after completion of the comprehensive assessment. The MDS/Care Plan Coordinator will ensure all resident Care Plans are accurate and current. R15's assessment for being at risk for falls was	07/07/2026

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F0656 SS = D	Continued from page 20 comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to develop a care plan for 1 of 13 residents (R15) who was identified as being at risk for falls upon admission. Findings include: R15's quarterly Minimum Data Set (MDS) assessment, accepted on 3/20/26, identified her cognition was intact, her vision was severely	F0656	Continued from page 20 entered into her care plan on 05/02/2026. Beginning the week of 06/07/2026 the DON will randomly select and audit for accuracy two Care Plans per week for two weeks, then one Care Plan per week for two weeks, then randomly as she may feel to be necessary. Results of audits will be brought to QAPI and reviewed for compliance or the need for further monitoring.	07/07/2026

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F0656 SS = D	Continued from page 21 impaired (no vision or sees only light, colors or shapes). R15 required moderate assistance of one staff for transfers, dressing, and hygiene. R15's comprehensive MDS assessment accepted on 12/22/25, identified the Care Area Assessment (CAA) portion of the MDS identified falls would be addressed on the care plan. Staff were to monitor for fall risks related to medication, new surroundings and adjustment due to vision and hearing deficits. They were to ensure the call light was within reach, ensure R15 knew where it was located, and attach the call light so it would not slide away due to her vision impairment. Interview on 5/10/26 at 1:38 p.m., with R15's family member (FM)-A identified R15 recently had a fall. She had been sitting in her wheelchair in her room. She fell asleep and fell face forward out of her chair hitting her face on the nightstand sustaining facial bruising. R15's 5/1/26 at 2:43 p.m., nursing progress note identified R15 had a fall on 5/1/26 at 10:01 a.m., that was not witnessed. The fall occurred in R15's room. She forgot to lock her brakes on her wheelchair, fell asleep, and leaned too far forward and tipped out of the chair. R15 sustained a facial bump and bruise and a skin tear on her right ring finger. Review of R15's current undated care plan made no mention that R15 was at risk for falls. There was nothing to identify what staff were to do to minimize R15's risk of falls. Interview on 5/12/26 at 10:18 a.m., with the MDS nurse identified R15 had no history of falls prior to admission to the facility. If a resident was identified as being at risk for falls upon admission but has no history of falls she does not always add that to the care plan regardless of the Care Area Assessment findings. Interview on 5/12/26 at 12:42 p.m., with the director of nursing (DON) identified it was her expectation that any resident who was assessed to be at risk for falls would have a section on the care plan to alert staff of those risks and how they were to provide care and minimize risk for injury. Review of the facilities 2/20/20, Care Plan policy	F0656		07/07/2026

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F0656 SS = D	Continued from page 22 identified staff were to develop a care plan within 7 days after completion of the comprehensive assessment. The care plan was to address the resident's needs, strengths, and preferences as identified in the comprehensive assessment with measurable objectives and timetable to meet the residents long and short-term goals for medical, nursing, and psycho-social needs that are identified in the assessment. The care plan was to list services that will be furnished to attain or maintain the resident's highest and practicable physical, mental, and psycho-social well-being. The care plan was to be reviewed and revised by the interdisciplinary team, the resident, and/or the legal guardian at least quarterly and updated at any time to account for day-to-day changes in care.	F0656		07/07/2026
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 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:	F0657	F0657 All residents will have an accurate and complete Care Plan developed within 7 days after completion of the comprehensive assessment. The Care Plans will be revised/updated as needed in response to a change in a resident's condition or need. The MDS/Care Plan Coordinator will ensure all resident Care Plans are revised/updated as needed. R2's care plan was revised on 06/09/2026 to indicate he has a pressure ulcer that requires continued monitoring and treatment. R15 passed away on 05/14/2026. Beginning the week of 06/07/2026 the DON will randomly select and audit for accuracy two Care Plans per week for two weeks, then one Care Plan per week for two weeks, then randomly as she may feel to be necessary. Results of audits will be brought to QAPI and reviewed for compliance or the need for further monitoring.	07/07/2026

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F0657 SS = D	Continued from page 23 Based on the facility failed to revise the care plans for 2 of 12 sampled residents (one who was to be receiving comfort cares (R15), and one (R2) who developed a pressure ulcer). Findings include: R15 R15's quarterly Minimum Data Set assessment, accepted on 3/20/26, identified her cognition was intact, she had diagnosis of edema, heart failure, high blood pressure, premature contractions of the heart ventricles, and tricuspid regurgitation (a heart condition that can cause extreme tiredness, shortness of breath and swelling in the belly, legs, or neck veins). R15 required moderate assistance of one staff for transfers, dressing, and hygiene. Intermittent observations on 5/10/26 from 11:30 a.m., to 7:00 p.m., and again on 5/11/26 from 7:33 a.m., to 4:30 p.m., identified R15 remained in her room was seated in her recliner. She could be heard coughing continuously and the cough was worsening. Review of R15's nursing progress notes identified on 5/6/26, at 4:30 p.m., R15 returned from AN appointment with new orders to provide comfort cares only. Staff were advised to not hospitalize R15, stop metolazone, increase Lasix to 80 milligrams (MG) twice daily, and discontinue any labs per family request. R15's 5/6/26, physicians (MD-B) progress note identified that she was seen at the clinic for concerns of fluid retention in her legs. The corresponding physicians' progress note identified R15 had a history of heart failure and chronic fluid retention and was experiencing weight gain, generalized swelling, and decreased strength. Although R15's diuretic medications had increased previously they were not seeing an improvement. R15 had weight gain over the past month that had been significant despite the medication changes. R15's respiratory symptoms included occasional shortness of breath and persistent cough, though she generally reported her breathing as pretty good. MD-B identified after discussion of R15's prognosis and limited benefit of further hospitalization; the family opted for comfort care. His plan was to do no	F0657		07/07/2026

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F0657 SS = D	Continued from page 24 further lab draws, not hospitalize her, and continue morphine as needed for comfort at the facility. The family did not want hospice at this time. R15's undated, current care plan identified R15 was on diuretic therapy (medication is given to alleviate excess fluid buildup in the tissues) related to edema (swelling from excess fluid) and high blood pressure with a focus for R15 to be free of discomfort. Staff were to administer diuretic medication as ordered and monitor for their side effects and report pertinent lab results to the physician. The care plan made no mention that R15 was to be provided comfort care at the facility, should not be hospitalized, or that staff were to discontinue all lab draws. In addition, the care plan did not identify how the facility should maintain comfort if R15's overall condition were to change. Further review of R15's Nursing progress notes identified on: 5/7/26 at 1:52 p.m., R15's family member requested the nurse to arrange for R15 to receive the catholic "last rights". A call was place to the Catholic church. 5/8/26 at 4:45 a.m., staff noted R15 was not resting well that night and had been coughing chronically since 10:45 p.m.. They administered as needed morphine 0.25 milliliters (ML) in attempts to alleviate her discomfort from chronic cough related to fluid overload. 5/8/26 at 5:28 a.m., staff noted the morphine was ineffective and R15 reported her pain scale was 8 of 10 which is considered severe. R15 did not appear to have any relief from her cough and discomfort. The nurse will continue to monitor. Interview on 5/11/26 at approximately 2:00 p.m., with registered nurse (RN)-A identified she was aware of the coughing. She presumed it was caused by fluid retention. She identified they had received an order from the physician to not send R15 to the hospital. Interview on 5/11/26, at 2:34 p.m., with director of nursing reported she was aware of R15's cough. She had been seen at the clinic on 5/6/26 and had new orders for comfort care and was not to be transported to the hospital.	F0657		07/07/2026

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F0657 SS = D	Continued from page 25 R15's 5/11/26 at 2:47 p.m., nursing progress note identified a nursing assistant reported R15 was coughing. R15 was not feeling well, was short of breath, and continued to cough. Staff documented they administered cough syrup and 0.25 milliliters (ML) of morphine and brought her some warm coffee. Staff noted R15 experienced very little relief from those measures. Follow up interview on 5/11/26 at 3:32 p.m., with the director of nursing identified they had sent a fax to the physician earlier but had not received a response. She further identified they could not call the doctor during clinic hours and had been advised to fax. They could call the nurse triage line but were told calling that line would be no faster than sending a fax. She agreed R15's care plan should have been revised to identify what staff were to do to provide comfort for R15 if her condition worsened. Review of the facilities March 2018, Palliative/End of Life Care-Clinical Protocol policy identified the interdisciplinary team would complete an assessment of the resident and family for the basis of the individualized palliative care plan. The assessment would include at least: 1. Documentation of disease status, including diagnosis and prognosis 2. Documentation of co-morbid medical and/or psychiatric conditions 3. Functional status 4. Strengths 5. Concerns, goals and values of the resident and family 6. Preferences and documentation for end-of-life decisions and care 7. Appropriateness of a hospice referral The comprehensive assessment was to recur on a regular basis and in response to significant changes of condition or change in resident and family goals or wishes. The physician was to help identify or verify underlying causes of A resident's decline or end stage/terminal status. Palliative (comfort) care was to focus on physical, psychological, social and	F0657		07/07/2026

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F0657 SS = D	Continued from page 26 spiritual quality of life for the resident and family. The physician was to order appropriate interventions for symptom relief, and advise the resident/patient, family, and facility staff about the prognosis and overall medical plan periodically, including any impact of significant changes of condition. The physician and staff were to monitor and assess the resident's course of treatment, identify complications or additional decline, and adjust their approaches accordingly. R2 R2's comprehensive MDS, accepted on 3/20/26, identified his cognition was severely impaired, and he required partial to moderate assistance of 1 staff for transfers, dressing, and hygiene. R2 had four Stage II pressure ulcers (top layer of skin has broken down, exposing the pinkish layer underneath the dermis). The Care Area Assessment (CAA) portion of the MDS identified staff were to address the pressure wounds on the care plan to identify that staff were to provide pressure ulcer treatment daily, monitor weekly and as needed, and update the physician of if there was a decline or signs of infection. The care plan goals would be to slow or minimize decline, minimize risks, and provide symptom relief or palliative measures. R2's current treatment administration record (TAR) identified a physician order to apply Calmoseptine (topical barrier cream) and a foam patch to the areas on buttocks daily. Review of R2's current, undated care plan identified he was at risk for skin integrity impairment and staff were to encourage good nutrition, avoid moisture, keep skin clean and dry, apply moisture barrier cream after toileting, and monitor for medication side effects such as rash. R2's care plan did not identify he had an actual pressure ulcer and made no mention what staff were to do to promote healing or reduce/minimize risk for infection or discomfort. Interview on 5/11/26 at 3:18 p.m., with nursing assistant (NA)-A identified she was aware R2 has a "rashy" area on his bottom. She reported staff ensure the open area on his bottom is clean then the nurse comes in and does his dressing. Staff check him once in the morning and once in the afternoon. She had never been told that he is supposed to be repositioned. He is supposed to	F0657		07/07/2026

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F0657 SS = D	Continued from page 27 have assistance with standing and transferring. Interview on 5/11/26 at 2:04 p.m., with the MDS nurse identified she did not revise the care plan to include R2's pressure ulcers. Normally, she would have added this with interventions and goals for healing but she "missed it". She agreed it should have been added so staff were aware of the interventions that should be implemented to promote healing and minimize risks. Interview on 5/11/26 at 2:19 p.m., with the DON identified it was her expectation that a pressure ulcer should be identified on the care plan with appropriate goals and interventions. Review of the facilities 2/20/20, Care Plan policy identified staff were to develop a care plan within 7 days after completion of the comprehensive assessment. The care plan was to address the resident's needs, strengths, and preferences as identified in the comprehensive assessment with measurable objectives and timetable to meet the residents long and short-term goals for medical, nursing, and psycho-social needs that are identified in the assessment. The care plan was to list services that will be furnished to attain or maintain the resident's highest and practicable physical, mental, and psycho-social well-being. The care plan was to be reviewed and revised by the interdisciplinary team, the resident, and/or the legal guardian at least quarterly and updated at any time to account for day-to-day changes in care.	F0657		07/07/2026
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment for	F0881	F0881 Within 48-72 hours after starting an antibiotic for a resident the facility will implement an "antibiotic time-out" comprehensive review to ensure it is effectiveness. The charge nurse will send the information to the prescribing physician for determination of the antibiotic's effectiveness. The Infection Preventionist (IP) will ensure implementation of the "antibiotic time-out" comprehensive review and that the information is sent to the prescribing physician.	07/07/2026

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F0881 SS = D	Continued from page 28 continued use of antibiotics for 2 of 3 (R19 and R22) sampled residents reviewed for antibiotic stewardship. Findings include: Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the residents' current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an "antibiotic time-out [ATO]". Review of Monthly Antibiotic surveillance reports from January 2026 through April 2026 identified columns for; resident's name, infection from previous month, infection type, symptoms, onset date, device, infection risk factors, diagnostic performed, date performed, test type, specimen source, results, antibiotic resistant organism, antibiotic name, dose, route, frequency, provider, antibiotic start date, antibiotic end date, total days of therapy, antibiotic reassessment "time out", transmission based precautions required, date symptoms resolved, and comments. Review of January 2026 surveillance identified R19 had symptoms of nasal congestion with no onset date. R19 had been started on doxycycline 100 milligrams (mg) orally, twice a day, beginning 1/15/26 with an end date of 1/22/26, and an ATO was documented as completed. The diagnoses listed was a sinus infection. There was no information in the column labeled "date symptoms resolved" to identify if R19's treatment had been successful or there was a need to change or continue treatment. R19's progress notes identified on: 1/15/26, R19 had been seen by doctor at the facility	F0881	Continued from page 28 Beginning 06/07/2026 for the next 4 weeks, following each antibiotic prescribed for a resident the DON will audit the implementation of the "antibiotic time-out" comprehensive review, that the information was sent to the prescribing physician for review and that the physician's response is received by the facility. Results of audits will be brought to QAPI and reviewed for compliance or the need for further monitoring. Compliance date: 07/07/2026	07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245553	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE , ELLSWORTH, Minnesota, 56129

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F0881 SS = D	Continued from page 29 and was started on doxycycline 100 mg for 7 days. 1/18/26, (identified as an antibiotic time out) staff documented R19 continued to have symptoms of a sinus infection with thick mucus. R19 reported feeling better. Staff noted R19 would continue taking the antibiotic. The note lacked any identification that the doctor was notified or reviewed the information to make an informed decision if the antibiotic should be continued, changed, or discontinued. Review of March 2026 surveillance identified R22, had symptoms of red, warm to touch with onset date of 2/12/26. R22 had been started on doxycycline 100 mg orally, twice a day, beginning on 3/12/26 with an end date of 3/19/26, and an ATO was documented as completed. The diagnoses listed was cellulitis. There was no information in the column labeled “date symptoms resolved” to identify if R22’s treatment had been successful or there was a need to change or continue treatment. R22’s progress notes identified on: 3/12/26, R22 had been seen by the doctor at the facility and started on doxycycline 100 mg twice a day for 7 days and refer to vascular surgery if family desires. 3/15/26, (identified as an antibiotic time out) staff documented R22 continued Doxycycline for cellulitis to right lower extremity. R22’s lower right extremity continued to appear red and slightly swollen and warm to touch. R22 was also noted to have increased confusion, staff were unsure if this was related to antibiotic use or worsening dementia. Staff noted minimal, if any improvement was observed from the antibiotic use. The note lacked any identification that the doctor was notified or reviewed the information to make an informed decision if the antibiotic should be continued, changed, or discontinued. Interview on 5/10/26 at 3:12 p.m., with the director of nursing (DON) identified the antibiotic “time-out” would be documented in the residents’ progress notes. The nurse would complete an assessment of the resident after starting an antibiotic and would documented that in the residents progress notes. That assessment information was not communicated to the prescribing provider. The DON stated, “I have talked with the medical director, but she said that she did not think her colleges would want to be	F0881		07/07/2026

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F0881 SS = D	Continued from page 30 bothered with that information". She revealed that the facility determined that the antibiotic was working if the resident was getting better or not. Interview on 5/11/26 at 8:30 a.m., with the infection preventionist (IP) identified that she had been in the IP position for less than a year. Her hours working in the IP role depended on staffing and if she had to work in another role. She typically worked on infection control 4-5 hours a week. She identified that if an antibiotic "time-out" was not completed she had just "missed" doing it. The providers have told the facility they do not want to see the information or the "time-out" form. The only way the facility determined if the antibiotic was working was if the residents' symptoms improved. She identified that the nurse made a progress note in the resident record on how the resident was doing on the antibiotic. She revealed the facility did not communicate that information with the prescribing provider that ordered the antibiotic as they did not want that information. Interview on 5/11/26 at 9:48 a.m., with the administrator identified he was unaware that there was an issue with antibiotic "time-out" and that the ordering physician should be updated on the resident's status after starting an antibiotic. He was unaware that the medical director had reported to the director of nursing that the providers did not want to review the antibiotic assessment information. Review of facility Antibiotic Flow Sheet that facility staff were supposed to be using identified columns for: Resident name Xray yes or no Prescribing Physician and Facility Date Treatment Started Specimen yes or no Indication for Antibiotic Culture yes or no Antibiotic Ordered with dosage/duration Route of Administration	F0881		07/07/2026

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F0881 SS = D	Continued from page 31 Specimen identified from culture Antibiotic time-out yes or no A place to document vital signs Last date of antibiotic given Nurses signature Has a different antibiotic been ordered for this same infection? The form lacked a column for the facility to make notes of how the resident was doing and for the provider to respond if the antibiotic should be continued, changed, or discontinued. Review of undated, Antibiotic Stewardship policy, identified the program goal was to reduce adverse events associated with antibiotic use and promote appropriate use of antibiotics to treat infection. The facility will implement policies and practices to improve antibiotic use, will monitor antibiotic use and outcomes, and provide feedback to the prescribing provider on antibiotic use and resistance. Antibiotic “time-out” at 72 hours after an antibiotic started will be completed to assess antibiotic need, duration, selection, and de-escalation potential and would be recorded in the resident’s record.	F0881		07/07/2026

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	245553	A. BUILDING **01 - MAIN BUILD...** B. WING	**05/11/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 05/11/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Parkview Manor 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) 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	K0000		06/06/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245553	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/11/2026**

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K0000 Bldg. 01	Continued from page 1 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: 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. The original building was constructed in 1970, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type I (332) construction; The 1st Addition was constructed in 1980, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type I (332) construction; The 2nd Addition was constructed in 1993. It consists of a Resident Room Addition and is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. The facility has a capacity of 36 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		06/06/2026

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K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, NFPA 13, Standard for the Installation of Sprinkler Systems, section 8.5.6, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/11/2026 at 8:57 AM, it was revealed by a review of available documentation that at the time of the survey, the facility could not provide a fire sprinkler 5-year inspection report. 2. On 05/11/2026 at 9:11 AM, it was revealed by observation that there were boxes blocking the sprinkler head in the kitchen freezer. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0353	K053 A 5-year inspection of the fire sprinkler system is scheduled to be completed on June 15, 2026 by Total Fire Protection. Results of the inspection will be sent to the Fire Marshal and a copy kept in the facility's fire plan binder. The Maintenance Director will direct Total Fire Protection to enter the 5-year inspection into the Service Agreement so that it is completed each cycle as required. Completion date: 06/15/2026 The boxes that were blocking the sprinkler head were removed from the shelf by the Maintenance Director at the time of survey. The Administrator brought the deficient practice to the attention of the Dietary Manager. The Administrator educated the Dietary Manager and her staff that no boxes could be placed on the shelf within 18" of the sprinkler head. Wire shelf dividers were purchased and placed to segment off the portion of the shelf in front of and either side of the sprinkler head. The Dietary Manager and/or Maintenance Director will monitor and inspect the shelf each day to ensure nothing is placed within the segmented portion of the shelf. Completion date: 06/03/2026	06/15/2026

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K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 05/11/2026 at 9:01 AM, it was revealed by observation that the generator battery charger, was being powered by a blue extension cord. On 05/11/2026 at 9:42 AM, it was revealed by observation that there was a fan plugged into a power strip and power strips that were daisy chained in room 18. An interview with the Maintenance Director verified these deficiencies finding at the time of discovery.	K0920	K0920 The Maintenance Director disconnected and removed the blue extension cord from the generator battery charger. The battery charger was relocated so that it could be plugged directly into an electrical receptacle. The Maintenance Director will monitor and ensure the battery charger remains plugged directly into the electrical receptacle. Completion date: 05/12/2026 The fan was unplugged from the power strip and plugged directly into an electrical receptacle and the second daisy chained power strip was disconnected and removed from the room at the time of survey. The Administrator and Maintenance Director educated the resident that no appliance with a heat generating motor can be plugged into a power strip and power strips cannot be daisy chained together. On 05/12/2026 the Maintenance Director inspected all of the resident rooms to ensure compliance with K0920. The Maintenance Director will randomly inspect resident rooms weekly and housekeeping staff will observe each day when working in resident rooms to ensure compliance with K0920. Compliance date: 05/11/2026	05/12/2026