Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 23, 2023

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: CCN: 245474
Cycle Start Date: December 8, 2022

Dear Administrator:

On December 29, 2022, we notified you a remedy was imposed. On January 26, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 20, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 12, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 29, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 12, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 20, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2023

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

Re: Reinspection Results
Event ID: C7Y312

Dear Administrator:

On January 26, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 8, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2022

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: CCN: 245474
Cycle Start Date: December 8, 2022

Dear Administrator:

On December 8, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 12, 2023.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 12, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 12, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 12, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Park View Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 12, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 June 8, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING _____ B. WING _____	C 12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW CARE CENTER	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
E 000	Initial Comments On 12/5/22 through 12/8/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		1/20/23

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

Electronically Signed | 01/06/2023

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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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 3 Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2, and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/07/2022 at 09:30 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Environmental Director, that the facility could not provide documentation at the time of the survey for weekly emergency generator inspections prior to August 8, 2022. An interview with the Environmental Director verified this deficient findings at the time of discovery.	E 041	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. E041 It is the policy of Cassia Park View Care Center to comply with (E041) To assure continued compliance, the following plan has been put into place; Measures put in place to ensure deficient practice does not recur: The facility has will maintain both weekly and monthly documentation of emergency generator testing. Maintenance staff will be educated on the tools, testing requirements and documentation. Effective implementation of actions will be monitored by: The Director of Maintenance will be responsible for the measures listed above and audit for compliance weekly. Those responsible to maintain compliance will be: The Director of Maintenance is responsible for maintain compliance. Completion date for certification purposes only is: 01/20/2023	

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F 000	Continued From page 4	F 000		
F 000	INITIAL COMMENTS On 12/5/22 through 12/8/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5474068C (MN78601) H54746423C (MN87652) H54746422C (MN85546) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		1/20/23

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F 550	Continued From page 5 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified	F 550	It is the policy of Cassia Park View to comply with F550.	

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F 550	Continued From page 6 experience for 1 of 4 residents (R73) observed for dining. Findings include: R73's admission Minimum Data Set (MDS) dated 10/18/22, identified R73 had a severe cognitive impairment and diagnoses included Alzheimer's disease with early onset, psychotic disorder with delusions, depression, anxiety, and weight loss. R73 was on Hospice care and required extensive staff assist for eating. R73's care plan dated 10/11/22, identified R73 required assistance with Activities of Daily Living (ADLs). Staff were directed to provide extensive assistance with eating. During an observation on 12/7/22, at 11:35 a.m. R73 was sitting in her tilt-in-space chair. R73 was in the dining room, at a table, watching TV. The noon meal had already began and R61 was sitting on R73's left side. R61 was eating her meal; however, R73 had not been served her meal. - At 12:27 p.m. R61 had finished eating her meal and pushed away from the table. However, R73 continued to wait for her meal to be served. - At 12:39 p.m. R73's meal was placed in front of R73 without the dome cover removed. - At 12:40 p.m. activity aide (AA)-A sat down with R73 and asked if R73 was ready to eat. R73 then grimaced and let out a long moan, but no words were spoken. AA-A began assisting R73 to eat her meal. During an interview on 12/7/22, at 1:59 p.m. nursing assistant (NA)-C stated there were nine residents who required assistance to eat in the	F 550	To assure continued compliance, the following plan has been put into place: Regarding cited resident: The dining experience for R73 will be part of a new two seating dining format. Actions taken to identify other potential residents having similar occurrences: All other residents will be incorporate in a new two seating dining format. All residents on the memory care unit will have their ability to eat reassessed. Measures put in place to ensure deficient practice does not recur: The memory care Nurse Manager will monitor weekly for timely serving of all residents. Effective implementation of actions will be monitored by: The memory care Nurse Manager will audit for timely serving of residents weekly X 4 weeks and then monthly X 2 months to ensure to ensure all residents are served timely. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance.	

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	245474	A. BUILDING _____ B. WING _____	C 12/08/2022

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F 550	Continued From page 7 memory care unit. Someone had to wait and it was a normal practice to bring all the residents to the dining room at the same time. NA-C stated she had to be honest and some residents just had to wait until someone was able to help them. During an interview on 12/7/22, at 2:12 p.m. licensed practical nurse (LPN)-A stated they just didn't have staff to assist all the residents with eating at the same time. LPN-A then stated she wouldn't want to sit and watch others eat and not be able to eat herself. During an observation on 12/8/22, at 8:47 a.m. R73 was sitting in her tilt-in-space chair in the middle of the dining room while other residents were eating breakfast meal. NA-C asked trained medication aide (TMA)-A if any staff were going to come to the dining room to assist residents. TMA-A stated she thought clinical manager (CM)-B would. - At 9:11 a.m. R73 continued to sit in the middle of the dining room. NA-C and AA-B were assisting other residents to eat. CM-B stepped into the dining room, but left. No staff offered or assisted R73. - At 9:40 a.m. AA-B assisted R73 to the dining table. R73's meal was placed in front of her, but the dome cover remained in place. - At 9:46 a.m. AA-B sat down and began assisting R73 with her meal. During an interview on 12/8/22, at 3:11 p.m. CM-B stated the facility did not have expectations regarding how long a resident waited to eat their meal. CM-B then stated he did not have enough staff for all residents to eat at once, but no food was placed in front of a resident until they were able to eat. The facility had tried to have separate	F 550	Completion date for certification purposes only is: 1/20/2023	

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F 550	Continued From page 8 dining times, but then things were happening in the other resident areas and staff were unaware because they were in the dining room. Further, it was just easier to supervise everyone in the dining room. CM-B stated there were no nursing assistants in the building who were available to float to the memory care unit to assist. CM-B then stated R73 probably waited because she was patient and did not make noise. CM-B stated he would not want to wait for his meal and residents should be allowed to eat in a reasonable amount of time. During an interview on 12/8/22, at 4:57 p.m. the director of nursing (DON) stated it was the first time she had been informed staff were not able to assist residents with eating in a reasonable amount of time. Meals could be staggered or another alternative could be found to prevent a resident needing to watch others eat for approximately 1.5 hours before eating themselves. The DON further stated eating within a reasonable time upon arrival to the dining room was expected. The facility policy Dining Room Services revised 3/17/21, identified individuals would be provided with nourishing, palatable, attractive meals that met daily and special nutritional needs. Individuals would be provided with services to maintain or improve eating skills. The dining experience would enhance the individual's quality of life and be supportive of the individual's needs during dining. The policy directed staff to assist as needed to assure adequate intake of food and fluid at the meal. Individuals would be assisted promptly and in a timely manner after the meal arrived.	F 550		

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F 800	Continued From page 9	F 800		
F 800 SS=F	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure food was palatable. This had the potential to affect 87 of 91 residents who ate food served out of the kitchen. Findings include: During an interview on 12/07/22, at 12:50 p.m. R33 stated the country fried steak was hard and mostly breading. R33 demonstrated how hard the meat was by knocking it against her plate, creating a dull noise. R33 stated she did not request alternate food from the kitchen as she had plans to leave soon after the meal. She did not eat any of the meat. During an interview on 12/07/22, at 12:54 p.m. R10 stated meat was tough. She did not eat any of the meat. She denied needing an alternate as she was not hungry after eating the rest of her lunch. During an interview with R11 on 12/07/22 at 12:55 p.m. she stated she could not chew it, "it's like a rock. Country fried rock". She stated she could not cut the country fried steak. She stated that she did not tell any of the staff.	F 800	It is the policy of Cassia Park View to comply with F800. To assure continued compliance, the following plan has been put into place: Regarding cited resident: All residents including R2, R11, and R33 were educated about the availability of meal alternatives if they do not like the feature meal or entr¿e. Actions taken to identify other potential residents having similar occurrences: No other residents□ concerns about the country fried steak were received. Review of grievance log did not indicate any food complaints September 2022 through December 2022. Measures put in place to ensure deficient practice does not recur: The facility recognizes the range of resident□s preferences and backgrounds that influence their individual measure of palatability of specific products like spicy vs mild and texture, ie tender vs crisp, etc. The country fried steak product served on	1/20/23

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F 800	Continued From page 10 During an interview on 12/07/22, at 12:56 p.m. Nursing Assistant (NA)-A stated the meat was not good., per R2. R2 stated she was saving her meat to demonstrate how hard it was at the resident council meeting scheduled for later in the day. NA-A stated the food lately had not been very good, the meat was hard and dry. NA-A stated the kitchen brought something else when requested by residents. NA-A stated residents with an altered diet did not have an issue with the country fried steak. On 12/07/22, at 12:58 p.m. Certified Dietary Manager (CDM) was informed of the residents' dissatisfaction with the country fried steak. CDM, stated she had nothing to do with production. On 12/07/22, at 1:06 p.m. The Registered Dietician (RD) was advised of the residents' dissatisfaction with the country fried steak. She was observed in the dining room interacting with the residents and offering alternate food to residents still in dining room. During an interview on 12/07/22, at 1:26 p.m. with the CDM and RD present, CDM stated that her responsibilities clinical end. She conducts interviews, prepares tray cards, and provides diet education. She stated she attended care conferences. She denies hearing of food complaints. She stated Chef and Food & Nutrition Supervisor are in charge of production. She stated the dietary staff records intake for breakfast and the nursing assistants record lunch and supper intake. She stated staff knew they can ask for alternate food choices for the residents if they are unhappy with their meal. She stated the residents will make their needs known if they are not satisfied with their food.	F 800	12/7/22 was a substitute received from our food vendor due to the normal product used being unavailable. If normal product continues to be unavailable, menu will be adjusted. Chef reviewed appropriate cooking methods with AM cook on 12/7/22. Staff were educated to report any complaints of food taste or texture to the kitchen staff and offer alternative items. Effective implementation of actions will be monitored by: Staff were educated to report any complaints of food taste or texture to the kitchen staff and offer alternative items. The facility will audit monthly for palatability at the monthly resident council meeting and by reviewing any resident grievance forms. If there is a group resident consensus from several residents about an specific item the facility will make efforts to find an alternative products. The Director of Activities will record and share the large scope themes with the Executive Chef and the results will be brought to the QAPI committee for review for ongoing monitoring. Those responsible to maintain compliance will be: The Executive Chef or designee, is responsible for maintaining compliance. Completion date for certification purposes only is: 1/20/2023	

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F 800	Continued From page 11 Review of grievance log did not indicate any food complaints September 2022 through December 2022.	F 800		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to ensure safe food temperatures on the Northwoods unit. This had the potential to affect 38 of 40 residents. Findings include: During observation and interview on 12/07/22, at 7:21 a.m. Dietary Aide (DA)-A checked temperature of foods on steamtable. DA-A stated she was looking for temperatures to be over 120. Food thermometer read 168 degrees Fahrenheit for pureed eggs. Food thermometer read 115.7 degrees Fahrenheit for Croissant egg and cheese sandwich, below required tempurature. Food thermometer read 130.4 degrees for scrambled eggs, below required temperature. DA-A documented food temperatures on the Final Cooking Temperatures form. DA-A did not check temperatures for the oatmeal, bacon or sausage	F 804	It is the policy of Cassia Park View to comply with F804. To assure continued compliance, the following plan has been put into place: Regarding cited resident: Chef instructed to immediately discard scrambled eggs that were below safe serving temperature. Chef immediately discarded sausage and bacon that were below safe serving temperatures. No residents received any of these items. Actions taken to identify other potential residents having similar occurrences: Food items that were temped below safe serving temperatures were immediately discarded and kitchen prepared new batch to be served. Chef immediately reviewed temperature expectations with	1/20/23

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F 804	Continued From page 12 as required. DA-A stated temperatures not within acceptable temperatures must be reported to the chef or kitchen supervisor. However, she did not report low temperatures as required. DA-A stated that new steamtables were on order. Record review of form titled Final Cooking Temperatures form does not indicate temperatures documented for Sunday or Monday breakfast. During observation and interview on 12/7/22, at 7:26 a.m. Chef stated that steamtable foods were to be checked for temperatures to be at least 135 degrees Fahrenheit. DA-A showed Chef food temperature log. Chef instructed for the scrambled eggs to be discarded. He checked the temperature of the sausage. Food thermometer read 125 degrees Fahrenheit. Chef indicated that the sausage and bacon was double-stacked in the steamtable. He discarded the sausage and bacon. The oatmeal temperature read 175 degrees Fahrenheit. Chef stated the kitchen would make food to replace discarded food for the residents. During interview on 12/7/22, at 7:54 a.m. Registered Nurse (RN)-A stated that foods are always checked for temperatures. She reported there had not been any gastro-intestinal illnesses in the previous three months. She stated foods were to be at 135 degrees to be served from steamtable. She stated 40 residents are served from the Northwoods kitchenette. During an interview on 12/7/22, at 7:57 a.m. the Director of Nursing (DON) stated that food temperatures are expected to be at 135 degrees to serve from the steamtable.	F 804	dietary aide-A. Measures put in place to ensure deficient practice does not recur: Education provided to dietary staff on 12/7/22 reviewing appropriate temperatures for final cooking, hot holding/serving & reheating, appropriate method of taking food temperatures and how to document food temperatures and not stacking food pans on top of one another but to put in the steam well. New steam tables arrived to facility on 12/30, were installed and facility began using which increased steam well availability. Effective implementation of actions will be monitored by: The Executive Chef or designee will audit dining room during breakfast to ensure temperatures are taken accurately and documented prior to service twice weekly x 4 weeks and then weekly x 2 months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Executive Chef or designee, is responsible for maintaining compliance. Completion date for certification purposes only is: 1/20/2023	

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F 804	Continued From page 13 During an observation on 12/7/22, at 8:02 a.m. the chef reviewed temperature expectations with DA-A, to be at 135 to serve from the steamtable. During an interview on 12/7/22, at 8:15 a.m. the Chef stated the reason the temperatures must be at 135 degrees or above to keep things out of the danger zone, so that no pathogens are growing. He stated that foods are checked for temperatures in the kitchen prior to being brought out to the kitchenette. Breakfast is the only meal served from the steamtable. Lunch and supper trays are prepared in the kitchen and served to the units on carts. He stated that there are steamtables on order and expected to arrive soon. During an interview on 12/7/22, at 1:26 p.m. Certified Dietary Manager (CDM) stated her responsibilities were on the clinical end, not food production. She stated that Chef and kitchen supervisor are responsible for the food production. Requested original documented food temperature log from Administrator on 12/8/22, at 12:20 p.m. Admin reported that the sheet that the form the steamtable food temperatures was documented on 12/8/22 was not located.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		1/20/23

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F 812	Continued From page 14 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to ensure expired food items were discarded appropriately from the kitchen and kitchenette. This had the potential to affect 87 of 91 residents. The facility also failed to properly clean the ice and water dispenser in the Northwoods kitchenette. This had the potential to affect 40 residents. Findings include: During observation and interview on 12/07/2022, at 10:33 a.m. tour of kitchenettes and kitchen conducted with Chef and Registered Dietician (RD). - Non-dairy creamer in kitchen dry storage had delivery date of 5/25/21. No expiration date indicated. -Two boxes of devil's food cake mix with expiration date of 9/28/22 on the shelf in the dry storage area in the kitchen. -Four plastic bags of light brown powder mix without labels, located on top of coffee cake mix.	F 812	It is the policy of Cassia Park View to comply with F812. To assure continued compliance, the following plan has been put into place: Regarding cited items: Chef discarded box of powder non-dairy creamer from dry storage on 12/7/22 and removed all powder non-dairy creamers from all kitchenettes. Chef discarded two boxes of expired devil□s food cake mix from dry storage on 12/7/22. Chef discarded four plastic bags of light brown powder mix that was unlabeled from dry storage on 12/7/22. Chef discarded bag of food labeled Room 418 found in Main Lane kitchenette refrigerator as well as bag containing expired jello and pudding on 12/7/22. Northwoods kitchenette water and ice dispenser was cleaned on (12/21/22). Actions taken to identify other potential	

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F 812	Continued From page 15 -Northwoods kitchenette water and ice dispenser was covered with a white scaly substance over the front, the tray, and outer edges. - The Main Lane kitchenette refrigerator contained a plastic bag labeled Room 418. The bag contained a cucumber, a clear plastic container with carrots and broccoli, and vegetable dip. The cucumber had multiple small circles with a white and fuzz-like matter. The container of carrots and broccoli were dated 11/23/22. The vegetable dip was dated 11/23/22. -Main Lane refrigerator also contained pudding labeled with expiration date 8/22/22 and jello labeled with expiration date 9/10/22. During an interview on 12/07/2022 at 10:40 a.m. Chef stated that the refrigerator, freezer, and dry strorage contents were reviewed daily by either a dietary aide, kitchen manager, or chef weekly. Chef stated resident personal food items were disgarded after seven days, the residue on the ice dispenser was from hard water and confirmed residents were served from the dispenser. Chef stated the plastic bags contained coffee cake topping, but there was no way to confirm contents or expiration date. He stated box top should have been retained for reference. RD stated per the distributor the expiration date of the creamer was 365 days after it was produced and the cake mix should have been removed and discarded. Review of policy titled Refrigerator and Freezer Storage, dated 1/1/2019, last revised 1/5/22 stated Food and Nutrition services, or other designated staff, will maintain clean food storage areas at all times.	F 812	items: Chef and RD completed audit of dry storage and all kitchenettes to ensure there were no other expired food items on 12/7/22. Measures put in place to ensure deficient practice does not recur: Education provided to dietary staff on 12/7/22 reviewing proper labeling/dating of food items in dry storage and kitchenette refrigerators and their shelf life/expiration dates and anything found past their expiration dates should immediately be discarded. Chef reviewed with dietary staff who is responsible for monitoring kitchen refrigerators. North Woods ice/water machine- on cleaning schedule & reviewed with staff. Effective implementation of actions will be monitored by: The Executive Chef or designee will audit kitchenette refrigerators & dry storage to ensure there is no expired food items weekly x 4 weeks and then monthly x 2 months. The Executive Chef or designee will audit North Woods ice/water machine weekly x 4 weeks and then monthly x 2 months to ensure it is cleaned appropriately. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be:	

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F 812	Continued From page 16	F 812	The Executive Chef or designee, is responsible for maintaining compliance. Completion date for certification purposes only is: 1/20/2023	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		1/20/23

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F 880	Continued From page 17 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff disinfected personal protective equipment (PPE) upon exiting a COVID-19 positive resident room.	F 880	F880 F It is the policy of Park View Care Center to comply with F880.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING _____ B. WING _____	C 12/08/2022

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F 880	Continued From page 18 This had the potential to affect all 91 residents that resided in the facility. Findings include: During observation on 12/05/22, at 6:21 p.m. a transmission based precaution (TBP) cart was next to R385's door. A sign was posted on the door indicating contact and droplet precautions and staff were to wear PPE including a face shield when entering R385's room. During interview on 12/06/22, at 10:44 a.m. the infection preventionist (IP) stated staff were instructed to wear full PPE including a face shield when entering a COVID-19 positive residents room. During observation on 12/7/22, at 8:59 a.m. licensed practical nurse (LPN)-A exited R385's room. LPN-A removed and placed her dirty face shield and N-95 mask on the top of the TBP cart. LPN-A used hand sanitizer after she removed the rest of the PPE. LPN-A picked up the dirty N-95 mask and face shield, carried them to the medication (med) cart, and placed the face shield on a narcotic book on top of the cart. LPN-A placed the N-95 in a paper bag, carried the bag back to the TBP cart and placed the bag inside the cart. The dirty face shield was still on top of the med cart. LPN-A returned to the med cart and proceeded to dispense another residents medication. During observation on 12/8/22, at 9:27 a.m. nursing assistant NA-C exited R385's room wearing PPE including a face shield. NA-C was not wearing gloves. NA-C removed the dirty face shield, placed it on top of the TBP cart and	F 880	To assure continued compliance, the following plan has been put into place; Regarding cited resident: The Infection Preventionist (IP) educated LPN-A and NA-C directly after the occurrences of incorrectly Doffing PPE. The cited resident (R385) has since discharged on 12/30/2022. Actions taken to identify other potential residents having similar occurrences: All residents could be affected thus the facility has started to educate all staff members including LPN-A and NA-C on standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use and donning and doffing of PPE. Measures put in place to ensure deficient practice does not recur: A root cause analysis was completed. A review of policies and procedures for donning and doffing PPE, source control masks, proper use of gowns, and standard and transmission-based precautions was completed. Facility Respiratory Protection Program policy was updated to indicate one-time use of n95 respirators. Effective implementation of actions will be monitored by: Source Control Masking Audit for employees will be completed every shift, 4x week x 1 week and then every shift,	

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F 880	Continued From page 19 removed the gown and N-95. NA-C picked up and placed the face shield in a paper bag and put it inside the TBP cart. NA-C was not observed to disinfect the top of the dirty TBP cart prior to walking away. During interview on 12/7/22, at 9:03 a.m. LPN-A stated she should have, but had not sanitized the face shield right away after exiting the R385's room. During joint interview on 12/8/22, at 9:27 a.m. NA-C stated she removed her gloves upon exiting R385's room and should have removed them prior to exiting the room. NA-C was not observed to use hand sanitizer and was not observed to sanitize the top of the TBP cart after placing the dirty face shield on top of the cart. During interview on 12/8/22, at 9:39 a.m. the IP stated she was going to have a discussion with the staff regarding properly disinfecting PPE. The facilities Clean-disinfect equipment policy directs staff to disinfect equipment per current COVID-19 guidelines. The facilities Personal Protective equipment - Infection Control policy directs staff certain PPE may be required, such as eye protection, during a respiratory virus pandemic.	F 880	2x week once compliance is met. Source Control Masking Audit for Residents will be completed every shift, 4x week x 1 week and then every shift, 2x week once compliance is met . Source Control Masking Audit for Visitors will be completed every shift, 4x week x 1 week and then every shift, 2x week once compliance is met . Real time audit for Donning and Doffing PPE using gowns with Transmission based precautions will be completed evert shift, 3x week x 1 week and then every shift, 2x week once compliance is met. Real time audit for Aerosolized Generating procedures to ensure PPE is in use will be completed 2x a week x 1 week and then 1 time a week once compliance is met. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance. Completion date for certification purposes only is: 1/20/2023	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2022

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

Re: State Nursing Home Licensing Orders
Event ID: C7Y311

Dear Administrator:

The above facility was surveyed on December 5, 2022 through December 8, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

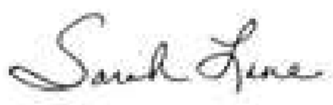
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00719	A. BUILDING: _____ B. WING _____	C 12/08/2022

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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 12/5/22 through 12/8/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. 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 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure food was palatable. This had the potential to affect 87 of 91 residents who ate food served out of the kitchen. Findings include: During an interview on 12/07/22, at 12:50 p.m. R33 stated the country fried steak was hard and mostly breading. R33 demonstrated how hard the meat was by knocking it against her plate, creating a dull noise. R33 stated she did not request alternate food from the kitchen as she had plans to leave soon after the meal. She did not eat any of the meat. During an interview on 12/07/22, at 12:54 p.m. R10 stated meat was tough. She did not eat any of the meat. She denied needing an alternate as she was not hungry after eating the rest of her lunch. During an interview with R11 on 12/07/22 at 12:55 p.m. she stated she could not chew it, "it's like a	2 960	Corrected	1/20/23

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2 960	Continued From page 3 rock. Country fried rock". She stated she could not cut the country fried steak. She stated that she did not tell any of the staff. During an interview on 12/07/22, at 12:56 p.m. Nursing Assistant (NA)-A stated the meat was not good., per R2. R2 stated she was saving her meat to demonstrate how hard it was at the resident council meeting scheduled for later in the day. NA-A stated the food lately had not been very good, the meat was hard and dry. NA-A stated the kitchen brought something else when requested by residents. NA-A stated residents with an altered diet did not have an issue with the country fried steak. On 12/07/22, at 12:58 p.m. Certified Dietary Manager (CDM) was informed of the residents' dissatisfaction with the country fried steak. CDM, stated she had nothing to do with production. On 12/07/22, at 1:06 p.m. The Registered Dietician (RD) was advised of the residents' dissatisfaction with the country fried steak. She was observed in the dining room interacting with the residents and offering alternate food to residents still in dining room. During an interview on 12/07/22, at 1:26 p.m. with the CDM and RD present, CDM stated that her responsibilities clinical end. She conducts interviews, prepares tray cards, and provides diet education. She stated she attended care conferences. She denies hearing of food complaints. She stated Chef and Food & Nutrition Supervisor are in charge of production. She stated the dietary staff records intake for breakfast and the nursing assistants record lunch and supper intake. She stated staff knew they can ask for alternate food choices for the	2 960		

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2 960	Continued From page 4 residents if they are unhappy with their meal. She stated the residents will make their needs known if they are not satisfied with their food. Review of grievance log did not indicate any food complaints September 2022 through December 2022. SUGGESTED METHOD OF CORRECTION: The facility could develop a process for frequent interaction with residents to elicit resident's perception of quality and palatability of food. The facility couldlog this feedback and take the results of these audits to the QAPI committee for review for ongoing monitoring. The facility could establish a process to deliberately ask residents questions about the food that is served during their individual care conferences. The facility could provide educaiton to staff in dining rooms to report any complaints of food taste or texture immediately to the kitchen staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview, and	21025	Corrected	1/20/23

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21025	Continued From page 5 documentation review the facility failed to ensure safe food temperatures on the Northwoods unit. This had the potential to affect 38 of 40 residents. Findings include: During observation and interview on 12/07/22, at 7:21 a.m. Dietary Aide (DA)-A checked temperature of foods on steamtable. DA-A stated she was looking for temperatures to be over 120. Food thermometer read 168 degrees Fahrenheit for pureed eggs. Food thermometer read 115.7 degrees Fahrenheit for Croissant egg and cheese sandwich, below required tempurature. Food thermometer read 130.4 degrees for scrambled eggs, below required temperature. DA-A documented food temperatures on the Final Cooking Temperatures form. DA-A did not check temperatures for the oatmeal, bacon or sausage as required. DA-A stated temperatures not within acceptable temperatures must be reported to the chef or kitchen supervisor. However, she did not report low temperatures as required. DA-A stated that new steamtables were on order. Record review of form titled Final Cooking Temperatures form does not indicate temperatures documented for Sunday or Monday breakfast. During observation and interview on 12/7/22, at 7:26 a.m. Chef stated that steamtable foods were to be checked for temperatures to be at least 135 degrees Fahrenheit. DA-A showed Chef food temperature log. Chef instructed for the scrambled eggs to be discarded. He checked the temperature of the sausage. Food thermometer read 125 degrees Fahrenheit. Chef indicated that the sausage and bacon was double-stacked in the steamtable. He discarded the sausage and	21025		

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21025	Continued From page 6 bacon. The oatmeal temperature read 175 degrees Fahrenheit. Chef stated the kitchen would make food to replace discarded food for the residents. During interview on 12/7/22, at 7:54 a.m. Registered Nurse (RN)-A stated that foods are always checked for temperatures. She reported there had not been any gastro-intestinal illnesses in the previous three months. She stated foods were to be at 135 degrees to be served from steamtable. She stated 40 residents are served from the Northwoods kitchenette. During an interview on 12/7/22, at 7:57 a.m. the Director of Nursing (DON) stated that food temperatures are expected to be at 135 degrees to serve from the steamtable. During an observation on 12/7/22, at 8:02 a.m. the chef reviewed temperature expectations with DA-A, to be at 135 to serve from the steamtable. During an interview on 12/7/22, at 8:15 a.m. the Chef stated the reason the temperatures must be at 135 degrees or above to keep things out of the danger zone, so that no pathogens are growing. He stated that foods are checked for temperatures in the kitchen prior to being brought out to the kitchenette. Breakfast is the only meal served from the steamtable. Lunch and supper trays are prepared in the kitchen and served to the units on carts. He stated that there are steamtables on order and expected to arrive soon. During an interview on 12/7/22, at 1:26 p.m. Certified Dietary Manager (CDM) stated her responsibilities were on the clinical end, not food production. She stated that Chef and kitchen	21025		

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21025	Continued From page 7 supervisor are responsible for the food production. Requested original documented food temperature log from Administrator on 12/8/22, at 12:20 p.m. Admin reported that the sheet that the form the steamtable food temperatures was documented on 12/8/22 was not located. SUGGESTED METHOD OF CORRECTION: The facility could develop education for staff responsible to serve food that includes the proper process to evaluate temperature of food prior to serving. Education on safe food handling and danger zone for time/ temperature control for safety (TCS) food could be provided. The facility could replace current steamtable or evaluate opportunity to fix current steamtable to maintain safe tempoerature of food. The Director of Food and Nutrition, Certified Dietary Manager, Registered Dietitican, or Chef could provide close oversight and documentation of temperaure monitoring of foods prior to serving to residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) da	21025		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and	21100	Corrected	1/20/23

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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
21100	Continued From page 8 documentation review the facility failed to ensure expired food items were discarded appropriately from the kitchen and kitchenette. This had the potential to affect 87 of 91 residents. The facility also failed to properly clean the ice and water dispenser in the Northwoods kitchenette. This had the potential to affect 40 residents. Findings include: During observation and interview on 12/07/2022, at 10:33 a.m. tour of kitchenettes and kitchen conducted with Chef and Registered Dietician (RD). - Non-dairy creamer in kitchen dry storage had delivery date of 5/25/21. No expiration date indicated. -Two boxes of devil's food cake mix with expiration date of 9/28/22 on the shelf in the dry storage area in the kitchen. -Four plastic bags of light brown powder mix without labels, located on top of coffee cake mix. -Northwoods kitchenette water and ice dispenser was covered with a white scaly substance over the front, the tray, and outer edges. - The Main Lane kitchenette refrigerator contained a plastic bag labeled Room 418. The bag contained a cucumber, a clear plastic container with carrots and broccoli, and vegetable dip. The cucumber had multiple small circles with a white and fuzz-like matter. The container of carrots and broccoli were dated 11/23/22. The vegetable dip was dated 11/23/22. -Main Lane refrigerator also contained pudding labeled with expiration date 8/22/22 and jello labeled with expiration date 9/10/22. During an interview on 12/07/2022 at 10:40 a.m. Chef stated that the refrigerator, freezer, and dry strorage contents were reviewed daily by either a	21100		

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	00719	A. BUILDING: _____ B. WING _____	C 12/08/2022

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21100	Continued From page 9 dietary aide, kitchen manager, or chef weekly. Chef stated resident personal food items were disgarded after seven days, the residue on the ice dispenser was from hard water and confirmed residents were served from the dispenser. Chef stated the plastic bags contained coffee cake topping, but there was no way to confirm contents or expiration date. He stated box top should have been retained for reference. RD stated per the distributor the expiration date of the creamer was 365 days after it was produced and the cake mix should have been removed and discarded. Review of policy titled Refrigerator and Freezer Storage, dated 1/1/2019, last revised 1/5/22 stated Food and Nutrition services, or other designated staff, will maintain clean food storage areas at all times. SUGGESTED METHOD OF CORRECTION: The facility could develop policies and procedures to ensure clear expectations for food storage and handling. The facility could designate someone to conduct weekly audits of food storage. The facility could develop a process for consistent monitoring of the contents of residents personal food items. The facility could take the results of these audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		1/20/23

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21805	Continued From page 10 courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified experience for 1 of 4 residents (R73) observed for dining. Findings include: R73's admission Minimum Data Set (MDS) dated 10/18/22, identified R73 had a severe cognitive impairment and diagnoses included Alzheimer's disease with early onset, psychotic disorder with delusions, depression, anxiety, and weight loss. R73 was on Hospice care and required extensive staff assist for eating. R73's care plan dated 10/11/22, identified R73 required assistance with Activities of Daily Living (ADLs). Staff were directed to provide extensive assistance with eating. During an observation on 12/7/22, at 11:35 a.m. R73 was sitting in her tilt-in-space chair. R73 was in the dining room, at a table, watching TV. The noon meal had already began and R61 was sitting on R73's left side. R61 was eating her meal; however, R73 had not been served her meal. - At 12:27 p.m. R61 had finished eating her meal and pushed away from the table. However, R73 continued to wait for her meal to be served. - At 12:39 p.m. R73's meal was placed in front of R73 without the dome cover removed. - At 12:40 p.m. activity aide (AA)-A sat down with	21805	Corrected	

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21805	Continued From page 11 R73 and asked if R73 was ready to eat. R73 then grimaced and let out a long moan, but no words were spoken. AA-A began assisting R73 to eat her meal. During an interview on 12/7/22, at 1:59 p.m. nursing assistant (NA)-C stated there were nine residents who required assistance to eat in the memory care unit. Someone had to wait and it was a normal practice to bring all the residents to the dining room at the same time. NA-C stated she had to be honest and some residents just had to wait until someone was able to help them. During an interview on 12/7/22, at 2:12 p.m. licensed practical nurse (LPN)-A stated they just didn't have staff to assist all the residents with eating at the same time. LPN-A then stated she wouldn't want to sit and watch others eat and not be able to eat herself. During an observation on 12/8/22, at 8:47 a.m. R73 was sitting in her tilt-in-space chair in the middle of the dining room while other residents were eating breakfast meal. NA-C asked trained medication aide (TMA)-A if any staff were going to come to the dining room to assist residents. TMA-A stated she thought clinical manager (CM)-B would. - At 9:11 a.m. R73 continued to sit in the middle of the dining room. NA-C and AA-B were assisting other residents to eat. CM-B stepped into the dining room, but left. No staff offered or assisted R73. - At 9:40 a.m. AA-B assisted R73 to the dining table. R73's meal was placed in front of her, but the dome cover remained in place. - At 9:46 a.m. AA-B sat down and began assisting R73 with her meal.	21805		

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21805	Continued From page 12 During an interview on 12/8/22, at 3:11 p.m. CM-B stated the facility did not have expectations regarding how long a resident waited to eat their meal. CM-B then stated he did not have enough staff for all residents to eat at once, but no food was placed in front of a resident until they were able to eat. The facility had tried to have separate dining times, but then things were happening in the other resident areas and staff were unaware because they were in the dining room. Further, it was just easier to supervise everyone in the dining room. CM-B stated there were no nursing assistants in the building who were available to float to the memory care unit to assist. CM-B then stated R73 probably waited because she was patient and did not make noise. CM-B stated he would not want to wait for his meal and residents should be allowed to eat in a reasonable amount of time. During an interview on 12/8/22, at 4:57 p.m. the director of nursing (DON) stated it was the first time she had been informed staff were not able to assist residents with eating in a reasonable amount of time. Meals could be staggered or another alternative could be found to prevent a resident needing to watch others eat for approximately 1.5 hours before eating themselves. The DON further stated eating within a reasonable time upon arrival to the dining room was expected. The facility policy Dining Room Services revised 3/17/21, identified individuals would be provided with nourishing, palatable, attractive meals that met daily and special nutritional needs. Individuals would be provided with services to maintain or improve eating skills. The dining experience would enhance the individual's quality of life and be supportive of the individual's needs	21805		

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21805	Continued From page 13 during dining. The policy directed staff to assist as needed to assure adequate intake of food and fluid at the meal. Individuals would be assisted promptly and in a timely manner after the meal arrived. SUGGESTED METHOD OF CORRECTION: The DON or designee could review/revise policies/procedures for dining room services to ensure dignity was maintained, and educate staff and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days..	21805		

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	245474	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/07/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/07/2022. At the time of this survey, Park View Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/10/2023

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Park View Care Center is a 1-story building with a partial basement. The building was constructed at four different times. The original building was constructed in 1961 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the northeast and was determined to be of Type II(111) construction. In 1979, an addition was constructed to the northwest and was determined to be of Type II(111) construction. In 2007 an addition was added to the southeast of the facility and was	K 000		

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K 000	Continued From page 2 determined to be of Type II(111) construction. All buildings have been surveyed as one. 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 92 beds and had a census of 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=B	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		1/20/23

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K 353	Continued From page 3 Based on observation and staff interview, the facility failed to maintain their sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/07/2022 between 09:00 AM and 12:00 PM, it was revealed by observation that there is a sprinkler head missing an escutcheaon plate in rooms 607 and 618. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 353	K 353 B This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia Sample Site to comply with K 353. To assure continued compliance, the following plan has been put into place: The missing escutcheon plants have been replaced Regarding cited plates: The identified missing escutcheon plates have been replaced. Actions taken to identify other potential missing plates: The facility maintenance staff have audited other rooms and common spaces for any missing escutcheon plates. Measures put in place to ensure deficient practice does not recur: The facility will audit for missing escutcheon plates monthly for 2 months. Effective implementation of actions will be monitored by: The Maintenance Director will monitor the escutcheon plate audits. Results of these audits will be reviewed by the facility QAPI committee and they will make the	

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K 353	Continued From page 4	K 353	decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Maintenance Director, or designee, is responsible for maintain compliance. Completion date for certification purposes only is: 1/20/2023	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 7.2.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/07/2022 between 09:00 AM and 12:00 PM, it was revealed by observation and document review that the K- fire extinguisher was missing monthly inspections from September to November on the tag.	K 355	It is the policy of Cassia Park View to comply with K355. To assure continued compliance, the following plan has been put into place. Regarding cited extinguisher: The identified K-fire extinguisher has had the current monthly inspection completed. Actions taken to identify other potential extinguishers having similar occurrences: All fire extinguishers will be identified on a facility map to ensure that monthly inspections are completed. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are	1/20/23

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K 355	Continued From page 5 An interview with the Environmental Director verified this deficient finding at the time of discovery.	K 355	recommended. Measures put in place to ensure deficient practice does not recur: The Maintenance Director will audit that the monthly inspections completed. Those responsible to maintain compliance will be: The Maintenance Director is responsible for maintain compliance. Completion date for certification purposes only is: 1/20/2023	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility.	K 712	It is the policy of Cassia Park View to comply with K 712. To assure continued compliance, the following plan has been put into place: Measures put in place to ensure deficient	1/20/23

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K 712	Continued From page 6 Findings include: On 12/07/2022 at 09:15AM, it was revealed by a review of available documentation that the following fire drill could not be verified for completion for the evening and night shifts in the 2nd quarter and 3rd quarter of 2022. An interview with the Environmental Director verified this deficient finding at the time of discovery.	K 712	practice does not recur: The A yearly schedule of Fire Drills has been completed and pre-planned including date and times for the upcoming year for all shifts. The facility has the appropriate fire drill documentation sheet to record the drills. Effective implementation of actions will be monitored by: Maintenance Director will audit to fire drills are completed monthly. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Maintenance Director or designee, is responsible for maintain compliance. Completion date for certification purposes only is: 1/20/2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918		1/20/23

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PARK VIEW CARE CENTER	**200 PARK LANE** **BUFFALO, MN 55313**

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K 918	Continued From page 7 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2, and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/07/2022 at 09:30 AM, it was revealed by a	K 918	It is the policy of Cassia Park View to comply with (K 918) To assure continued compliance, the following plan has been put into place: Measures put in place to ensure deficient practice does not recur: The facility has will maintain both weekly and monthly documentation of emergency generator testing. Maintenance staff will be educated on the tools, testing requirements and documentation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 8 review of available emergency generator test and inspection documentation and an interview with the Environmental Director, that the facility could not provide documentation at the time of the survey for weekly emergency generator inspections prior to August 8, 2022. An interview with the Environmental Director verified this deficient findings at the time of discovery.	K 918	Effective implementation of actions will be monitored by: The Director of Maintenance will be responsible for the measures listed above and audit for compliance weekly and submit to the Campus Administrator. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Maintenance is responsible for maintain compliance. Completion date for certification purposes only is: 01/20/2023	