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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DJWK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00719

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245474**

2.STATE VENDOR OR MEDICAID NO.
(L2) **163843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK VIEW CARE**
(L4) **CENTER 200 PARK LANE**
(L5) **BUFFALO, MN** (L6) **55313**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/28/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **124** (L18)

13.Total Certified Beds **124** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	124			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Gary Nederhoff, Unit Supervisor — 05/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 05/29/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 5/19/2014 the facility is certified for 124 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered 5/29/2014

Medicare Provider # 245474

May 29, 2014

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

Dear Ms. Dirks:

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

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

Effective May 19, 2014, the above facility is certified for:

124 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 29, 2014

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

RE: Project Number S5474024 & Complaints Numbered H5474023 & H5474024

Dear Ms. Dirks:

On April 25, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 10, 2014 that included an investigation of complaints numbered H5474023 & H5474024 which were determined unsubstantiated. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 28, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 19, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 10, 2014, effective May 19, 2014 and therefore remedies outlined in our letter to you dated April 25, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245474	A. Building B. Wing	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
PARK VIEW CARE CENTER	200 PARK LANE BUFFALO, MN 55313

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0309** Reg. # **483.25** LSC	**05/19/2014**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	**05/19/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KJ	05/29/2014	10160	05/28/2014
CMS RO				

Followup to Survey Completed on: 4/10/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245474	A. Building B. Wing 01 - MAIN BUILDING 01	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
PARK VIEW CARE CENTER	200 PARK LANE BUFFALO, MN 55313

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	05/19/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/KJ	05/29/2014	27200	05/28/2014
Reviewed By CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/8/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245474	A. Building B. Wing 02 - CHAPEL	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
PARK VIEW CARE CENTER	200 PARK LANE BUFFALO, MN 55313

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 05/19/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KJ	Date: 05/29/2014	Signature of Surveyor: 27200	Date: 05/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/8/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DJWK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00719

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245474**

2.STATE VENDOR OR MEDICAID NO.
(L2) **163843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK VIEW CARE CENTER**
(L4) **200 PARK LANE**
(L5) **BUFFALO, MN** (L6) **55313**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/10/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **124** (L18)

13.Total Certified Beds **124** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	124			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Annette Truebenbach, HFE NE II — 05/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/04/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed 04/10/14, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. Complaints numbered H5474023 & H5474024 were found to be unsubstantiated. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 25, 2014

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

RE: Project Number S5474024

Dear Ms. Dirks:

On April 10, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the April 10, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5474024. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 20, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 10, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 10, 2014 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
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Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Division of Compliance Monitoring
Telephone: Fax:

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING _____ B. WING _____	04/10/2014

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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaints H5474023 and H5474024 was completed and neither of the two complaints were substantiated.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor skin conditions	F 309	F309: Provide Care/Services for Highest Well Being	5/19/14

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

Electronically Signed | 04/30/2014

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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F 309	Continued From page 1 for healing or need for a change in treatment for 1 of 1 resident (R2) who was frequently incontinent of urine and experienced skin breakdown of the groin area. Findings include: R2 was observed on 4/10/14 to have a reddened scrotum area that was painful and had been treated for approximately one month according to interview with nursing assistant (NA)-A on 4/10/14. There was no skin assessment completed after the development of the reddened and painful scrotum to determine what interventions should have been developed based on the assessment and after one month the Zinc cream was not assessed if it was an effective treatment or if another treatment was warranted. R2's most current diagnoses, according to the significant change Minimum Data Set (MDS)(an assessment of the residents current health needs), dated 1/30/14, revealed congestive heart failure, neurogenic bladder and diabetes mellitus. The MDS identified R2 as frequently incontinent of bladder, extensive assistance of two staff for transfers and toileting and a brief interview for mental status (BIMS) score of 15 which is cognitively intact. Also R2 was admitted to the facility over ten years ago. R2's care plan for skin, dated 12/09/08 listed the resident at risk for skin breakdown related to urinary incontinence. However, the care plan did not identify any interventions addressing the reddened and painful area on the scrotum. The nursing assistant care sheet, undated also did not identify any interventions to address scrotum skin breakdown related to incontinence. R2's	F 309	It has been and remains the policy of Park View Care Center to provide residents the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Regarding cited resident R2 (skin breakdown due to incontinence): The attending physician met with resident R2 on 4-15, examined his perineal area & discussed the risks of R2 not promptly alerting staff of toileting needs, refusal of scheduled toileting or need to change incontinent brief (skin breakdown, pain/discomfort). R2□s care plan & NA/R work list have been updated with R2□s agreed upon scheduled toileting plan based on the Unit Manager□s assessment. NA/R staff is to alert nurse if R2 is refusing toileting or perineal care. Refusals of incontinent care will be documented. Nurse to check perineal/scrotal area daily for redness & report to M.D. if no improvement with current orders or R2□s continued non-compliance with toileting program. Unit Manager will review licensed staff skin assessment notes done with R2□s weekly bath to coordinate needed changes in care/treatment. Unit Manager will continue to meet weekly with R2 to discuss any concerns he has with his care/treatment.	

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F 309	Continued From page 2 significant change in status skin note assessment note, dated 1/30/14 did not address the risk of skin breakdown related to R2's frequent incontinence of urine. R2's nursing progress notes included: On 4/05/14, at 7:24 a.m., Resident (R2) was in pain this shift from his shoulder and also mainly his scrotal area. Scrotal area pain is caused by his increase in lasix (a diuretic medication) he says and from incontinence. R2 was given tylenol 650 mg at 00:15 (12:15 a.m.), then when not effective was given oxycodone (a narcotic pain medication) 5 mg at 01:00 (1:00 a.m.) Resident again called at 04:00 (4:00 a.m.) and wanted another oxycodone and this was given to him at 05:00 (5:00 a.m.). On 4/02/14, at 7:12 a.m., Resident (R2) requested zinc to be applied to his scrotum for irritation. During interview on 4/9/14, at 11:34 a.m., family (F)-A said R2 was sore in the scrotal area and staff was applying zinc oxide on it. F-A then said that R2 was toileted only when the call light was pushed. Observations of R2's cares on 4/10/14, at 8:30 a.m., revealed R2's call light being answered by nursing assistant (NA)-A. RN-B came in the room at 8:32 a.m. to help with the transfer of R2 into the wheelchair. R2 sat up using his right arm to grab the bed railing, and swung to a sitting position. RN-B wheeled over a standing lift, and NA-A secured the lift harness about R2's waist and staff raised R2 up in the stand. While R2 was standing, NA-A removed the incontinent brief which she confirmed was soiled with urine. NA-A	F 309	Actions taken to identify other potential residents having similar occurrences (prioritization): Each Unit Manager/nurse designee will assess the perineal area of each current incontinent resident on their respective unit to assure that any skin issues found have the appropriate treatment plan in place. Care plans will be updated as warranted by assessment. Prioritization of audits: 1. Resident R2 2. Current residents with known incontinence 3. New admissions with incontinence Measures put into place to ensure deficient practice does not reoccur: 1. Staff Education: Licensed & NA/R staff education will be provided by May 19,2014 regarding-facility incontinence care policy & procedures, prompt reporting of skin concerns to licensed staff, toileting programs & prompt F/U to M.D. for warranted treatment changes. 2. Each Unit Manager/nurse designee will assess the perineal area of each current incontinent resident on their respective unit to assure that any skin issues found have the appropriate	

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F 309	Continued From page 3 cleaned R2's perineal area and then grabbed a cup of white paste which she stated was zinc oxide which she applied to R2's scrotum. The scrotum was observed to be reddened but no open areas. R2 repeatedly stated, " Ouch, it's sore" as the cream was applied. NA-A confirmed resident's bottom was usually sore with the cream application. R2 was assisted into their wheelchair. During interview on 4/10/14, at 10:20 a.m., registered nurse (RN)-B said R2 was currently toileted per his request and had a history of refusal when on a toileting programs. Surveyor inquired about the use of zinc oxide on R2's scrotum. RN-B said she was unaware of the soreness until it was brought to her attention during this interview. RN-B said aides ask the nurse for the cream and then they apply as needed. The treatment for skin redness and use of the cream is on written on the facility standing orders. RN-B went on to say that the Nurses may not chart this type of treatment on the treatment sheet as was the case for R2. On further interview concerning assessment of redden skin and effectiveness of the Zinc Oxide RN-B confirmed the zinc oxide was not on the treatment sheet nor was the reddened skin area on scrotum assessed to determine if the Zinc Oxide was effective in treating the reddened area. During interview on 4/10/14, at 10:42, the DON said the zinc barrier cream was on the standing orders for wound care, and would be applied by the NA after cleansing. Barrier creams were not necessarily on the treatment plan, as there would not necessarily be any specific charting on the skin rash other than the weekly skin/shower day documentation.	F 309	treatment plan in place. Care plans will be updated as warranted by assessment. 3. The Unit Manager is responsible to coordinate & keep updated each incontinent resident□s care plan & NA/R work list to reflect the type of toileting program established for each resident & any treatment interventions related to perineal skin care needs. 4. Each of the four Unit Managers/designees is to conduct weekly for at least the next six months, one random visualization check of an incontinent resident□s perineal area to identify & F/U on care need changes. This is a total of 4 random audits per week. Effective Implementation of actions will be monitored by: 1. Licensed staff, Unit Manager & Staff Development Coordinator will monitor staff compliance & resident care need changes through random observations of perineal cares provided by NA/R staff. 2. For the next 90 days or longer per QA committee recommendation, the Staff Development Coordinator will conduct random perineal care audits, provide instruction as needed with NA/R staff & provide audit results to the QA committee.	

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F 309	Continued From page 4 During interview on 4/10/14, at 11:22 a.m. NA-A said R2 had been having zinc oxide applied to the scrotum due to irritation for about a month. Review of the nursing progress notes including weekly skin documentation for R2 over the last month did not reveal any documentation or monitoring of R2's reddened scrotum, to determine if the condition was improving or if a change in treatment would be required.	F 309	Those responsible to maintain compliance are: 1. Licensed staff, Unit Manager, Staff Development Coordinator. 2. The Director of Nursing will monitor to assure audit completion, staff re-instruction & compliance with facility policy & procedures are followed. 3. The Quality Assurance Committee, through review of the audit reports submitted by the Staff Development Coordinator.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate dental services were provided or offered related to broken dentures for 1 of 2 residents (R38) reviewed for dental services. Findings include:	F 412	F412: Routine/Emergency Dental Services It has been and remains the policy of Park View Care Center to obtain from an outside resource, routine and emergency dental services for our residents (to the	5/19/14

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F 412	Continued From page 5 R38 was admitted to the facility on 8/15/12, with diagnoses that included dementia, reflux, anxiety, behavior disturbance and delusions. R38's annual minimum data set (MDS), dated 7/31/13, indicated R38 had no natural teeth or tooth fragments. R38 required supervision with eating and extensive assistance with personal hygiene, including teeth. R38's quarterly MDS, dated 1/17/14, indicated R38 was severely cognitively impaired. R38's care plan, dated 8/15/12, directed staff to "Cue resident to wash face, comb hair, brush teeth...Staff assist with what resident is unable to complete." A review of the Admission Inventory Of Valuables, dated 8/15/12, indicated R38 had upper and lower dentures on admission to the facility. A review of the work list that nursing assistants (NA) use to direct the care they provide to the residents, indicated R38 had upper and lower dentures. During a telephone interview on 4/7/14, at 7:50 p.m., R38's family member indicated R38 had a full upper denture and a broken bottom denture. R38's family member indicated the house dentist would be coming to the facility to look at the broken dentures "soon." R38's family member stated R38 eats soft food so "does okay" with the upper denture, but indicated the lower denture would be fixed. During an interview on 4/8/14, at 1:07 p.m., health unit coordinator (HUC)-B indicated the house	F 412	extent covered under the state plan). Regarding cited resident R38 (Broken Dentures): R38□s son, Andy, attended her care conference on 4-15-14 & stated that he did not wish to have lower dentures replaced as R38 is consuming her meals without difficulty. He is aware that she frequently hides dentures, refuses to remove dentures @ night & has dropped the dentures causing breakage in the past. R38□s care plan & NA/R work list have been updated for NA/R to only have her upper dentures in for meal times, then removed, cleaned & put in denture cup in room. Actions taken to identify other potential residents having similar occurrences (prioritization) Each Unit Manager/designee will assess residents with known oral prosthetics to assure they are present, being used & assess for any oral care needs. If needs are identified, the resident□s family will be notified & resident scheduled for F/U dental care services. Care plan & NA/R work list to be updated for residents with oral prosthetics. Prioritization of audits: " R38 " Current residents with oral prosthetics " New admissions with oral prosthetics Measures put into place to ensure	

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F 412	Continued From page 6 dentist was scheduled to come at the end of the week but, when she checked the house dentist's schedule, R38 was not on the list. HUC-B stated the house dentist would make another visit at the end of the month, but was unsure of that schedule at this time. During an observation on 4/9/14, at 7:20 a.m., R38 was in the dining room, eating breakfast. R38 was independently eating oatmeal, and ate most of the oatmeal without difficulty. R38 did not respond to questions asked. R38 was observed to not have lower denture in mouth. During an observation on 4/10/14, at 7:36 a.m., R38 was eating scrambled eggs and a banana. Again, R38 ate most of the breakfast meal without difficulty. R38's lower denture was not in her mouth. During an interview on 4/10/14, at 8:05 a.m., unit manager (UM)-C stated she was aware that R38 often takes out her dentures or refuses to put them in but was unsure of her dental status because HUC-B and medical records (MR)-D take care of the residents' dental needs. During an interview on 4/10/14, at 8:15 a.m., HUC-B indicated that she couldn't recall what had happened in the past with R38's dental situation. During an interview on 4/10/14, at 8:26 a.m., MR-D indicated R38 saw the dental hygienist on 8/2/13 for an annual visit. A review of the documentation from this visit indicated R38 had full upper denture and no lower denture. During an interview and observation of R38's room on 4/10/14, at 8:35 a.m., UM-C indicated	F 412	deficient practice does not reoccur: " Oral prosthetics will be listed on the NA/R work list & resident□s care plan. Individual issues regarding the oral prosthetics & care will be individualized in the care plan. " Nursing staff will be re-educated on the policy & procedure for prompt reporting, documentation & F/U family notification of dental concerns or broken oral prosthetics & F/U treatment interventions. " The Health Information Coordinator (facility□s dental care liaison) will coordinate timely F/U dental services for identified needs. " The Unit manager is responsible to keep the resident□s care plan updated with needed changes & to conduct weekly @ least 1 random visual oral care audit for presence of oral prosthetics or oral care needs & F/U on identified needs. Effective Implementation will be monitored by: " Licensed staff & Unit Manager will monitor staff compliance & resident oral care needs through random observation of oral cares & presence of oral care prosthetics @ meals. " The Unit Manager will conduct random oral care visualization audits, complete the Dental Concern form when care is needed & give completed Concern Form to the facility□s dental liaison (HIC) for F/U dental services. " For the next 90 days or longer per Quality Assurance committee	

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F 412	Continued From page 7 she was not able to locate R38's lower denture. UM-C stated she talked to the NA's that routinely care for R38, and "they vaguely remember her dropping her lower dentures and breaking them." UM-C stated she would have to go back in R38's charting to find that. UM-C indicated that maybe the denture was taken to be fixed and never returned, but she didn't know. During an interview on 4/10/14, at 1:00 p.m., trained medication assistant (TMA)-A stated, "It's been at least 6 months ago since I remember her [R38] having her bottom denture. It would disappear and then we'd find it." TMA-A indicated she remembers the bottom denture "getting dropped and broke in half" but doesn't recall what happened after that. During a follow-up telephone conversation on 4/10/14, at 1:05 p.m., R38's family member indicated 6 or 7 months ago, the bottom denture was missing and it was found, and then remembers that it got broken. R38's family member stated, "She had a check up a while back and I assumed they were going to fix it." R38's family member was not aware that the staff was not able to locate the bottom denture. R38's family member indicated the bottom denture should be fixed, stating "It would be different if she was on a liquid diet but as far as I know, she's still eating pancakes. There's no sense having her grind on gums." A review of the facility's policy titled, Dental Services, included, "To provide dental services to all residents...4. To provide emergency dental service as it becomes necessary..." No further information was provided.	F 412	recommendation, audit results will be reviewed by the QA committee. Those responsible to maintain compliance are: " Licensed staff &Unit Manager. " The Director of Nursing will monitor to assure audit completion, staff re-instruction & compliance with facility policy & procedures. " The Quality Assurance Committee, through review of the audit reports submitted will provide oversight & direction.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Park View Care Center - Chaple addition was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/30/2014

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Facility was inspected as two buildings: Park View Care Center's Chapel addition in 2007 is a 1 story addition added to the southeast of the facility and was determined to by of type II (111) construction and meets the construction type allowed for a new building. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 124 and had a census of 120 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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	245474	A. BUILDING **02 - CHAPEL** B. WING _____	**04/08/2014**

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
K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect 120 of 120 residents, visitors and staff of the facility. Findings include: On facility tour between 9:00 AM to 1:00 PM on 04/08/2014, observations reveled that the spare	K 056	The required number of sprinkler heads have been ordered and will be kept in storage. The Director of Environmental Services is responsible for periodic inspections to be sure that the required sprinkler heads are available when needed.	5/19/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING **02 - CHAPEL** B. WING _____	**04/08/2014**

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
K 056	Continued From page 3 sprinkler head boxlocated next to the main sprinkler riser assemble was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the elevated temperature heads that are located in both the northwest and the southwest elevator equipment rooms, and the type of sprinkler head that is located in the storage room across from the sprinkler riser. This was confirmed by the Environmental Services Director (UP).	K 056		

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 _____	**04/08/2014**

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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Park View Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/30/2014

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.

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 _____	**04/08/2014**

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
K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Facility was inspected as two buildings: Park View Care Center is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1961 and was determined to be of . Type II(111) construction. In 1968, an addition was constructed to the northeast and was determined to be of Type II(111) construction. In 1979, an addition was constructed to the northwest and was determined to be of Type II(111) construction. In 2007 an addition was added to the southeast of the facility and was determined to by of type II (111) construction Because the original building and the 2 of the additions meet the construction type allowed for existing buildings and 1 addition for the construction type allowed for new building the facility was inspected as two buildings. The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the	K 000		

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 _____	**04/08/2014**

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
K 000	Continued From page 2 corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 124 and had a census of 120 at the time of the survey.	K 000		
K 056 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that	K 056	The required number of sprinkler heads have been ordered and will be keep in storage. The Director of Environmental Services is responsible for periodic inspections to make sure that the required sprinkler heads are always available when needed.	5/19/14

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 _____	**04/08/2014**

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
K 056	Continued From page 3 would affect 120 of 120 residents, visitors and staff of the facility. Findings include: On facility tour between 9:00 AM to 1:00 PM on 04/08/2014, observations reveled that the spare sprinkler head boxlocated next to the main sprinkler riser assemble was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the elevated temperature heads that are located in both the northwest and the southwest elevator equipment rooms, and the type of sprinkler head that is located in the storage room across from the sprinkler riser. This was confirmed by the Environmental Services Director (UP).	K 056		