

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 93NN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00719

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245474 2.STATE VENDOR OR MEDICAID NO. (L2) 163843200	3. NAME AND ADDRESS OF FACILITY (L3) PARK VIEW CARE CENTER (L4) 200 PARK LANE (L5) BUFFALO, MN (L6) 55313	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 3. Termination 5. Validation 7. On-Site Visit 2. Recertification 4. CHOW 6. Complaint 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 03/01/2013 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds 124 (L18) 13.Total Certified Beds 124 (L17)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u>2. Technical Personnel</u> Compliance Based On: <u>3. 24 Hour RN</u> <u>1. Acceptable POC</u> <u>4. 7-Day RN (Rural SNF)</u> <u>5. Life Safety Code</u> <u>6. Scope of Services Limit</u> <u>7. Medical Director</u> <u>8. Patient Room Size</u> <u>9. Beds/Room</u> B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A (L12)	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID (L37) 124 (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): See Attached Remarks		
17. SURVEYOR SIGNATURE <u>Sarah Grebenc, Unit Supervisor</u>	Date : 03/19/2013 (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Nicole Steege, Program Specialist</u>
Date: 03/19/2013 (L20)		

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

19. DETERMINATION OF ELIGIBILITY <u>X</u> 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 05/01/1987 (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: <u>VOLUNTARY</u> 00 <u>INVOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active	
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 03001 (L31)	
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 03/06/2013 (L33)	
30. REMARKS DETERMINATION APPROVAL		

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 93NN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00719

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

Page 2

CCN: 24-5474

Item 16 Continuation for CMS-1539

At the time of the standard survey completed on January 10, 2013, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On March 1, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction, and on February 8, 2013 the Department of Public Safety completed a PCR and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on January 10, 2013, effective January 28, 2013. Therefore, the remedies outlined in our letter dated January 16, 2013 will not be imposed.

See attached CMS-2567B for the results of the March 1, 2013 and February 8, 2013 revisits.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5474

March 19, 2013

Ms. Ann Dirks, Administrator
Park View Care Center
200 Park Lane
Buffalo, Minnesota 55313

Dear Ms. Dirks:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 28, 2013 the above facility is recommended for:

124 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 124 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, which appears to read "Nicole Steege", is positioned below the word "Sincerely,".

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 19, 2013

Ms. Ann Dirks, Administrator
Park View Care Center
200 Park Lane
Buffalo, Minnesota 55313

RE: Project Number S5474023

Dear Ms. Dirks:

On January 16, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 10, 2013. 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 March 1, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction, and on February 8, 2013 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 January 10, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 28, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 10, 2013, effective January 28, 2013 and therefore remedies in our letter to you dated January 16, 2013, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, which appears to read "Sarah Grebenc", is positioned below the "Sincerely," text.

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245474	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/1/2013
Name of Facility PARK VIEW CARE CENTER		Street Address, City, State, Zip Code 200 PARK LANE BUFFALO, MN 55313

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 F0309 Reg. # 483.25 LSC	Correction Completed 01/28/2013	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	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By SG/NCS	Date: 3/19/13	Signature of Surveyor: 28589	Date: 3/1/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/10/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245474	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 2/8/2013
Name of Facility PARK VIEW CARE CENTER		Street Address, City, State, Zip Code 200 PARK LANE BUFFALO, MN 55313

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 _____ Reg. # NFPA 101 LSC K0029	Correction Completed 01/14/2013	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	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	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By PS/NCS	Date: 3/19/13	Signature of Surveyor: 27200	Date: 2/8/13
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/8/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 93NN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00719

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5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 01/10/2013 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 2 AOA 1 TJC 3 Other	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP 09 ESRD 10 NF 11 IMR 12 RHC 13 PTIP 14 CORF 15 ASC 16 HOSPICE 22 CLIA	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds 124 (L18) 13.Total Certified Beds 124 (L17)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: <u>1.</u> Acceptable POC <u>2.</u> Technical Personnel <u>3.</u> 24 Hour RN <u>4.</u> 7-Day RN (Rural SNF) <u>5.</u> Life Safety Code <u>6.</u> Scope of Services Limit <u>7.</u> Medical Director <u>8.</u> Patient Room Size <u>9.</u> Beds/Room X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B (L12)	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF (L37) 18/19 SNF 124 (L38) 19 SNF (L39) ICF (L42) IMR (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): See Attached Remarks		
17. SURVEYOR SIGNATURE <u>Mary Rogers, Social Work Specialist</u>	Date : 02/08/2013 (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Nicole Steege, Program Specialist</u>
Date: 03/01/2013 (L20)		

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

19. DETERMINATION OF ELIGIBILITY <u>X</u> 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 05/01/1987 (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) <u>VOLUNTARY</u> 00 <u>INVOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active	
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 03001 (L31)	
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	
DETERMINATION APPROVAL		

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

Page 2
Provider Number: 24-5474
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on January 10, 2013, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit after January 28, 2013.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5181

January 16, 2013

Ms. Ann Dirks, Administrator
Park View Care Center
200 Park Lane
Buffalo, Minnesota 55313

RE: Project Number S5474023

Dear Ms. Dirks:

On January 10, 2013, 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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc
Minnesota Department of Health
Midtown Square
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7365

Fax: (320) 223-7348

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 February 19, 2013, 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 February 19, 2013 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 April 10, 2013 (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 July 10, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

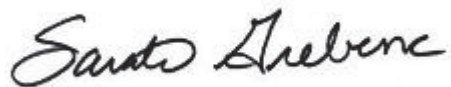
Park View Care Center

January 16, 2013

Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, reading "Sarah Grebenc". The signature is written in a cursive, flowing style.

Sarah Grebenc, Unit Supervisor

Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

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

RECEIVED

PRINTED: 01/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ JAN 31 2013 MN Dept of Health St. Cloud	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER

PARK VIEW CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**200 PARK LANE
BUFFALO, MN 55313**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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.	F 000	F 000 This Plan of Correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement pain management interventions identified by the physician for 1 of 3 residents (R32) reviewed in the sample for pain management. Findings include: R32 had diagnoses that included obesity and osteoarthritis. The significant change minimum data set (MDS) dated 12/4/12, indicated R32 was cognitively intact and required extensive	F 309	F309 Adequate and Proper Nursing Care It has been and remains the policy of Park View Care Center to provide residents adequate and proper nursing care and treatment, personal and custodial care, and supervision based on their individual needs and preferences as identified in their comprehensive resident assessment and plan of care.	

OK
2/8/13
SB

Continued on Page 2

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ann R. Duba

TITLE

ADMINISTRATOR

(X6) DATE

1/24/2013

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

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

PRINTED: 01/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER PARK VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 PARK LANE BUFFALO, MN 55313
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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) COMPLETION DATE
F 309	Continued From page 1 assistance of two persons with transfers. The nursing assistant care sheet, undated, indicated that R32 utilized a standing lift for transfers. The care plan dated 8/24/12, indicated R32 transferred with the assist of two and the use of a ceiling lift. During interview on 1/9/13, at 1:22 p.m., R32 stated that when she sat on the toilet, it hurt the back of her legs. R32 stated she thought her physician had made a note to use a towel under her legs to decrease pain. R32 reported facility staff had not used the towel under her legs during transfers. Further interview with R32 on 1/9/13, at 2:30 p.m., she thought the towel would help to decrease her pain. During an observation on 1/10/13, at 9:58 a.m., two nursing assistants (NA)-A and NA-B assisted R32 to transfer from the toilet and used a standing lift. Both NAs verbalized their awareness of the pain R32 experienced in her legs. The NAs did not indicate any supports needed to transfer R32, aside from use of the standing lift. No towel was noted to be used during the transfer. NA-A, NA-B and R32 acknowledged that this was a typical transfer. Review of a referral form dated 11/21/12, revealed that physician-A had written an order for a towel to be placed under R32's legs when a lift was used to assist her on the toilet. A pain management nursing progress note dated 12/25/12, at 1:13 p.m. included that R32 was on a scheduled pain regime of Tylenol 1000 milligrams (mg) three times a day and Ultram 50 mg twice a	F 309	Regarding cited resident R 32 - The Unit Manager has reviewed this resident's medical record & has instituted the physician's order for a towel to be placed under her leg with standing lift transfers for toileting to decrease discomfort/pain related to her skin sticking to the toilet seat causing her discomfort. This information has been included on the resident's care plan & on the NA/R work list. Actions taken to identify other potential residents having similar occurrences: (Pain Management) - Each Unit Manager will audit their respective unit's resident's physician orders related to pain management, ordered interventions, implementation & individualized pain management care plans. Measures put into place and monitoring to ensure deficient practice does not reoccur: - Licensed staff and Health information staff has received instruction regarding order transcription & timely care plan & NA/R work list updating from physician orders. - The Unit Manager/licensed staff will monitor on an on-going basis, their resident's physician orders/progress notes, licensed staff report, documentation & pain medication usage via MAR to assure identified pain management issues are addressed,	01/10/2013

Continued on Page 3

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER

PARK VIEW CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

200 PARK LANE
BUFFALO, MN 55313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 day. The note also indicated R32 stated her pain was primarily in her knees when she stood and transferred with the standing lift. The note included that R32 rated the pain at a six on a zero to ten scale. The note indicated R32 described the pain as sharp and the pain resolved after R32 sat in her wheelchair. During interview on 1/10/13, at approximately 10:30 a.m., registered nurse (RN)-B stated that R32's transfers should be reviewed by the facility's safe patient handling committee to ensure safety for R32 and staff. RN-B was not aware of the physician order for towel placement during transfers to the toilet. During interview on 1/10/13, at 2:40 p.m., RN-B stated information in regards to the use of the towel should have been on the nursing assistant care sheets and in the care plan.	F 309	physician notified & orders implemented & communicated to nursing staff. 1 Weekly random audit will be done by each Unit Manager/designee with a resident regarding their pain management effectiveness. Revisions to the plan will be made as warranted. - When possible, the interdisciplinary team will ask the residents during their care conference for feedback on their pain management program & its effectiveness. Resident information will be used to alter the plan as warranted. - The Director of Nursing will oversee continuing compliance. - For @ least the next two quarterly QA meetings the audit findings will be reported to & reviewed by the QA committee @ their meeting.	01/28/13

PRINTED: 01/16/2013
FORM APPROVED
OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

01/08/2013 09:03

BUFFALO, MN 55313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
EXIT: 01/10/2013 DATE: 02/19/2013	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. At the time of this survey, Park View Care Center 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 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	K000 This Plan of Correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. <i>prock</i> <i>1/8 2-4-13</i> JAN 31 2013	2013 JAN 31 2013 01391

(X6) DATE

ADMINISTRATOR

1/24/2013

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

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2013
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NAME OF PROVIDER OR SUPPLIER PARK VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 PARK LANE BUFFALO, MN 55313
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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) COMPLETION DATE
K 000	Continued From page 1 Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Facility was inspected as two buildings: Park View Care Center is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1961 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the northeast and was determined to be of Type II(111) construction. In 1979, an addition was constructed to the northwest and was determined to be of Type II(111) construction. In 2007 an addition was added to the southeast of the facility and was determined to be of type II (111) construction. Because the original building and the 2 of the additions meet the construction type allowed for existing buildings and 1 addition for the construction type allowed for new building the facility was inspected as two buildings.	K 000		

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

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NAME OF PROVIDER OR SUPPLIER

PARK VIEW CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**200 PARK LANE
BUFFALO, MN 55313**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K.000	Continued From page 2 The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 124 and had a census of 122 at the time of the survey.	K 000		
K 029 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff and visitors as smoke and fire in this rooms could enter the corridor making it untenable.	K 029	K029 The vertical penetrations located in the ceiling of the records storage area and the lower level "alcove" storage area have all been sealed with fire caulk. Director of Environmental Services is responsible for periodic inspections. This will ensure that no penetrations occur in the future without fire caulk.	01/14/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2013
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NAME OF PROVIDER OR SUPPLIER PARK VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 PARK LANE BUFFALO, MN 55313
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K 029	Continued From page 3 Findings include: On facility tour between 10:30 AM to 1:30 PM on 01/08/2013, observations revealed that there were multiple vertical penetrations located in the ceiling of the records storage room and that there was also a penetration found around an electrical conduit located in the 1 hour rated wall of the lower level "Alcove" storage area separating the storage area from the adjacent resident room. This was confirmed by the Environmental Services Director (UP).	K 029		01/08/2013 APPROVED 0938-0391

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CHAPEL B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2013
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NAME OF PROVIDER OR SUPPLIER PARK VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 PARK LANE BUFFALO, MN 55313
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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Park View Care Center - Chapel addition was found 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 18 New Health Care. Facility was inspected as two buildings: Park View Care Center's Chapel addition in 2007 is a 1 story addition added to the southeast of the facility and was determined to be of type II (111) construction and meets the construction type allowed for a new building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 124 and had a census of 122 at the time of the survey.	K 000	K000 This Plan of Correction constitutes my written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. <i>2-4-13</i>	01/15/2013 APPROVED 01/15/2013 01/13 01/20/2013 APPROVED 01/20/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5181

January 16, 2013

Ms. Ann Dirks, Administrator
Park View Care Center
200 Park Lane
Buffalo, Minnesota 55313

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5474023

Dear Ms. Dirks:

The above facility was surveyed on January 7, 2013 through January 10, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The 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.

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 that 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.

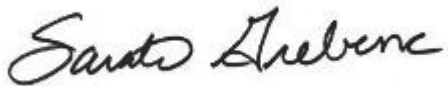
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division Street, Suite 212, St. Cloud, Minnesota 56301-4557. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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.

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,

A handwritten signature in black ink, appearing to read "Sarah Grebenc". The signature is fluid and cursive, with the first name "Sarah" and last name "Grebenc" clearly distinguishable.

Sarah Grebenc, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7365 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00719	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER PARK VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 PARK LANE BUFFALO, MN 55313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
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 January 7, 8, 9, and 10, 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were 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.		

Minnesota Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00719	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER PARK VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 PARK LANE BUFFALO, MN 55313		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From page 1 Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.		
2 830	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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00719	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2013
NAME OF PROVIDER OR SUPPLIER PARK VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 PARK LANE BUFFALO, MN 55313		
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2 830	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement pain management interventions identified by the physician for 1 of 3 residents (R32) reviewed in the sample for pain management. Findings include: R32 had diagnoses that included obesity and osteoarthritis. The significant change minimum data set (MDS) dated 12/4/12, indicated R32 was cognitively intact and required extensive assistance of two persons with transfers. The nursing assistant care sheet, undated, indicated that R32 utilized a standing lift for transfers. The care plan dated 8/24/12, indicated R32 transferred with the assist of two and the use of a ceiling lift. During interview on 1/9/13, at 1:22 p.m., R32 stated that when she sat on the toilet, it hurt the back of her legs. R32 stated she thought her physician had made a note to use a towel under her legs to decrease pain. R32 reported facility staff had not used the towel under her legs during transfers. Further interview with R32 on 1/9/13, at 2:30 p.m., she thought the towel would help to decrease her pain. During an observation on 1/10/13, at 9:58 a.m., two nursing assistants (NA)-A and NA-B assisted R32 to transfer from the toilet and used a standing lift. Both NAs verbalized their awareness of the pain R32 experienced in her legs. The NAs	2 830			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00719	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2013
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2 830	Continued From page 3 did not indicate any supports needed to transfer R32, aside from use of the standing lift. No towel was noted to be used during the transfer. NA-A, NA-B and R32 acknowledged that this was a typical transfer. Review of a referral form dated 11/21/12, revealed that physician-A had written an order for a towel to be placed under R32's legs when a lift was used to assist her on the toilet. A pain management nursing progress note dated 12/25/12, at 1:13 p.m. included that R32 was on a scheduled pain regime of Tylenol 1000 milligrams (mg) three times a day and Ultram 50 mg twice a day. The note also indicated R32 stated her pain was primarily in her knees when she stood and transferred with the standing lift. The note included that R32 rated the pain at a six on a zero to ten scale. The note indicated R32 described the pain as sharp and the pain resolved after R32 sat in her wheelchair. During interview on 1/10/13, at approximately 10:30 a.m., registered nurse (RN)-B stated that R32's transfers should be reviewed by the facility's safe patient handling committee to ensure safety for R32 and staff. RN-B was not aware of the physician order for towel placement during transfers to the toilet. During interview on 1/10/13, at 2:40 p.m., RN-B stated information in regards to the use of the towel should have been on the nursing assistant care sheets and in the care plan. SUGGESTED PERIOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure	2 830			

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2 830	Continued From page 4 residents receive the appropriate care and services for pain management. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) Days	2 830			
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived. Conditions of Waiver: - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold In Tube, T-SPOT®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the	21400			

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21400	Continued From page 5 resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident tuberculosis program was in compliance with current standards of practice, related to documentation of the measured induration of the skin test results, for 3 of 5 residents (R1, R169 and R35) reviewed in the sample for tuberculin skin testing. Findings include: Tuberculin skin test results for R1 lacked documented measurement of induration for both steps one and two of testing. R1 was admitted to the facility on 10/9/12. Review of medication administration record (MAR) dated 10/1/12 to 10/31/12, revealed R1 had tuberculin skin testing results read on 10/11/12 and 10/19/12. The results were documented as "neg" and "-", indicating negative results. No measurements of induration were indicated for these results. Tuberculin skin test results for R169 lacked	21400			

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21400	Continued From page 6 documented measurement of induration for step one of testing. R169 was admitted to the facility on 9/12/12. Review of the MAR dated 9/1/12 to 9/30/12, revealed R169 had step one tuberculin skin testing results read on 9/14/12. The results were documented as "x", indicating negative results. No measurement of induration were indicated for these results. Tuberculin skin test results for R35 lacked documented measurement of induration for step two of testing. R35 was admitted to the facility on 7/12/12. Review of the MAR dated 7/1/12 to 7/31/12, revealed R35 had step two tuberculin skin testing results read on 7/22/12. The results were documented as "-", indicating negative results. No measurement of induration were indicated for these results. During interview on 1/10/13, at 3:30 p.m. registered nurse (RN-D) verified these findings. RN-D reported she needed to remind the facility's nursing staff that documentation of the induration measurements for tuberculin skin test results was a requirement. Review of the facility's Two Step Tuberculin Testing procedure dated 4/8/97, identified the test administration, test results and appropriate chest x-ray results were to be documented in the resident's chart. The procedure lacked instruction for the documented results to include the measurement of induration.	21400			

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21400	Continued From page 7 Review of the facility's Tuberculosis Prevention and Control Policy dated 12/11/12, revealed tuberculin skin test results were to be interpreted using the measurement of induration. The policy also lacked instruction for the documented results to include the measurement of induration. Review of Centers for Disease Control (CDC) Tuberculin Skin Testing dated 4/10 identified results of tuberculin skin testing was to include the following: name and signature of the person reading the test, the date and time the test was read, the exact number of millimeter (mm) of induration (if no induration, document "0" mm), and the interpretation of the reading . Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure Tuberculosis skin testing is documented in accordance with current standards of practice. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21400			