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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3E4Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245436**

2.STATE VENDOR OR MEDICAID NO.
(L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER WELLS INC**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2009**

6. DATE OF SURVEY **07/17/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

CCN 24-5436

Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on July 17 2015. Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 has been forwarded. Approval of the waiver request has been requested.

17. SURVEYOR SIGNATURE Date : 06/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 07/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
07/08/2015 (L33)

Posted 07/22/2015 Co.

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 21, 2015

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

Re: Enclosed Reinspection Results - Project Number S5436024

Dear Mr. Johannsen:

On July 17, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 17, 2015. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 21, 2015

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

RE: Project Number S5436024

Dear Mr. Johannsen:

On June 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 21, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 29, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 21, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 29, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 21, 2015, effective June 29, 2015 and therefore remedies outlined in our letter to you dated June 4, 2015, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the May 21, 2015 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245436	A. Building B. Wing	7/17/2015

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **06/29/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **06/29/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/29/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/29/2015**
ID Prefix **F0490** Reg. # **483.75** LSC	Correction Completed **06/29/2015**	ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **06/29/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	07/21/2015	28591	07/17/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/21/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245436	A. Building B. Wing **01 - MAIN BUILDING 01**	6/29/2015

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **06/29/2015**	ID Prefix	Correction Completed **06/29/2015**	ID Prefix	Correction Completed **06/29/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0018		LSC K0021		LSC K0050	
ID Prefix	Correction Completed **06/29/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0069		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	07/21/2015	35482	06/29/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
5/21/2015	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 21, 2015

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

Re: Enclosed Reinspection Results - Project Number S5436024

Dear Mr. Johannsen:

On July 17, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 17, 2015. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00784	A. Building B. Wing	7/17/2015

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20145** Reg. # **MN Rule 4658.0050 Subp.** LSC	Correction Completed **06/29/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **06/29/2015**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **06/29/2015**
ID Prefix **20610** Reg. # **MN Rule 4658.0445 Subp.** LSC	Correction Completed **06/29/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **06/29/2015**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **06/29/2015**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **06/29/2015**	ID Prefix **21525** Reg. # **MN Rule 4658.1305 A.B.C** LSC	Correction Completed **06/29/2015**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **06/29/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	07/21/2015	28591	07/17/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/21/2015				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3E4Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245436**
2.STATE VENDOR OR MEDICAID NO.
(L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER WELLS INC**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2009**

6. DATE OF SURVEY **05/21/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 06/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
AW K67 sent to Rochi 07/08/2015 Co.
Posted 07/08/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 4783

June 4, 2015

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc.
55 Tenth Street Southeast
Wells, Minnesota 56097

RE: Project Number S5436024

Dear Mr. Johannsen:

On May 21, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not

attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 30, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 30, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 21, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 21, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	**F280- IT IS OUR INTENT TO COMPLY WITH THE REGULATION :RIGHT TO PARTICIPATE PLANNING CARE-REVISE** The facilities compliance for monitoring changes in bladder/bowel continence and revision of plan of care were reviewed by the Director of Nursing and Asst Director of Nursing. Resident R10's plan of care was updated. Changes in continence will be communicated to nursing and care plans will be revised accordingly. Director of Nursing and/or Asst Director of Nursing will review and assess changes in continence and revise the care plan to reflect this.	

approved kmt 6/19/15

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

Administrator 17 June 2015

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

RECEIVED
JUN 18 2015
Minnesota Department of Health
Marshall

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F 280	Continued From page 1 by: Based on interview and document review the facility failed to revise the care plan related to a change in urinary continence for 1 of 1 (R10) resident reviewed for urinary incontinence. Findings include: R10, admitted on 1/2/15, had diagnoses which included congestive heart failure (CHF), mantle cell lymphoma, history of urinary tract infection and diabetes mellitus type II. The current physician orders indicated that R10 receives Lasix 20 milligrams daily (water pill) for CHF. Review of the Minimum Data Set (MDS) assessments related to bladder status indicated that R10 had no episodes of bladder incontinence for the 5 day assessment completed on 1/9/15, the 14 day assessment completed on 1/15/15 and the 30 day assessment completed on 2/1/15. The assessment completed on 3/5/15, indicated R10 had occasional episodes (less than 7 episodes of incontinence) of bladder incontinence in the assessment period. The care plan dated 1/22/15, for R10 indicated staff would assist with toileting but did not include any interventions related to the change in urinary status, occasional incontinence. When the electronic urinary history charting completed by the nursing assistants was reviewed, it was noted that R10 had experienced occasional episodes of urinary incontinence since February 2015 (past 3 months). Review of this documentation indicated that urinary incontinence occurred typically mid-morning. No revision to the care plan was noted. During interview and observation on 5/21/15, at	F 280	Care plans will be reviewed weekly for one quarter and as needed thereafter by nursing. To sustain compliance the facility will audit care plans monthly and discuss quarterly at QA meeting. Corrective action will be completed by June 29, 2015	

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F 280	Continued From page 2 8:00 a.m. R10 indicated she required staff assistance to go to the bathroom due to a history of falling but denied urinary incontinence stating, "I have trouble with my bowels". It was then noted that R10 used the call light to summon staff to the room and requested assistance to ambulate into the bathroom. When interviewed on 5/20/15, at 12:38 p.m. the assistant director of nursing (ADON) verified the care plan had not been revised to include urinary incontinence. She further reported the care plan would be updated as necessary when changes were noted and reported by the nursing assistants. When interviewed on 5/21/15, at 7:51 a.m. registered nurse (RN)-D verified that R10 had a change in bladder continence and the plan of care should have been revised to include interventions which address the episodes of incontinence.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and fluids were served at the prescribed texture and consistency according to the care plan for 1 of 4 residents (R5) receiving thickened liquids.	F 282	**F282- It is our intent to comply with regulation: Services by Qualified Persons/per Care Plan.** Staff is educated on the consistency of food/fluids of this resident to his plan of care checking at each service for appropriate consistency. Since this survey residents diet has advanced to mechanical soft.	

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F 282	Continued From page 3 Findings include: R5's current diagnoses according to the physician's orders, dated 5/21/14, included dysphagia (difficulty swallowing) and cough. R5's most current speech therapy evaluation, dated 1/6/15 revealed delay in swallowing and risk for aspiration. The evaluation also identified and a need for thickened fluids at nectar consistency. A physician visit note, dated 5/16/15, included a diagnosis of aspiration pneumonia and an order for a speech evaluation. R5's physician's orders, dated 5/21/15, contained orders for nectar thickened liquids. R5's quarterly minimum data set (MDS), dated 4/21/15 identified a mechanically altered diet, pain or difficulty in swallowing and supervision and setup with eating activities. R5's care plan, last revised 4/21/15 indicated R5's diet was mechanical soft with nectar thickened liquids. R5's nutritional care area assessment (CAA), dated 2/10/15 identified a history of chewing and swallowing problems and a need for a mechanically altered diet with nectar thickened liquids. During interview on 5/19/15, at 11:54 a.m. Family-A stated she had expressed concerns with facility management including the administrator related to staff not thickening R5's fluids to the	F 282	Individuals with observed indicators of dysphagia will be referred to the SLP for evaluation. SLP will make appropriate recommendation to the physician for proper food consistency and fluid thickness. The food service department will be responsible for preparing and serving the diet as ordered. New food service employees will be provided training by the Certified Dietary Manager or other assigned personnel at orientation as to the proper preparation of foods/fluids for dysphagia diets. Food service and nursing staff will be educated on the recognition of food/fluid consistencies by SLP on 19 June 2015. Food service employees will be observed by the CDM or other assigned personnel to ensure preparation techniques are being followed to achieve the proper food/fluid consistency. Random audit of food/fluid consistency will be done weekly by CDM for one quarter and reported to Interdisciplinary team weekly and QA committee quarterly. Random audits to be monthly thereafter reported to the QA committee quarterly.	

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F 282	Continued From page 4 appropriate consistency and that communication between facility departments was poor, no one knew what was going on with R5's foods. During observation on 5/19/15, at 12:15 p.m. revealed R5 was served coffee, water and tomato juice for his liquids at lunch. The coffee was thin and not nectar consistency and the water was thin with sediment on the bottom of the glass. Interview with the DON at this time confirmed that the water had not been mixed thoroughly and that the coffee had not been thickened. The DON took it back to the kitchen staff to thicken the coffee and to stir up the water to nectar consistency. During the observation R5 was taking sips of the coffee when the surveyor identified the thin liquid. R5 did not cough or choke when taking the sips. During observation on 5/20/15, at 8:33 a.m. R5 was seated at the breakfast table and his coffee had not been thickened. The dietary manager (DM) confirmed the coffee had not been thickened and took it back to the kitchen to thicken to the proper consistency. During interview on 5/20/15, at 11:41 a.m. Cook-B indicated all R5's foods needed to be pureed and fluids thickened to nectar consistency. R5's tray card was reviewed and indicated all his fluids needed to be nectar thick. During interview on 5/19/15, at 1:52 p.m. dietary aide (DA)-A stated R5 should be on nectar thickened liquids and that coffee took longer to set up, it needed to "Set a while," before being brought to the resident. During interview on 5/20/15, at 8:10 a.m. Family-B indicated there had been ongoing	F 282	Corrective action will be complete June 29, 2015.	

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F 282	Continued From page 5 concerns with the facility thickening R5's fluids too thick, " Like a blizzard consistency." and stated he had become angry and had to show staff how to properly thicken the fluids. The facility policy, entitled Thickened Liquids, dated 11/14, indicated if an order is received from the doctor for thickened liquids these are prepared in accordance to package directions per doctor order. If resident is not tolerating these or there are indications that this will not be beneficial a swallow evaluation is requested. SLP recommendations will be followed.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess a change in urinary continence so that an individualized plan could be developed for 1 of 3 residents (R10) reviewed for urinary incontinence. Findings include:	F 315	**F315- IT IS OUR INTENET TO COMPLY WITH THE REGULATION: NO CATHETER, PREVENT UTI, RESTORE BLADDER** The facilities compliance for monitoring changes in bladder/bowel continence and revision of plan of care were reviewed by the Director of Nursing and Asst Director of Nursing. Resident R10's plan of care was updated. Director of Nursing and/or ADON will review residents who need assistance with toileting and assure they are receiving the necessary services to prevent potential decline in toileting.	

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F 315	Continued From page 6 R10, admitted on 1/2/15, had diagnoses which included congestive heart failure (CHF), mantle cell lymphoma, history of urinary tract infection and diabetes mellitus type II. The current physician orders indicated that R10 receives Lasix 20 milligrams daily (water pill) for CHF. Review of the Minimum Data Set (MDS) assessments related to bladder status indicated R10 had no episodes of bladder incontinence for the 5 day assessment completed on 1/9/15, the 14 day assessment completed on 1/15/15 and the 30 day assessment completed on 2/1/15. The assessment completed on 3/5/15, indicated R10 had occasional episodes (less than 7 episodes of incontinence) of bladder incontinence during the assessment period. The nursing care plan for R10 indicated staff would assist with toileting but did not include interventions related to occasional incontinence. When the electronic urinary history charting completed by the nursing assistants was reviewed, it was noted that R10 had experienced occasional episodes of urinary incontinence since February 2015 (past 3 months). Reivew of this documentation indicated that urinary incontinence occurred typically mid- morning. Documentation was lacking to indicate whether times of incontinence had any correlation with the use of the Lasix (water pill) and/or whether a scheduling toileting plan would be helpful to maintain urinary continence. During interview and observation on 5/21/15, at 8:00 a.m. R10 indicated she required staff assistance to go to the bathroom due to a history of falling but denied urinary incontinence stating, "I have trouble with my bowels". It was then	F 315	Changes in continence will be communicated to nursing and care plans will be revised accordingly. Director of Nursing and/or Asst Director of Nursing will review and assess changes in continence and revise the care plan to reflect this. Care plans will be reviewed weekly for one quarter and monthly thereafter for one year or as needed by nursing. To sustain compliance the facility will audit care plans; this will be discussed quarterly at QA meeting Corrective action will be completed by June 29, 2015	

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F 315	Continued From page 7 noted that R10 used the call light to summon staff to the room and requested assistance to ambulate into the bathroom. When interviewed on 5/20/15, at 12:38 p.m. the assistant director of nursing (ADON) verified that R10 had experienced episodes of urinary incontinence during the assessment period dated 3/5/15. The ADON indicated a bladder reassessment was completed at that time and a plan had been developed to improve and maintain urinary continence. However, the ADON further verified the careplan did not address the urinary incontinence. She further reported the care plan should be updated as necessary when changes were noted and reported by the nursing assistants. The ADON further indicated that R10 had cognition changes that varied throughout the day. When interviewed on 5/21/15, at 7:51 a.m. registered nurse (RN)-D reported the ADON completes the urinary assessments with input from the nursing staff and that information is used to complete the MDS. RN-D verified that R10 had a change in bladder continence and the plan of care should have been updated to include interventions which address the episodes of incontinence to promote continence and it had not been revised. The facility failed to assess the change in bladder continence so that an individualized toileting plan could be developed to maintain and/or improve bladder continence.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 8 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and fluids were served at the prescribed texture and consistency, failed to ensure family were educated on appropriate feeding techniques and failed to ensure the risks and benefits of noncompliance with a therapeutic diet were discussed with the resident and family for 1 of 4 residents (R5) receiving thickened liquids. Findings include: R5's current diagnoses according to the physician's orders, dated 5/21/14, included dysphagia (difficulty swallowing) and cough. R5's most current speech therapy evaluation, dated 1/6/15 revealed delay in swallowing and risk for aspiration. The evaluation also identified and a need for thickened fluids at nectar consistency. A physician visit note, dated 5/16/15, included a diagnosis of aspiration pneumonia and an order for a speech evaluation. R5's physician's orders, dated 5/21/15, contained orders for nectar thickened liquids.	F 323	**F323- It is our intent to comply with regulation: Free of accident hazards/supervision/devices.** Staff is educated on the consistency of food/fluids of this resident to his plan of care checking at each service for appropriate consistency. Since this survey residents diet has advanced to mechanical soft. Individuals with observed indicators of dysphagia will be referred to the SLP for evaluation. SLP will make appropriate recommendation to physician for proper food consistency and fluid thickness. The food service department will be responsible for the preparing and serving the diet as ordered. New food service employees will be provided training by the Certified Dietary Manager or other assigned personnel at orientation as to the proper preparation of foods/fluids for dysphagia diets. Food service and nursing staff will be educated on the recognition of food/fluid consistencies by SLP on 19 June 2015.	

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F 323	Continued From page 9 R5's quarterly minimum data set (MDS), dated 4/21/15 identified a mechanically altered diet, pain or difficulty in swallowing and supervision and setup with eating activities. R5's care plan, last revised 4/21/15 indicated R5's diet was mechanical soft with nectar thickened liquids. R5's nutritional care area assessment (CAA), dated 2/10/15 identified a history of chewing and swallowing problems and a need for a mechanically altered diet with nectar thickened liquids. R5's nursing progress notes revealed entries related to the following: 12/19/14 - Speech therapy recommended thickened liquids d/t (due to aspiration). 1/27/15 - Care conference held for resident with family complaints of too much thickener in R5's water. 3/4/15 - Resident with blood sugar of 66 (low) 3/30/15 - Low blood sugars, insulin held until after supper. 4/21/15 - Care conference held with family reporting concerns about fluid consistency not being prepared by the facility as ordered. 4/30/15 - Ate blueberry double crust pie brought in by daughter. 5/11/15 - Dietician review due to family concerns with food items and fluid consistencies - recommended speech evaluate fluid texture and have family sign a waiver if family makes other consistencies. 5/15/15 - Staff alerted by family member that R5 was gagging and coughing on his coffee.	F 323	Food service employees will be observed by the CDM or other assigned personnel to ensure preparation techniques are being followed to achieve the proper food/fluid consistency. Random audit of food/fluid consistency will be done weekly by CDM for one quarter and reported to Interdisciplinary team weekly and QA committee quarterly. Random audits to be monthly thereafter reported to the QA committee quarterly. Corrective action will be complete June 29, 2015.	

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F 323	Continued From page 10 5/16/15 - Coughing on AM medications and sent to emergency room for evaluation. Returned with aspiration pneumonia and orders for oral antibiotics. During observation on 05/18/15, at 5:34 p.m., R5 was noted to be at the dining room being assisted to eat ice cream by family member (FM)-A. FM-A stated R5 had been in the hospital over the weekend with aspiration pneumonia and was now on pureed foods with nectar thickened fluids. No coughing was noted during the observation of the meal. Four other nursing assistants (unidentified) were seated in the dining room during the observation. During interview on 5/18/15, at 5:30 p.m., the assistant director of nursing (ADON) and registered nurse (RN)-A stated R5 ' s family had been trained on how to feed him. Training materials for family were requested and the ADON indicated she would get them from the director of nursing (DON). During observation on 5/18/15, at 6:30 p.m. R5 was seated in his wheelchair being fed ice cream by FM-A. At 6:40 p.m. No coughing was observed while eating the ice cream, however after FM-A left the room R5 began coughing. During interview on 5/18/15, at 6:30 p.m. the DON stated R5's family had not been trained to assist with feeding and nursing staff should have intervened to stop family from continuing to feed R5. The DON further indicated she would have speech therapy educate family the following day and that prior to this evening R5 had been feeding himself independently.	F 323		

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F 323	Continued From page 11 During interview on 5/18/15, at 7:49 p.m. the DON stated R5 and his family had been educated on the risk and benefits of failing to comply with his therapeutic diet. The DON indicated that the ice cream R5 was eating would not be approved for someone on nectar thickened fluids, and that there had been an " Ongoing battle, " between the facility and family members related to feeding R5 foods that were not approved based on his current diet orders. The DON indicated the facility had a signed waiver for R5 for failure to comply with the therapeutic diet and she would provide the documentation. The DON further indicated the dietary manager (DM) had this information. During interview on 5/19/15, at 8:47 a.m., the DM indicated she thought family had been educated on the risks and benefits of feeding R5 food and fluids not of the correct consistency and that family had a history of noncompliance with diet textures. The DM was unable to provide any documentation related to education of family or the resident at this time. During further interview on 5/19/15, at 8:58 a.m., the DON indicated that R5 had been educated on the risks and benefits of taking in food and fluids not approved on his diet and she had "Lots of documentation," on it that could be provided. Review of R5's medical record at this time lacked evidence of family teaching or training related to food and fluid consistencies that were appropriate for R5. On 5/19/15, at 2:42 p.m. the DON provided copies of R5's progress notes which included new entries for the dates of 5/1/15, 4/21/15, 4/3/15 and 12/3/15 indicating the DON had	F 323		

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F 323	Continued From page 12 discussed noncompliance with R5's family related to failing to follow the therapeutic diet and potential for aspiration pneumonia. The time stamp on the electronic medical record indicated the entries were placed into R5's medical record on or after 9:36 a.m. on 5/19/15. During interview, the DON stated the information had been in a "Soft file," in her office and she had entered the notes into R5's chart to make them "Easier to find. " The DON indicated the entries should have been placed into the medical record at the time of the events. During interview on 5/19/15, at 11:54 a.m. FM-A stated family had never had a discussion on the risks and benefits of giving regular texture foods or thin liquids to R5. FM-A stated she had brought in sweets to help R5's blood sugar stay up throughout the night because he was diabetic and not eating as well, and indicated nursing had agreed with this practice. FM-A further stated she had expressed concerns with facility management related to staff not thickening R5's fluids to the appropriate consistency and that communication between facility departments was poor, no one knew what was going on with R5's foods. During observation on 05/19/15, at 12:15 p.m. revealed R5 was served coffee, water and tomato juice for his liquids at lunch. The coffee was thin and not nectar consistency and the water was thin with sediment on the bottom of the glass. Interview with the DON at this time confirmed the water had not been mixed thoroughly and the coffee had not been thickened. The DON took it back to the kitchen staff to thicken the coffee and to stir the water to a nectar consistency. During the observation R5 was taking sips of the coffee	F 323		

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F 323	Continued From page 13 when the surveyor identified the thin liquid. R5 did not cough or choke when taking the sips. During observation on 5/20/15, at 8:33 a.m. R5 was seated at the breakfast table and his coffee had not been thickened. The dietary manager (DM) confirmed the coffee had not been thickened and took it back to the kitchen to thicken to the proper consistency. The DM further stated staff had thought family requested the coffee not to be thickened, however, if family wanted any changes to the fluid consistency a waiver needed to be signed. During interview on 5/20/15, at 11:41 a.m. Cook (C)-B indicated all R5's foods needed to be pureed and fluids thickened to nectar consistency. R5's tray card was reviewed and indicated all his fluids needed to be nectar thick. During interview on 5/20/15, at 12:24 p.m. R5 stated his food was "Good," but was unable to be interviewed further regarding his preferences related to food and fluid texture changes. R5 was able to feed himself independently. During interview on 5/19/15, at 1:52 p.m. dietary aide (DA)-A stated R5 should be on nectar thickened liquids and that coffee took longer to set up, it needed to "Set a while," before being brought to the resident. During interview on 5/20/15, at 8:10 a.m. FM-B indicated the first education they had received related to risk of aspiration pneumonia with diet noncompliance was provided by the emergency room physician on 5/16/15 when R5 was sent to the hospital for evaluation and returned with aspiration pneumonia. FM-B further stated there	F 323		

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F 323	Continued From page 14 had been ongoing concerns with the facility thickening R5's fluids too thick, "Like a blizzard consistency," and stated he had become angry and had to show staff how to properly thicken the fluids. FM-B indicated no one from facility ever talked with the spouse about food or fluids R5 should not have served or they would have "Stopped bringing them in if he wasn't supposed to have them." The facility policy, entitled Residents Requiring Assistance with Feeding - Feeding of Residents by Family Members, last revised 4/10, indicated the director of nursing was responsible for training family members who desired to feed their family members. The policy further stated the resident should be assessed by a nurse and a determination made that the resident may be safely fed by a family member. The facility policy, entitled Non-Compliance with Therapeutic Diet, undated, indicated when residents request foods not allowed on their therapeutic or mechanically altered diets, or refuse those foods offered on prescribed diets, the food service manager developed an alternate plan to meet the needs of the resident. The policy further stated that the resident or responsible party may be asked to sign a release indicating refusal to follow the prescribed diet. If the release is utilized, it is updated annually. The facility policy, entitled Thickened Liquids, dated 11/14, indicated if an order is received from the doctor for thickened liquids these are prepared in accordance to package directions per doctor order. If resident is not tolerating these or there are indications that this will not be beneficial a swallow evaluation is requested. SLP	F 323		

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F 323	Continued From page 15 recommendations will be followed.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to adequately assess clinical indications for use of psychoactive medications including antidepressants and antianxiety medications for 2 of 5 residents (R14, R38) whose medications were reviewed.	F 329	**F-329 it is our intent to comply with Regulation: Drug regimen is free from Unnecessary drugs.** The facilities compliance for monitoring medication was reviewed by the DON, ADON And consulting pharmacist. A checklist for medications that require monitoring for dose reduction, target behaviors was implemented and a monthly summarization of dose reduction and target behaviors will be reviewed monthly by the DON, ADON, and consulting pharmacist. The AIMS, MOSES and DISCUS will be used quarterly and as needed to monitor for side effects and effectiveness. All monthly reports from the consulting Pharmacist are currently reviewed by the DON and ADON and correspondence with the doctor will be tracked on a monthly Basis. To sustain compliance the facility will Audit target behaviors, dosage change Or reduction and these will be discussed Quarterly at QA meeting. Corrective action will be completed by June 29 , 2015	

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F 329	Continued From page 16 Findings include: R14's admission record indicated R14 had been admitted to the facility on 10/23/13, with diagnoses including: anxiety state, hypertension, chronic stage III kidney disease, esophageal reflux, hyperlipidemia, depressive disorder, cognitive impairment-mild, and anemia-normocytic. Review of R14's signed physician orders dated May 2015, indicated orders for Ativan 0.5 milligrams (mg) by mouth (PO) two times daily (BID) for anxiety (an antianxiety medication initiated 12/13/14), Remeron (an antidepressant) 15 mg PO every bedtime (QHS) for depression (initiated 3/23/14), and Sertraline (an antidepressant) 50 mg QHS for depressive disorder (initiated 3/23/14). The consultant pharmacist's review dated 12/25/14, included a recommendation: "advise if a slight reduction to Ativan 0.25 mg (0.5 mg) Q P.M. is appropriate at this time, with continuation of Remeron/Zoloft at current dose to facilitate reduction attempts." The corresponding physician's response dated 1/7/15 included, "Will continue as is" with no additional information documented to justify not following through with a gradual dose reduction. Behavior monitoring for the months of January, February, March and April 2015 indicated no behaviors and/or no changes. On 5/20/15, at 8:45 a.m. the DON verified there was no additional information regarding the recommended dose reduction in the resident's	F 329		

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F 329	Continued From page 17 record. During a telephone interview conducted on 5/20/15, at 10:20 a.m. with the consultant pharmacist it was verified that the physician response to the 12/25/14 recommendation for potential dosage reduction was not adequate and the physician had not readdressed the issue. Review of R38's current physician orders included an order for Celexa (antidepressant) 20 mg daily for treatment of depression (initiated 7/22/13). R38's care plan last revised 3/3/15, indicated R38 had a diagnosis of depression and that R38 used Celexa for treatment of. The care plan further indicated a dose reduction of R38's psychotropic medications should be reviewed at least every six months. R38's quarterly minimum data set (MDS) dated 3/3/15, identified a current Patient Health Questionnaire (PHQ-9) score of 0 (no depression). R38's mood and behavior monitoring assessment dated 5/17/15, entitled Parkview Behavioral Conditions, revealed no current symptoms of depression and indicated R38 was stable at this time. Review of a pharmacy recommendation dated 10/30/14, indicated a recommendation to the physician requesting review of whether the current Celexa dose was appropriate for baseline symptom management. The physician had responded on 10/31/14 to continue the current dose of the Celexa but did not document justification of the reasons for continued use.	F 329		

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F 329	Continued From page 18 Interview with the DON on 5/20/15 at 10:00 am confirmed that there was no documented justification for continued use of the resident's Celexa. The DON also confirmed the resident had not exhibited any mood/behaviors in the past several months.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as	F 356	**F-356 it is our intent to comply with Regulation: Posted Staffing Information.** The facilities compliance for monitoring posted staffing information was reviewed by the Administrator, DON and ADON. DON will educate and express to nurse staff this is a regulatory document which must be posted daily, at her monthly nurse meeting on 16 June. A checklist to ensure this is posted on a daily basis will be completed by the DON, ADON or other personnel as assigned. Performance will be monitored by completing the second check and will be discussed at Quarterly QA Corrective action will be completed by June 29 , 2015	

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F 356	Continued From page 19 required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to consistently include current census information on the daily nursing hours posting of which had the potential to affect all 44 residents residing at the facility. Findings include: During observation on 5/18/15, at 2:00 p.m. the facility nursing hour posting was noted to be missing the census information. Additional observations were made on 5/19/15, at 1:00 p.m. and 5/20/15, at 11:30 a.m. and the census information continued to be missing on the hours posting. During interview on 5/20/15, at 1:00 p.m. the administrator confirmed the nursing hours posting lacked the census information. The administrator further stated there had been concerns with this issue in the past and he had been monitoring this concern.	F 356		
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assure the consulting pharmacist monitored resident medication regimens monthly, and the facility failed to ensure recommendations for the physician were acted upon or justification for no action documented for 4 of 5 residents (R14, R21, R29 and R38) reviewed for unnecessary medications. This deficient practice had the potential to affect all 44 residents currently residing in the facility. Findings include: Review of R38's current physician orders included an order for Celexa (antidepressant) 20 mg daily for treatment of depression (initiated 7/22/13). R38's care plan last revised 3/3/15, indicated R38 had a diagnosis of depression and that R38 used Celexa for treatment of depression. The care plan further indicated a dose reduction of R38's psychotropic medications should be reviewed at least every six months. R38's quarterly minimum data set (MDS) dated 3/3/15, identified a current Patient Health Questionnaire (PHQ-9) score of 0 (no depression). R38's mood and behavior monitoring assessment dated 5/17/15, entitled Parkview Behavioral Conditions, revealed no current symptoms of	F 428	**F-428 - It is our intent to comply with Regulation- Drug regimen review, report Irregular. Act on** The consulting pharmacist was paid for his services and will be monitoring for unnecessary medication in accordance with his contract. He did return on June 10th to review medications and will continue to visit on a monthly basis without interruption. He will attend the next QA meeting. Physicians were educated on the importance of reviewing risks and benefits and this being documented on the consulting pharmacist note. DON and ADON will both review monthly visits and recommendations and ensure follow up if needed with physician. DON will notify administrator and email consulting pharmacist if a visit is not completed by the 25th of the month. Records of consulting pharmacist visits will be recorded in residents chart and maintained for review and discussed at quarterly QA meeting Corrective action will be completed by June 29, 2015	

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F 428	Continued From page 21 depression and indicated R38 was stable at this time. Review of a pharmacy recommendation dated 10/30/14, indicated a recommendation to the physician requesting review of whether the current Celexa dose was appropriate for baseline symptom management. The physician had responded on 10/31/14 to continue the current dose of the Celexa but did not document justification of the reasons for continued use. Interview with the DON on 5/20/15 at 10:00 am confirmed that there was no documented justification for continued use of the resident's Celexa. The DON also confirmed the resident had not exhibited any mood/behaviors in the past several months. In addition, review of the consultant pharmacist documentation revealed no January or April 2015 reviews had been conducted for R38. R14's admission record indicated R14 had been admitted to the facility on 10/23/13, with diagnoses including: anxiety state, hypertension, chronic stage III kidney disease, esophageal reflux, hyperlipidemia, depressive disorder, cognitive impairment-mild, and anemia-normocytic. Review of R14's signed physician orders dated May 2015, indicated orders for Ativan 0.5 milligrams (mg) by mouth (PO) two times daily (BID) for anxiety (an antianxiety medication initiated 12/13/14), Remeron (an antidepressant) 15 mg PO every bedtime (QHS) for depression (initiated 3/23/14), and Sertraline (an antidepressant) 50 mg QHS for depressive disorder (initiated 3/23/14).	F 428		

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F 428	Continued From page 22 The consultant pharmacist's review dated 12/25/14, included a recommendation: "advise if a slight reduction to Ativan 0.25 mg (0.5 mg) Q P.M. is appropriate at this time, with continuation of Remeron/Zoloft at current dose to facilitate reduction attempts." The corresponding physician's response dated 1/7/15 included, "Will continue as is" with no additional information documented to justify not following through with a gradual dose reduction. There had been no pharmacy reviews conducted for January or April 2015. Behavior monitoring for R14 for the months of January, February, March and April 2015 indicated no behaviors and/or no changes. On 5/20/15, at 8:45 a.m. the DON verified there was no additional information regarding the recommended dose reduction for R14 documented in the resident's record. During a telephone interview conducted on 5/20/15, at 10:20 a.m. with the consultant pharmacist it was verified that the physician response to the 12/25/14 recommendation for potential dosage reduction for R14 was not adequate and the physician had not readdressed the issue During an interview on 5/19/15, at 3:35 p.m. the assistant director of nursing (ADON) verified the consultant pharmacist is supposed to visit the facility on a monthly basis and is supposed to review all resident records. The ADON further verified the pharmacist had not conducted reviews in January or April 2015 and stated she	F 428		

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F 428	Continued From page 23 did not know whether if he would come in May 2015. On 5/19/15, at 4:15 p.m. the director of nursing (DON) confirmed the consultant pharmacist had not reviewed records in the facility for the month of January 2015, April 2015 and so far not for the month of May 2015. The DON further stated she did not know if he would come in May 2015. The DON further stated the consultant pharmacist had not attended the most recent QA&A meeting. During a telephone interview conducted on 5/20/15, at 10:20 a.m. with the consultant pharmacist it was verified he had not been in the facility to perform a medication review for January 2015 or April 2015 r/t non-payment. R29's current diagnoses according to the care plan dated 3/27/15, included depression, anxiety and agitation with slight psychosis. Review of R29's pharmacy consultant notes for the previous ten months revealed the last monthly visit was conducted on 3/26/15, and no visits were made for the months of 1/15 or 4/15. R21's current diagnoses according to the face sheet, dated 5/21/15, included coronary atherosclerosis, depression, osteoarthrosis and atrial fibrillation. Review of R21's pharmacy consultant notes for the previous ten months revealed the last monthly visit was conducted on 3/31/15, and no visits were made for the months of 1/15 or 4/15. During interview on 5/21/15, at 8:58 a.m. the DON stated the consultant pharmacist had conducted reviews at the end of 12/14 and	F 428		

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F 428	Continued From page 24 thought this should "Cover both December and January." The DON further stated she was aware the pharmacist had not been to the facility in April due to non-payment of the bill and had forwarded this information to the administrator via email. The facility Pharmaceutical Consulting Contract, dated 2/4/11 indicated the consultant shall perform a monthly drug regimen review of each resident's pharmaceutical care plan and personal record for the purpose of identifying drug problems, potential drug problems and irregularities related to drug therapy.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	**F431- It is our content to comply with Regulation: Drug Records, Label/Store Drugs & Biological** The facilities compliance for monitoring Policy And Procedure for Administration and Handling Of Medications was reviewed by the DON, ADON And administrator. Medication carts were Checked for outdates, medication not dated and Compliance was discussed at nurses training on June 9 With all nursing staff. Each nurse is responsible for maintaining all medication In the cart throughout their shift and ensuring there are Correctly dated and not outdated medications inside.	

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F 431	Continued From page 25 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure outdated resident medications located on the medication carts were not available for use for 5 of 44 residents (R2, R29, R41, R49 & R76) and failed to ensure that outdated stock medication was not available for use for all 44 residents who reside in the facility and who may require medication from the outdated stock supply items. Findings include: During observation of the east medication administration cart with licensed practice nurse (LPN)- B on 5/20/15, at 9:01 a.m. an opened and partially used bottle of Mi-acid (stomach/gas relief medication) original strength liquid was noted to have an expiration date of January 2015. LPN-B indicated she was uncertain when a resident had last been administered the medication but it was the only bottle of Mi-acid located and available on the cart. LPN-B indicated this was the last bottle that would have been used on an as needed basis (PRN).	F 431	DON and ADON will complete weekly cart audits along with The consulting pharmacist on a monthly basis. These results will be reviewed and discussed with DON, ADON and Administrator and also presented and discussed At quarterly QA meeting. Corrective action will be completed by June 29 , 2015	

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F 431	Continued From page 26 It was noted that R29 had one (1) opened bottle of Levobunolol 0.5% eye drops which was currently in use and not dated when opened. LPN-B indicated the facility policy was to date the medication when opened and if not dated when opened, it should not be used and a new bottle should be obtained from the pharmacy. LPN-B verified the eye drop medication was currently utilized and was uncertain when initially opened for use. It was noted that R2 had a bottle of Antacid Calcium 750 mg with a printed expiration date of 11/01/14. The Medication Administration Record (MAR) noted the last date of administration was 12/5/14, which was administered 36 days after the expiration date noted on the label. During review of the west medication cart with LPN-C on 5/20/15, at 9:40 a.m. R49 was noted to have one (1) bottle of Timolol 0.5% with a printed expiration date of 4/17/15. The May 2015 electronic MAR indicated R49 was currently receiving Timolol 0.5% and last administered the morning of 5/20/15. LPN-C verified she had used this bottle to administer R49's Timolol. R49 also had one (1) bottle of Latanoprost 0.005% with a printed expiration date of 4/17/15. According to the MAR and verified by LPN-C this medication was last administered on 5/19/15. In addition, the bottle of Timolol was not dated when opened. It was noted that R76 had one (1) bottle of Artificial tears not dated when opened. LPN-C verified the eye drops were currently administered at HS (hour of sleep) on a daily basis. It was noted that R41 had one (1) bottle of Lubricant eye drops with a printed expiration date	F 431		

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F 431	Continued From page 27 of 4/2015. According to the MAR and verified by LPN-C, this medication was administered daily and last administered the morning of 5/20/15. During an interview with the director of nursing (DON) on 5/20/15, at 10:00 a.m. it was verified that medications located on the medication carts were to be monitored for expired medications and medication expiration dates were to be checked prior to administration. The DON further stated she expected the nurses to follow the policy for correct administration of medications. Review of the undated policy and procedure titled, Policy and Procedure for Administration and Handling of Medications: Out of Date Medications: Medications having a specific expiration date shall not be used after the date of expiration. Stock Supply of Drugs: Medications procurable without prescription may be retained in stock supply. These shall be dated on recept to prevent the accumulation of outdated or deteriorated items. There was no policy provided detailing monitoring or reviewing the medication carts/stock medications for dating or expiration. The DON verified that the facility did not have a policy that addressed this issue.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	Continued From page 28 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to properly disinfect the multi-use glucometer (blood sugar meter) according to facility policy for 3 of 4 residents (R2, R24 and R33) observed during glucose monitoring of which had the potential to affect 13 of 13 residents (R2, R5,R10, R13, R22, R24, R25, R27, R33, R37, R41, R55) who utilized a	F 441	**F441 it is our intent to comply with regulation:** **INFECTION CONTROL, PREVENT SPREAD, LINENS** The facilities compliance for monitoring- maintaining an infection control program that provides a safe, sanitary and comfortable environment was reviewed by the DON, ADON and Administrator. All nursing staff met on June 9, 2015 and were instructed to clean glucometers with a alcohol wipes per manufacturer's recommendations and allow to dry. If the glucometer is in a plastic container this should not be placed on a residents bed or anywhere in the room unless it is wiped clean with an alcohol wipe. Director of Nursing and/or ADON will complete random weekly audits on the compliance for one quarter and present at the quarterly QA meeting. Audit will be complete quarterly thereafter. Corrective action will be completed by June 29, 2015	

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F 441	Continued From page 29	F 441		

glucometer; and failed to properly disinfect the glucometer storage tray after it had been placed on the residents bed during the glucose check and then placed in the medication storage cart.

Findings include:

R2's current physician orders dated 5/20/15, indicated a diagnosis of diabetes type II. The physician's orders also indicated R2 was to receive blood sugar checks four times a day.

During observation on 5/20/15, at 7:30 a.m. licensed practical nurse (LPN)-B utilized a mutli-use glucometer to check R2's blood sugar. LPN-B placed the glucometer storage tray on top of the residents bed. After LPN-B obtained the residents blood sugar results, she proceeded to clean the top and bottom of the glucometer with a alcohol swab with 1 swipe and placed it back into the storage tray. LPN-B then placed the glucometer storage tray in the facility medication cart next to other resident supplies without further sanitization.

R24's current physician orders sheets dated 5/20/15, identified a diagnosis of diabetes type II. The physicians orders also indicated R24 was to receive blood sugar checks every morning.

During observation on 5/20/15, at 7:30 a.m., LPN-B used a multi-use glucometer to check R24's blood sugar. LPN-B placed the glucometer storage tray on top of the residents bed. After LPN-B obtained the residents blood sugar results, she proceeded to clean the top and bottom of the glucometer with a alcohol swab with 1 swipe and placed it back into the storage tray. LPN-B then placed the glucometer storage tray in the facility

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F 441	Continued From page 30 medication cart next to other resident supplies without further sanitization. R33's current physician orders sheets dated 5/20/15, identified a diagnosis of diabetes type II. The physicians orders also indicated R33 was to receive blood sugar checks every morning. During observation on 5/20/15, at 7:30 a.m. LPN-B used a multi-use glucometer to check R33's blood sugar. LPN-B placed the glucometer storage tray on top of the residents bed. After LPN-B obtained the residents blood sugar results she proceeded to clean the top and bottom of the glucometer with a alcohol swab with 1 swipe and placed it back into the storage tray. LPN-B then placed the glucometer storage tray in the facility medication cart next to other resident supplies without sanitizing. When interviewed on 5/20/15, at 8:00 a.m. about the proper cleaning of the multi-use glucometer between residents, LPN-B indicated it was the facility policy to clean the glucometer after resident use with an alcohol swab. LPN-B further indicated she has always cleaned the glucometer meters with an alcohol swab between residents. During interview on 5/20/15, at 9:00 a.m. the director of nursing (DON) indicated LPN-B should have followed the facility policy when cleaning the glucometer and the glucometer storage container before placing it back into the medication cart. The facility undated policy, titled Disinfection of Blood Glucose Monitors, directed after using the glucometer staff were to thoroughly cleanse with a PDI sani-wipe (chemical sanitizer) and to wipe down all surfaces of the glucometer with the wipe	F 441		

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F 441	Continued From page 31 and to provide contact time per chemical recommendations and to allow to air dry before next use. The facility undated policy, entitled Disinfecting Equipment Shared between Residents, directed staff to disinfect all equipment shared between resident's with the use of a PDI-sanicloth wipe and to allow the equipment to air drive. When the manufacturer's recommendations were requested, it did not not reference the proper cleaning required when used for multi-use purposes. The ASCP's (American Society for Clinical Pathology) Summary of Glucometer Cleaning Guidelines, dated February 2010, recommended the following: If the manufacturer does not provide specific cleaning recommendations or as a conservative approach to infection control for glucometers with minimal cleaning requirements, facilities may want to consider cleaning glucometers with high-level disinfectants.	F 441		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure appropriate resources were available for	F 490		

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F 490	Continued From page 32 maintaining monthly pharmacy services as part of the operation of the facility. This had the potential to affect all 44 residents in the facility. Findings include: Refer to F428: Based on interview and document review, the facility failed to assure the consulting pharmacist monitored resident medication regimens monthly for unnecessary medications. This deficient practice had the potential to affect all 44 residents currently residing in the facility. During an interview on 5/19/15, at 3:35 p.m. the assistant director of nursing (ADON) verified the consultant pharmacist is supposed to visit the facility on a monthly basis and is supposed to review all resident records. The ADON further verified the pharmacist had not conducted reviews in January or April 2015 and stated she did not know whether if he would come in May 2015. On 5/19/15, at 4:15 p.m. the director of nursing (DON) confirmed the consultant pharmacist had not reviewed records in the facility for the month of January 2015, April 2015 and so far not for the month of May 2015. The DON further stated she did not know if he would come in May 2015. The DON further stated the consultant pharmacist had not attended the most recent QA&A meeting. During a telephone interview conducted on 5/20/15, at 10:20 a.m. with the consultant pharmacist it was verified he had not been in the facility to perform a medication review for January 2015 or April 2015 related to non-payment. During interview on 5/21/15, at 8:58 a.m. the	F 490	**F-490- It is our intent to comply with Regulation- Effective Administration/Resident Well Being.** The consulting pharmacist was paid for his services and will be monitoring for unnecessary medication in accordance with his contract. He did return on June 10th to review medications and will continue to visit on a monthly basis without interruption. He will attend the next QA meeting. DON and ADON will both review monthly visit and recommendations and ensure follow up if needed with physician. DON will notify administrator and email consulting pharmacist if there is not a visit Completed by the 25th of the month. Records of consulting pharmacist visits will be recorded in residents chart and maintained for review and discussed at quarterly QA meeting Corrective action will be completed by June 29, 2015	

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F 490	Continued From page 33 DON stated she was aware the pharmacist had not been to the facility in April due to non-payment of the bill and had forwarded this information to the administrator via email. The facility Pharmaceutical Consulting Contract, dated 2/4/11 indicated the consultant shall perform a monthly drug regimen review of each resident's pharmaceutical care plan and personal record for the purpose of identifying drug problems, potential drug problems and irregularities related to drug therapy.	F 490		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical record contained timely documentation related to family and resident education regarding therapeutic diet orders for 1 of 1 resident (R5) in the sample who received thickened fluids.	F 514	**F514- It is our intent to comply with regulation:** **Resident records- Complete/Accurate/Accessible** The facilities compliance for records was reviewed by the DON and ADON. All documentation or assessments in paper for will be entered into resident's electronic chart and will be accessible to all Authorized staff. All family discussions and resident issues will be documented in progress notes. DON, ADON and or other assigned personnel will review electronic charts on a weekly basis to ensure proper assessments and documentation Is available and this will be discussed at the quarterly QA meeting. Corrective action will be completed by June 29,2015	

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F 514	Continued From page 34 Findings include: R5's current diagnoses according to the physician's orders, dated 5/21/14, included dysphagia (difficulty swallowing) and cough. A physician visit note, dated 5/16/15 included a diagnosis of aspiration pneumonia and an order for a speech evaluation. R5's physician's orders, dated 5/21/15, contained orders for nectar thickened liquids. R5's quarterly minimum data set (MDS), dated 4/21/15 identified a mechanically altered diet, pain or difficulty in swallowing and supervision and setup with eating activities. R5's care plan, last revised 4/21/15 indicated R5's diet was mechanical soft with nectar thickened liquids. R5's nutritional care area assessment (CAA), dated 2/10/15 identified a history of chewing and swallowing problems and a need for a mechanically altered diet with nectar thickened liquids. During observation on 05/18/15, at 5:34 p.m. R5 was noted to be at the dining room being assisted to eat ice cream by family (F)-A. F-A stated R5 had been in the hospital over the weekend with aspiration pneumonia and was now on pureed foods with nectar thickened fluids. No coughing was noted during the observation of the meal. During observation on 5/18/15, at 6:30 p.m. R5 was seated in his wheelchair being fed ice cream	F 514		

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F 514	Continued From page 35 by F-A. At 6:40 p.m. no coughing was observed while eating the ice cream, however after F-A left the room R5 began coughing. During interview on 5/18/15, at 7:49 p.m. the DON stated R5 and his family had been educated on the risk and benefits of failing to comply with his therapeutic diet. The DON indicated the ice cream R5 was eating would not be approved for someone on nectar thickened fluids, and that there had been an " Ongoing battle, " between the facility and family members related to feeding R5 foods that were not approved based on his current diet orders. The DON indicated the facility had a signed waiver for R5 for failure to comply with the therapeutic diet and she would provide the documentation. During further interview on 5/19/15, at 8:58 a.m., the DON indicated that R5 had been educated on the risks and benefits of taking in food and fluids not approved on his diet and she had " Lots of documentation," on it that could be provided. Review of R5's medical record at this time lacked evidence of risk/benefit discussions with the resident or family. On 5/19/15, at 2:42 p.m. the DON provided copies of R5's progress notes which included new entries for the dates of 5/1/15, 4/21/15, 4/3/15 and 12/3/15 indicating the DON had discussed noncompliance with R5's family related to failing to follow the therapeutic diet and potential for aspiration pneumonia. The time stamp on the electronic medical record indicated the entries were placed into R5's medical record on or after 9:36 a.m. on 5/19/15. During interview, the DON stated the information had been in a "Soft file," in her office which was not	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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F 514	Continued From page 36 part of R5's medical record and she had entered the notes into R5's chart to make them " Easier to find. " The DON indicated the entries should have been placed into the medical record at the time of the events and agreed the information should be in R5's permanent medical record. The DON did not state what her expectation would be related to the time frame for late entries to be placed into the chart. On 5/21/15 at 10:30 a.m. the policy for late entries of progress notes into the medical record was requested, the DON stated the facility did not have a policy regarding this.	F 514		

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

F5436024

PRINTED: 06/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on May 21, 2015. At the time of this survey, Parkview Care Center Wells Inc. was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	POC ok 6-25-15 AW K67 RECEIVED JUN 19 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 5-21-15 DC: 6-30-15

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

Robert Thompson | Administrator | 17 June 2015

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

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	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER WELLS INC	**55 TENTH STREET SOUTHEAST** **WELLS, MN 56097**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Parkview Care Center Wells Inc. is a 1-story building. The original building was constructed in 1961 and was determined to be of Type II (222) construction. In 1967, an addition was constructed and determined to be of Type II(222) construction, with a partial basement. In 1999, an addition was constructed and was determined to be of Type II(000) construction. The building will be surveyed as one building Type II (000). The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 50 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain one or more corridor doors in the means of egress, in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.6.3. In a fire emergency, this deficient practice could adversely affect 23 of 46	K 018	**It is our intent to comply with Regulations NFPA 101 Life Safety Code Standard.** **K018 –** Maintenance Supervisor adjusted the kitchen door auto closure on May 21. The door now closes and latches consistently. Maintenance Supervisor or assigned personnel will perform a random audit of facility doors monthly and report to Maintenance Supervisor and QA committee to ensure doors are closing and latching properly. Maintenance Supervisor or other assigned personnel will audit weekly for one quarter and monthly thereafter reporting to the QA committee and the Administrator. Corrective Action will be complete by 29 June 2015.	

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K 018	Continued From page 3 residents. FINDINGS INCLUDE: On 05/21/2015 at 11:55 AM, observation revealed the door from the Kitchen to the Dining Room did not positively latch into its frame, as the self-closing device was not functioning properly. This finding was verified with the chief building engineer (SR)at the time of discovery.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by	K 021	**K021 -** Maintenance Supervisor adjusted the door in lower level auto closure on May 21. The door now closes and latches consistently. Maintenance Supervisor or assigned personnel will perform a random audit of facility doors monthly and report to Maintenance Supervisor and QA committee to ensure doors are closing and latching properly. Maintenance Supervisor or other assigned personnel will audit weekly for one quarter and monthly thereafter reporting to the QA committee and the Administrator. Corrective Action will be complete by 29 June 2015.	

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K 021	Continued From page 4 devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Finding include: On facility tour between 9:30 AM and 12:30 PM on 5/21/2015, observation revealed, that the door from the lower level to the stairwell did not positively latch as the self clsing device was not operational. This deficient practice was confirmed by the facility Maintenance Supervisor (SR) at the time of discovery.	K 021		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050		

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K 050	Continued From page 5 This STANDARD is not met as evidenced by: Based upon a review of available reports and records, it was determined the facility had failed to conduct one or more fire drills on a quarterly basis for each shift, in accordance with NFPA 101 (2000) Chapter 19, Section 19.7.1.2.. In a fire emergency, this deficient practice could adversely affect the safety of 20 of 20 patients, staff and visitors throughout the facility. FINDINGS INCLUDE: On 5/21/15 between 9:00 AM and 12:30 PM, observation revealed: A review of the facility's fire drill reports was conducted with the Chief Building Engineer [SR]. A review of available documentation confirmed that required fire drills were not conducted on the Day-shift [07:00 hours to 15:00 hours] during the 4th Quarter 2014 and on the Evening-shift [15:00 hours to 23:00 hours] during the 2nd quarter 2014. This deficient practice was confirmed with the Buidling Mainteneance Supervisor (SR) at the time of discovery.	K 050	**K050 -** Review by Administrator and Maintenance Supervisor found the fire drills for 2014 were out of order; a drill had in fact been complete for the day shift in the fourth quarter, however the evening fire drill in the second quarter was missed. Following recommendation by the Fire Marshall to limit Fire Drill entries to one Life Safety Code Book will reduce/eliminate this from happening in the future. The Life Safety Code Book entries will be reviewed by the QA committee quarterly to ensure compliance in this area. Corrective Action for this will be complete 29 June 2015.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	**K067 –** Apply for Annual Waiver	

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K 067	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations and documentation review, the facility's general ventilating and air conditioning system (HVAC) in the 1960's buildings is not installed in accordance with the 2000 NFPA 101 LSC, Section 19.5.2.1 and 1999 NFPA 90A, Sections 2-3.11 and 3-4.7. A noncompliant HVAC system could affect all 45 residents. Findings include: On facility tour between 9:00 AM and 11:00 AM on 05/21/2015, observation revealed, that the corridors in the 1961 and 1967 buildings are being utilized as the supply air plenum for the resident rooms. Annual waiver as been approved in previous year. This deficient practice was confirmed by the Facility Maintenance Director (SR) at the time of discovery.	K 067		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not maintained in accordance with 2000 NFPA 101 - 9.2.3 and 1998 NFPA 96 section 8.2. This deficient practice could affect all 25 residents.	K 069		

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K 069	Continued From page 7 Findings include: On facility tour between 9:30 AM and 12:30 PM on 05/21/2015, the review of the kitchen hood system inspection documentation for the past 12 months revealed that the kitchen hood was not inspected every 6 months. The last documented inspection was on 10/14/2014. This deficient practice was confirmed by the Administrator (SR) at the time of discovery.	K 069	**K069 –** Maintenance Supervisor will schedule a required inspection for the kitchen hood system by 29 June 2015. This Inspection detail will be communicated with Dietary Manager and QA committee for its importance to our compliance with this regulation and safety of our facility; will be placed on a calendar of the Dietary Manager and Maintenance Supervisor every six months to ensure the inspection is complete and reported to the QA committee upon completion. Completion will be documented in Life Safety Code Book and reported to the QA committee and/or Administrator. Compliance will be achieved by 29 June 2015.	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K67 HVAC Equipment shall comply with Sec 9.2 and NFPA 90A.	A waiver is requested for K 67 for the following reasons: A. There will be no adverse effect on the health and safety of the facilities residents and staff since: a. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13. b. The facility is smoke free and signs to that effect are prominently posted at all major entrances. c. Annual service and maintenance contracts exist to service all the facilities fire protection systems (i.e. fire alarm, sprinkler system, and portable fire extinguishers.) d. The building fire alarm system is monitored to provide automatic fire department notification. e. The HVAC system automatically shuts down when the fire alarm is activated. f. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. g. Fire drills are conducted monthly on all shifts. B. Compliance with this provision would impose an unreasonable hardship on the facility since: a. Bid obtained from the Schwickert Company to fabricate and install the new supply and return ductwork through corridors is quoted at $119,438.00. This bid does not include removal, moving or re-installation of ceiling grid, electrical wiring, control wiring, plumbing piping, control wiring with suppression system, permits, signed drawings, or state plan review costs. b. There is concern about whether the building electrical system is adequate to handle the additional HVAC equipment required. c. The building is in compliance with all other fire safety requirements. d. LSC(OO), Sec 9.2.1 gives the A.HJ authority to allow existing HVAC systems that do not comply it NFPA 90A to be continued in service.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

SCHWICKERT'S®
TECTA AMERICA

February 19, 2013

Park View Care Center
55 10th St SE
Wells MN 56097

Attn: Tim Orbell

Re: Resident Room Ventilation Budgets 2013

Dear Tim:

Per your request Schwickert's is resubmitting our budget proposal for Resident Room Ventilation. Budget numbers are based upon current material and labor pricing.

I have reviewed the sizes of the resident rooms and the ventilation requirements for Nursing Facilities. We would need to supply each room with 70 cubic feet per minute of outside air and balance exhaust to the same. This would give you the two air changes per hour in each room and more than the ten air changes in the bathroom. The corridors also have a requirement of four air changes per hour. This modification would cause the corridors to be under aired. I have come up with the following budgets.

1. Install new supply duct on the roof and duct in a diffuser into each resident room. The budget for this would be $51,188.00.
2. Install two new makeup air handlers to meet increased ventilation in corridors. The budget for this would be $68,250.00.

These budgets do not include permits, signed drawings or state plan review costs.

Sincerely,

Dan Shortall

Project Manager/Estimator

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	00784	A. BUILDING: _____ B. WING _____	05/21/2015

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2 000	Initial Comments ******ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 18, 19, 20 and 21, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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(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) COMPLETE DATE
2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 145	MN Rule 4658.0050 Subp. 3.B Licensee;Appointment of Administrator Subp. 3. Responsibilities. A licensee is responsible for: Appointment of a licensed nursing home administrator who is responsible for the operation of the home in accordance with law and established policies and whose authority to serve as administrator is delegated in writing.	2 145		

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	00784	A. BUILDING: _____ B. WING _____	05/21/2015

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2 145	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure appropriate resources were available for maintaining monthly pharmacy services as part of the operation of the facility. This had the potential to affect all 44 residents in the facility. Findings include: Refer to F428: Based on interview and document review, the facility failed to assure the consulting pharmacist monitored resident medication regimens monthly for unnecessary medications. This deficient practice had the potential to affect all 44 residents currently residing in the facility. During an interview on 5/19/15, at 3:35 p.m. the assistant director of nursing (ADON) verified the consultant pharmacist is supposed to visit the facility on a monthly basis and is supposed to review all resident records. The ADON further verified the pharmacist had not conducted reviews in January or April 2015 and stated she did not know whether if he would come in May 2015. On 5/19/15, at 4:15 p.m. the director of nursing (DON) confirmed the consultant pharmacist had not reviewed records in the facility for the month of January 2015, April 2015 and so far not for the month of May 2015. The DON further stated she did not know if he would come in May 2015. The DON further stated the consultant pharmacist had not attended the most recent QA&A meeting. During a telephone interview conducted on	2 145		

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2 145	Continued From page 3 5/20/15, at 10:20 a.m. with the consultant pharmacist it was verified he had not been in the facility to perform a medication review for January 2015 or April 2015 related to non-payment. During interview on 5/21/15, at 8:58 a.m. the DON stated she was aware the pharmacist had not been to the facility in April due to non-payment of the bill and had forwarded this information to the administrator via email. The facility Pharmaceutical Consulting Contract, dated 2/4/11 indicated the consultant shall perform a monthly drug regimen review of each resident's pharmaceutical care plan and personal record for the purpose of identifying drug problems, potential drug problems and irregularities related to drug therapy. SUGGESTED METHOD OF CORRECTION: The governing body will ensure the administrator has allocated the appropriate funds to fulfill the consulting pharmacist contract and so that monthly pharmacy reviews are conducted without interruption. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 145		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		

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2 565	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and fluids were served at the prescribed texture and consistency according to the care plan for 1 of 4 residents (R5) receiving thickened liquids. Findings include: R5's current diagnoses according to the physician's orders, dated 5/21/14, included dysphagia (difficulty swallowing) and cough. R5's most current speech therapy evaluation, dated 1/6/15 revealed delay in swallowing and risk for aspiration. The evaluation also identified and a need for thickened fluids at nectar consistency. A physician visit note, dated 5/16/15, included a diagnosis of aspiration pneumonia and an order for a speech evaluation. R5's physician's orders, dated 5/21/15, contained orders for nectar thickened liquids. R5's quarterly minimum data set (MDS), dated 4/21/15 identified a mechanically altered diet, pain or difficulty in swallowing and supervision and setup with eating activities. R5's care plan, last revised 4/21/15 indicated R5's diet was mechanical soft with nectar thickened liquids. R5's nutritional care area assessment (CAA), dated 2/10/15 identified a history of chewing and swallowing problems and a need for a mechanically altered diet with nectar thickened	2 565		

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2 565	Continued From page 5 liquids. During interview on 5/19/15, at 11:54 a.m. Family-A stated she had expressed concerns with facility management including the administrator related to staff not thickening R5's fluids to the appropriate consistency and that communication between facility departments was poor, no one knew what was going on with R5's foods. During observation on 5/19/15, at 12:15 p.m. revealed R5 was served coffee, water and tomato juice for his liquids at lunch. The coffee was thin and not nectar consistency and the water was thin with sediment on the bottom of the glass. Interview with the DON at this time confirmed that the water had not been mixed thoroughly and that the coffee had not been thickened. The DON took it back to the kitchen staff to thicken the coffee and to stir up the water to nectar consistency. During the observation R5 was taking sips of the coffee when the surveyor identified the thin liquid. R5 did not cough or choke when taking the sips. During observation on 5/20/15, at 8:33 a.m. R5 was seated at the breakfast table and his coffee had not been thickened. The dietary manager (DM) confirmed the coffee had not been thickened and took it back to the kitchen to thicken to the proper consistency. During interview on 5/20/15, at 11:41 a.m. Cook-B indicated all R5's foods needed to be pureed and fluids thickened to nectar consistency. R5's tray card was reviewed and indicated all his fluids needed to be nectar thick. During interview on 5/19/15, at 1:52 p.m. dietary aide (DA)-A stated R5 should be on nectar thickened liquids and that coffee took longer to	2 565		

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2 565	Continued From page 6 set up, it needed to "Set a while," before being brought to the resident. During interview on 5/20/15, at 8:10 a.m. Family-B indicated there had been ongoing concerns with the facility thickening R5's fluids too thick, " Like a blizzard consistency." and stated he had become angry and had to show staff how to properly thicken the fluids. The facility policy, entitled Thickened Liquids, dated 11/14, indicated if an order is received from the doctor for thickened liquids these are prepared in accordance to package directions per doctor order. If resident is not tolerating these or there are indications that this will not be beneficial a swallow evaluation is requested. SLP recommendations will be followed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility	2 570		

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2 570	Continued From page 7 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to revise the care plan related to a change in urinary continence for 1 of 1 (R10) resident reviewed for urinary incontinence. Findings include: R10, admitted on 1/2/15, had diagnoses which included congestive heart failure (CHF), mantle cell lymphoma, history of urinary tract infection and diabetes mellitus type II. The current physician orders indicated that R10 receives Lasix 20 milligrams daily (water pill) for CHF. Review of the Minimum Data Set (MDS) assessments related to bladder status indicated that R10 had no episodes of bladder incontinence for the 5 day assessment completed on 1/9/15, the 14 day assessment completed on 1/15/15 and the 30 day assessment completed on 2/1/15. The assessment completed on 3/5/15, indicated R10 had occasional episodes (less than 7 episodes of incontinence) of bladder incontinence in the assessment period. The care plan dated 1/22/15, for R10 indicated staff would assist with toileting but did not include any interventions related to the change in urinary	2 570		

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2 570	Continued From page 8 status, occasional incontinence. When the electronic urinary history charting completed by the nursing assistants was reviewed, it was noted that R10 had experienced occasional episodes of urinary incontinence since February 2015 (past 3 months). Review of this documentation indicated that urinary incontinence occurred typically mid-morning. No revision to the care plan was noted. During interview and observation on 5/21/15, at 8:00 a.m. R10 indicated she required staff assistance to go to the bathroom due to a history of falling but denied urinary incontinence stating, "I have trouble with my bowels". It was then noted that R10 used the call light to summon staff to the room and requested assistance to ambulate into the bathroom. When interviewed on 5/20/15, at 12:38 p.m. the assistant director of nursing (ADON) verified the care plan had not been revised to include urinary incontinence. She further reported the care plan should be updated as necessary when changes were noted and reported by the nursing assistants. When interviewed on 5/21/15, at 7:51 a.m. registered nurse (RN)-D verified that R10 had a change in bladder continence and the plan of care should have been revised to include interventions which address the episodes of incontinence and promote continence. SUGGESTED METHOD OF CORRECTION: The DON or designee could review any policies, procedures or facility processes for resident care plan development for urinary incontience. Appropriate staff could be educated regarding any changes. The DON or designee could develop a system to monitor the care plan to	2 570		

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2 570	Continued From page 9 ensure revisions are completed timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 570		
2 610	MN Rule 4658.0445 Subp. 2 Clinical Record; Form entres & authentication Subp. 2. Form of entries and authentication. Data collected must be timely, accurate, and complete. All entries must be entered, authenticated, and dated by the person making the entry. If a nursing home uses an electronic paperless means of storing the clinical record, the nursing home must comply with part 4658.0475. All entries must be made as soon as possible after the observation or treatment in order to keep the clinical record current. In cases where authentication is done electronically or by rubber stamp, safeguards to prevent unauthorized use must be in place, and a rubber stamp may be used only if allowed by the licensing rules for that health care professional. Nursing assistants may document in the nursing notes if allowed by nursing home policy. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical record contained timely documentation related to family and resident education regarding therapeutic diet orders for 1 of 1 resident (R5) in the sample who received thickened fluids. Findings include: R5's current diagnoses according to the	2 610		

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2 610	Continued From page 10 physician's orders, dated 5/21/14, included dysphagia (difficulty swallowing) and cough. A physician visit note, dated 5/16/15 included a diagnosis of aspiration pneumonia and an order for a speech evaluation. R5's physician's orders, dated 5/21/15, contained orders for nectar thickened liquids. R5's quarterly minimum data set (MDS), dated 4/21/15 identified a mechanically altered diet, pain or difficulty in swallowing and supervision and setup with eating activities. R5's care plan, last revised 4/21/15 indicated R5's diet was mechanical soft with nectar thickened liquids. R5's nutritional care area assessment (CAA), dated 2/10/15 identified a history of chewing and swallowing problems and a need for a mechanically altered diet with nectar thickened liquids. During observation on 05/18/15, at 5:34 p.m. R5 was noted to be at the dining room being assisted to eat ice cream by family (F)-A. F-A stated R5 had been in the hospital over the weekend with aspiration pneumonia and was now on pureed foods with nectar thickened fluids. No coughing was noted during the observation of the meal. During observation on 5/18/15, at 6:30 p.m. R5 was seated in his wheelchair being fed ice cream by F-A. At 6:40 p.m. no coughing was observed while eating the ice cream, however after F-A left the room R5 began coughing. During interview on 5/18/15, at 7:49 p.m. the	2 610		

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2 610	Continued From page 11 DON stated R5 and his family had been educated on the risk and benefits of failing to comply with his therapeutic diet. The DON indicated the ice cream R5 was eating would not be approved for someone on nectar thickened fluids, and that there had been an " Ongoing battle, " between the facility and family members related to feeding R5 foods that were not approved based on his current diet orders. The DON indicated the facility had a signed waiver for R5 for failure to comply with the therapeutic diet and she would provide the documentation. During further interview on 5/19/15, at 8:58 a.m., the DON indicated that R5 had been educated on the risks and benefits of taking in food and fluids not approved on his diet and she had " Lots of documentation," on it that could be provided. Review of R5's medical record at this time lacked evidence of risk/benefit discussions with the resident or family. On 5/19/15, at 2:42 p.m. the DON provided copies of R5's progress notes which included new entries for the dates of 5/1/15, 4/21/15, 4/3/15 and 12/3/15 indicating the DON had discussed noncompliance with R5's family related to failing to follow the therapeutic diet and potential for aspiration pneumonia. The time stamp on the electronic medical record indicated the entries were placed into R5's medical record on or after 9:36 a.m. on 5/19/15. During interview, the DON stated the information had been in a "Soft file," in her office which was not part of R5's medical record and she had entered the notes into R5's chart to make them " Easier to find. " The DON indicated the entries should have been placed into the medical record at the time of the events and agreed the information should be in R5's permanent medical record.	2 610		

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2 610	Continued From page 12 The DON did not state what her expectation would be related to the time frame for late entries to be placed into the chart. On 5/21/15 at 10:30 a.m. the policy for late entries of progress notes into the medical record was requested, the DON stated the facility did not have a policy regarding this. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the medical record contained timely documentation related to resident and family education. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 610		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		

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2 830	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and fluids were served at the prescribed texture and consistency, failed to ensure family were educated on appropriate feeding techniques and failed to ensure the risks and benefits of noncompliance with a therapeutic diet were discussed with the resident and family for 1 of 4 residents (R5) receiving thickened liquids. Findings include: R5's current diagnoses according to the physician's orders, dated 5/21/14, included dysphagia (difficulty swallowing) and cough. R5's most current speech therapy evaluation, dated 1/6/15 revealed delay in swallowing and risk for aspiration. The evaluation also identified and a need for thickened fluids at nectar consistency. A physician visit note, dated 5/16/15, included a diagnosis of aspiration pneumonia and an order for a speech evaluation. R5's physician's orders, dated 5/21/15, contained orders for nectar thickened liquids. R5's quarterly minimum data set (MDS), dated 4/21/15 identified a mechanically altered diet, pain or difficulty in swallowing and supervision and setup with eating activities. R5's care plan, last revised 4/21/15 indicated R5's diet was mechanical soft with nectar	2 830		

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2 830	Continued From page 14 thickened liquids. R5's nutritional care area assessment (CAA), dated 2/10/15 identified a history of chewing and swallowing problems and a need for a mechanically altered diet with nectar thickened liquids. R5's nursing progress notes revealed entries related to the following: 12/19/14 - Speech therapy recommended thickened liquids d/t (due to aspiration). 1/27/15 - Care conference held for resident with family complaints of too much thickener in R5's water. 3/4/15 - Resident with blood sugar of 66 (low) 3/30/15 - Low blood sugars, insulin held until after supper. 4/21/15 - Care conference held with family reporting concerns about fluid consistency not being prepared by the facility as ordered. 4/30/15 - Ate blueberry double crust pie brought in by daughter. 5/11/15 - Dietician review due to family concerns with food items and fluid consistencies - recommended speech evaluate fluid texture and have family sign a waiver if family makes other consistencies. 5/15/15 - Staff alerted by family member that R5 was gagging and coughing on his coffee. 5/16/15 - Coughing on AM medications and sent to emergency room for evaluation. Returned with aspiration pneumonia and orders for oral antibiotics. During observation on 05/18/15, at 5:34 p.m., R5 was noted to be at the dining room being assisted to eat ice cream by family member (FM)-A. FM-A stated R5 had been in the hospital over the	2 830		

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PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

(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) COMPLETE DATE
2 830	Continued From page 15 weekend with aspiration pneumonia and was now on pureed foods with nectar thickened fluids. No coughing was noted during the observation of the meal. Four other nursing assistants (unidentified) were seated in the dining room during the observation. During interview on 5/18/15, at 5:30 p.m., the assistant director of nursing (ADON) and registered nurse (RN)-A stated R5 ' s family had been trained on how to feed him. Training materials for family were requested and the ADON indicated she would get them from the director of nursing (DON). During observation on 5/18/15, at 6:30 p.m. R5 was seated in his wheelchair being fed ice cream by FM-A. At 6:40 p.m. No coughing was observed while eating the ice cream, however after FM-A left the room R5 began coughing. During interview on 5/18/15, at 6:30 p.m. the DON stated R5's family had not been trained to assist with feeding and nursing staff should have intervened to stop family from continuing to feed R5. The DON further indicated she would have speech therapy educate family the following day and that prior to this evening R5 had been feeding himself independently. During interview on 5/18/15, at 7:49 p.m. the DON stated R5 and his family had been educated on the risk and benefits of failing to comply with his therapeutic diet. The DON indicated that the ice cream R5 was eating would not be approved for someone on nectar thickened fluids, and that there had been an " Ongoing battle, " between the facility and family members related to feeding R5 foods that were not approved based on his current diet orders. The DON indicated the	2 830		

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2 830	Continued From page 16 facility had a signed waiver for R5 for failure to comply with the therapeutic diet and she would provide the documentation. The DON further indicated the dietary manager (DM) had this information. During interview on 5/19/15, at 8:47 a.m., the DM indicated she thought family had been educated on the risks and benefits of feeding R5 food and fluids not of the correct consistency and that family had a history of noncompliance with diet textures. The DM was unable to provide any documentation related to education of family or the resident at this time. During further interview on 5/19/15, at 8:58 a.m., the DON indicated that R5 had been educated on the risks and benefits of taking in food and fluids not approved on his diet and she had "Lots of documentation," on it that could be provided. Review of R5's medical record at this time lacked evidence of family teaching or training related to food and fluid consistencies that were appropriate for R5. On 5/19/15, at 2:42 p.m. the DON provided copies of R5's progress notes which included new entries for the dates of 5/1/15, 4/21/15, 4/3/15 and 12/3/15 indicating the DON had discussed noncompliance with R5's family related to failing to follow the therapeutic diet and potential for aspiration pneumonia. The time stamp on the electronic medical record indicated the entries were placed into R5's medical record on or after 9:36 a.m. on 5/19/15. During interview, the DON stated the information had been in a "Soft file," in her office and she had entered the notes into R5's chart to make them "Easier to find. " The DON indicated the entries should have been placed into the medical record	2 830		

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2 830	Continued From page 17 at the time of the events. During interview on 5/19/15, at 11:54 a.m. FM-A stated family had never had a discussion on the risks and benefits of giving regular texture foods or thin liquids to R5. FM-A stated she had brought in sweets to help R5's blood sugar stay up throughout the night because he was diabetic and not eating as well, and indicated nursing had agreed with this practice. FM-A further stated she had expressed concerns with facility management related to staff not thickening R5's fluids to the appropriate consistency and that communication between facility departments was poor, no one knew what was going on with R5's foods. During observation on 05/19/15, at 12:15 p.m. revealed R5 was served coffee, water and tomato juice for his liquids at lunch. The coffee was thin and not nectar consistency and the water was thin with sediment on the bottom of the glass. Interview with the DON at this time confirmed the water had not been mixed thoroughly and the coffee had not been thickened. The DON took it back to the kitchen staff to thicken the coffee and to stir the water to a nectar consistency. During the observation R5 was taking sips of the coffee when the surveyor identified the thin liquid. R5 did not cough or choke when taking the sips. During observation on 5/20/15, at 8:33 a.m. R5 was seated at the breakfast table and his coffee had not been thickened. The dietary manager (DM) confirmed the coffee had not been thickened and took it back to the kitchen to thicken to the proper consistency. The DM further stated staff had thought family requested the coffee not to be thickened, however, if family wanted any changes to the fluid consistency a	2 830		

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2 830	Continued From page 18 waiver needed to be signed. During interview on 5/20/15, at 11:41 a.m. Cook (C)-B indicated all R5's foods needed to be pureed and fluids thickened to nectar consistency. R5's tray card was reviewed and indicated all his fluids needed to be nectar thick. During interview on 5/20/15, at 12:24 p.m. R5 stated his food was "Good," but was unable to be interviewed further regarding his preferences related to food and fluid texture changes. R5 was able to feed himself independently. During interview on 5/19/15, at 1:52 p.m. dietary aide (DA)-A stated R5 should be on nectar thickened liquids and that coffee took longer to set up, it needed to "Set a while," before being brought to the resident. During interview on 5/20/15, at 8:10 a.m. FM-B indicated the first education they had received related to risk of aspiration pneumonia with diet noncompliance was provided by the emergency room physician on 5/16/15 when R5 was sent to the hospital for evaluation and returned with aspiration pneumonia. FM-B further stated there had been ongoing concerns with the facility thickening R5's fluids too thick, "Like a blizzard consistency," and stated he had become angry and had to show staff how to properly thicken the fluids. FM-B indicated no one from facility ever talked with the spouse about food or fluids R5 should not have served or they would have "Stopped bringing them in if he wasn't supposed to have them." The facility policy, entitled Residents Requiring Assistance with Feeding - Feeding of Residents by Family Members, last revised 4/10, indicated	2 830		

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2 830	Continued From page 19 the director of nursing was responsible for training family members who desired to feed their family members. The policy further stated the resident should be assessed by a nurse and a determination made that the resident may be safely fed by a family member. The facility policy, entitled Non-Compliance with Therapeutic Diet, undated, indicated when residents request foods not allowed on their therapeutic or mechanically altered diets, or refuse those foods offered on prescribed diets, the food service manager developed an alternate plan to meet the needs of the resident. The policy further stated that the resident or responsible party may be asked to sign a release indicating refusal to follow the prescribed diet. If the release is utilized, it is updated annually. The facility policy, entitled Thickened Liquids, dated 11/14, indicated if an order is received from the doctor for thickened liquids these are prepared in accordance to package directions per doctor order. If resident is not tolerating these or there are indications that this will not be beneficial a swallow evaluation is requested. SLP recommendations will be followed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care and services are provided to ensure appropriate care of residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess a change in urinary continence so that an individualized plan could be developed for 1 of 3 residents (R10) reviewed for urinary incontinence. Findings include: R10, admitted on 1/2/15, had diagnoses which included congestive heart failure (CHF), mantle cell lymphoma, history of urinary tract infection and diabetes mellitus type II. The current physician orders indicated that R10 receives Lasix 20 milligrams daily (water pill) for CHF. Review of the Minimum Data Set (MDS) assessments related to bladder status indicated	2 910		

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2 910	Continued From page 21 R10 had no episodes of bladder incontinence for the 5 day assessment completed on 1/9/15, the 14 day assessment completed on 1/15/15 and the 30 day assessment completed on 2/1/15. The assessment completed on 3/5/15, indicated R10 had occasional episodes (less than 7 episodes of incontinence) of bladder incontinence during the assessment period. The nursing care plan for R10 indicated staff would assist with toileting but did not include interventions related to occasional incontinence. When the electronic urinary history charting completed by the nursing assistants was reviewed, it was noted that R10 had experienced occasional episodes of urinary incontinence since February 2015 (past 3 months). Reivew of this documentation indicated that urinary incontinence occurred typically mid- morning. Documentation was lacking to indicate whether times of incontinence had any correlation with the use of the Lasix (water pill) and/or whether a scheduling toileting plan would be helpful to maintain urinary continence. During interview and observation on 5/21/15, at 8:00 a.m. R10 indicated she required staff assistance to go to the bathroom due to a history of falling but denied urinary incontinence stating, "I have trouble with my bowels". It was then noted that R10 used the call light to summon staff to the room and requested assistance to ambulate into the bathroom. When interviewed on 5/20/15, at 12:38 p.m. the assistant director of nursing (ADON) verified that R10 had experienced episodes of urinary incontinence during the assessment period dated 3/5/15. The ADON indicated a bladder reassessment was completed at that time and a	2 910		

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2 910	Continued From page 22 plan had been developed to improve and maintain urinary continence. However, the ADON further verified the careplan did not address the urinary incontinence. She further reported the care plan should be updated as necessary when changes were noted and reported by the nursing assistants. The ADON further indicated that R10 had cognition changes that varied throughout the day. When interviewed on 5/21/15, at 7:51 a.m. registered nurse (RN)-D reported the ADON completes the urinary assessments with input from the nursing staff and that information is used to complete the MDS. RN-D verified that R10 had a change in bladder continence and the plan of care should have been updated to include interventions which address the episodes of incontinence to promote continence and it had not been revised. The facility failed to assess the change in bladder continence so that an individualized toileting plan could be developed to maintain and/or improve bladder continence. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents who needed assistnace with toileting, to assure they are receiving the necessary treatment/services to prevent potential decline in toileting. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

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21390	Continued From page 23	21390		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to properly disinfect the multi-use glucometer (blood sugar meter) according to facility policy for 3 of 4 residents (R2, R24 and R33) observed during glucose monitoring of which had the potential to affect 13	21390		

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21390	Continued From page 24 of 13 residents (R2, R5,R10, R13, R22, R24, R25, R27, R33, R37, R41, R55) who utilized a glucometer; and failed to properly disinfect the glucometer storage tray after it had been placed on the residents bed during the glucose check and then placed in the medication storage cart. Findings include: R2's current physician orders dated 5/20/15, indicated a diagnosis of diabetes type II. The physician's orders also indicated R2 was to receive blood sugar checks four times a day. During observation on 5/20/15, at 7:30 a.m. licensed practical nurse (LPN)-B utilized a mutli-use glucometer to check R2's blood sugar. LPN-B placed the glucometer storage tray on top of the residents bed. After LPN-B obtained the residents blood sugar results, she proceeded to clean the top and bottom of the glucometer with a alcohol swab with 1 swipe and placed it back into the storage tray. LPN-B then placed the glucometer storage tray in the facility medication cart next to other resident supplies without further sanitization. R24's current physician orders sheets dated 5/20/15, identified a diagnosis of diabetes type II. The physicians orders also indicated R24 was to receive blood sugar checks every morning. During observation on 5/20/15, at 7:30 a.m., LPN-B used a multi-use glucometer to check R24's blood sugar. LPN-B placed the glucometer storage tray on top of the residents bed. After LPN-B obtained the residents blood sugar results, she proceeded to clean the top and bottom of the glucometer with a alcohol swab with 1 swipe and placed it back into the storage tray. LPN-B then	21390		

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21390	Continued From page 25 placed the glucometer storage tray in the facility medication cart next to other resident supplies without further sanitization. R33's current physician orders sheets dated 5/20/15, identified a diagnosis of diabetes type II. The physicians orders also indicated R33 was to receive blood sugar checks every morning. During observation on 5/20/15, at 7:30 a.m. LPN-B used a multi-use glucometer to check R33's blood sugar. LPN-B placed the glucometer storage tray on top of the residents bed. After LPN-B obtained the residents blood sugar results she proceeded to clean the top and bottom of the glucometer with a alcohol swab with 1 swipe and placed it back into the storage tray. LPN-B then placed the glucometer storage tray in the facility medication cart next to other resident supplies without sanitizing. When interviewed on 5/20/15, at 8:00 a.m. about the proper cleaning of the multi-use glucometer between residents, LPN-B indicated it was the facility policy to clean the glucometer after resident use with an alcohol swab. LPN-B further indicated she has always cleaned the glucometer meters with an alcohol swab between residents. During interview on 5/20/15, at 9:00 a.m. the director of nursing (DON) indicated LPN-B should have followed the facility policy when cleaning the glucometer and the glucometer storage container before placing it back into the medication cart. The facility undated policy, titled Disinfection of Blood Glucose Monitors, directed after using the glucometer staff were to thoroughly cleanse with a PDI sani-wipe (chemical sanitizer) and to wipe down all surfaces of the glucometer with the wipe	21390		

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21390	Continued From page 26 and to provide contact time per chemical recommendations and to allow to air dry before next use. The facility undated policy, entitled Disinfecting Equipment Shared between Residents, directed staff to disinfect all equipment shared between resident's with the use of a PDI-sanicloth wipe and to allow the equipment to air drive. When the manufacturer's recommendations were requested, it did not not reference the proper cleaning required when used for multi-use purposes. The ASCP's (American Society for Clinical Pathology) Summary of Glucometer Cleaning Guidelines, dated February 2010, recommended the following: If the manufacturer does not provide specific cleaning recommendations or as a conservative approach to infection control for glucometers with minimal cleaning requirements, facilities may want to consider cleaning glucometers with high-level disinfectants. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff related to the standard of practice when cleaning the glucometer between resident use and then conduct periodic audits to ensure facility policy is implemented consistently. The results of the audit could be reported to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		

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21390	Continued From page 27 SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review/revise policies and procedures for infection control surveillance and data collection/analysis, then inservice staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained.	21525		

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21525	Continued From page 28 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assure the consulting pharmacist monitored resident medication regimens monthly, and the facility failed to ensure recommendations for the physician were acted upon or justification for no action documented for 4 of 5 residents (R14, R21, R29 and R38) reviewed for unnecessary medications. This deficient practice had the potential to affect all 44 residents currently residing in the facility. Findings include: Review of R38's current physician orders included an order for Celexa (antidepressant) 20 mg daily for treatment of depression (initiated 7/22/13). R38's care plan last revised 3/3/15, indicated R38 had a diagnosis of depression and that R38 used Celexa for treatment of depression. The care plan further indicated a dose reduction of R38's psychotropic medications should be reviewed at least every six months. R38's quarterly minimum data set (MDS) dated 3/3/15, identified a current Patient Health Questionnaire (PHQ-9) score of 0 (no depression). R38's mood and behavior monitoring assessment dated 5/17/15, entitled Parkview Behavioral Conditions, revealed no current symptoms of depression and indicated R38 was stable at this time.	21525		

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PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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21525	Continued From page 29 Review of a pharmacy recommendation dated 10/30/14, indicated a recommendation to the physician requesting review of whether the current Celexa dose was appropriate for baseline symptom management. The physician had responded on 10/31/14 to continue the current dose of the Celexa but did not document justification of the reasons for continued use. Interview with the DON on 5/20/15 at 10:00 am confirmed that there was no documented justification for continued use of the resident's Celexa. The DON also confirmed the resident had not exhibited any mood/behaviors in the past several months. In addition, review of the consultant pharmacist documentation revealed no January or April 2015 reviews had been conducted for R38. R14's admission record indicated R14 had been admitted to the facility on 10/23/13, with diagnoses including: anxiety state, hypertension, chronic stage III kidney disease, esophageal reflux, hyperlipidemia, depressive disorder, cognitive impairment-mild, and anemia-normocytic. Review of R14's signed physician orders dated May 2015, indicated orders for Ativan 0.5 milligrams (mg) by mouth (PO) two times daily (BID) for anxiety (an antianxiety medication initiated 12/13/14), Remeron (an antidepressant) 15 mg PO every bedtime (QHS) for depression (initiated 3/23/14), and Sertraline (an antidepressant) 50 mg QHS for depressive disorder (initiated 3/23/14). The consultant pharmacist's review dated 12/25/14, included a recommendation: "advise if	21525		

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21525	Continued From page 30	21525		

a slight reduction to Ativan 0.25 mg (0.5 mg) Q P.M. is appropriate at this time, with continuation of Remeron/Zoloft at current dose to facilitate reduction attempts." The corresponding physician's response dated 1/7/15 included, "Will continue as is" with no additional information documented to justify not following through with a gradual dose reduction.

There had been no pharmacy reviews conducted for January or April 2015.

Behavior monitoring for R14 for the months of January, February, March and April 2015 indicated no behaviors and/or no changes.

On 5/20/15, at 8:45 a.m. the DON verified there was no additional information regarding the recommended dose reduction for R14 documented in the resident's record.

During a telephone interview conducted on 5/20/15, at 10:20 a.m. with the consultant pharmacist it was verified that the physician response to the 12/25/14 recommendation for potential dosage reduction for R14 was not adequate and the physician had not readdressed the issue

During an interview on 5/19/15, at 3:35 p.m. the assistant director of nursing (ADON) verified the consultant pharmacist is supposed to visit the facility on a monthly basis and is supposed to review all resident records. The ADON further verified the pharmacist had not conducted reviews in January or April 2015 and stated she did not know whether if he would come in May 2015.

On 5/19/15, at 4:15 p.m. the director of nursing

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21525	Continued From page 31 (DON) confirmed the consultant pharmacist had not reviewed records in the facility for the month of January 2015, April 2015 and so far not for the month of May 2015. The DON further stated she did not know if he would come in May 2015. The DON further stated the consultant pharmacist had not attended the most recent QA&A meeting. During a telephone interview conducted on 5/20/15, at 10:20 a.m. with the consultant pharmacist it was verified he had not been in the facility to perform a medication review for January 2015 or April 2015 r/t non-payment. R29's current diagnoses according to the care plan dated 3/27/15, included depression, anxiety and agitation with slight psychosis. Review of R29's pharmacy consultant notes for the previous ten months revealed the last monthly visit was conducted on 3/26/15, and no visits were made for the months of 1/15 or 4/15. R21's current diagnoses according to the face sheet, dated 5/21/15, included coronary atherosclerosis, depression, osteoarthrosis and atrial fibrillation. Review of R21's pharmacy consultant notes for the previous ten months revealed the last monthly visit was conducted on 3/31/15, and no visits were made for the months of 1/15 or 4/15. During interview on 5/21/15, at 8:58 a.m. the DON stated the consultant pharmacist had conducted reviews at the end of 12/14 and thought this should "Cover both December and January." The DON further stated she was aware the pharmacist had not been to the facility in April due to non-payment of the bill and had forwarded this information to the administrator via email.	21525		

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21525	Continued From page 32 The facility Pharmaceutical Consulting Contract, dated 2/4/11 indicated the consultant shall perform a monthly drug regimen review of each resident's pharmaceutical care plan and personal record for the purpose of identifying drug problems, potential drug problems and irregularities related to drug therapy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the Consulting Pharmacist could establish a system to monitor medication expiration dates and ensure there is a policy to instruct nurses on documentation and adhering to the expiration dates. The DON could randomly audit the system and report audits to the quality assurance committee. TIME PERIOD OF CORRECTION: Fourteen (14) days.	21525		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State	21535		

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21535	Continued From page 33 Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to adequately assess clinical indications for use of psychoactive medications including antidepressants and antianxiety medications for 2 of 5 residents (R14, R38) whose medications were reviewed. Findings include: R14's admission record indicated R14 had been admitted to the facility on 10/23/13, with diagnoses including: anxiety state, hypertension, chronic stage III kidney disease, esophageal reflux, hyperlipidemia, depressive disorder, cognitive impairment-mild, and anemia-normocytic. Review of R14's signed physician orders dated May 2015, indicated orders for Ativan 0.5 milligrams (mg) by mouth (PO) two times daily (BID) for anxiety (an antianxiety medication initiated 12/13/14), Remeron (an antidepressant) 15 mg PO every bedtime (QHS) for depression (initiated 3/23/14), and Sertraline (an antidepressant) 50 mg QHS for depressive disorder (initiated 3/23/14). The consultant pharmacist's review dated	21535		

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21535	Continued From page 34 12/25/14, included a recommendation: "advise if a slight reduction to Ativan 0.25 mg (0.5 mg) Q P.M. is appropriate at this time, with continuation of Remeron/Zoloft at current dose to facilitate reduction attempts." The corresponding physician's response dated 1/7/15 included, "Will continue as is" with no additional information documented to justify not following through with a gradual dose reduction. Behavior monitoring for the months of January, February, March and April 2015 indicated no behaviors and/or no changes. On 5/20/15, at 8:45 a.m. the DON verified there was no additional information regarding the recommended dose reduction in the resident's record. During a telephone interview conducted on 5/20/15, at 10:20 a.m. with the consultant pharmacist it was verified that the physician response to the 12/25/14 recommendation for potential dosage reduction was not adequate and the physician had not readdressed the issue. Review of R38's current physician orders included an order for Celexa (antidepressant) 20 mg daily for treatment of depression (initiated 7/22/13). R38's care plan last revised 3/3/15, indicated R38 had a diagnosis of depression and that R38 used Celexa for treatment of. The care plan further indicated a dose reduction of R38's psychotropic medications should be reviewed at least every six months. R38's quarterly minimum data set (MDS) dated 3/3/15, identified a current Patient Health	21535		

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21535	Continued From page 35 Questionnaire (PHQ-9) score of 0 (no depression). R38's mood and behavior monitoring assessment dated 5/17/15, entitled Parkview Behavioral Conditions, revealed no current symptoms of depression and indicated R38 was stable at this time. Review of a pharmacy recommendation dated 10/30/14, indicated a recommendation to the physician requesting review of whether the current Celexa dose was appropriate for baseline symptom management. The physician had responded on 10/31/14 to continue the current dose of the Celexa but did not document justification of the reasons for continued use. Interview with the DON on 5/20/15 at 10:00 am confirmed that there was no documented justification for continued use of the resident's Celexa. The DON also confirmed the resident had not exhibited any mood/behaviors in the past several months. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure medications are adequately assessed for clinical indications of continued use for antidepressants and anti-anxiety medications and monitoring of psychoactive medications. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		