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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DYL7

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: **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 **06/06/2016** (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 **123** (L18)

13.Total Certified Beds **123** (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
	123			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 06/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 07/01/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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.
00803
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/29/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245474
July 1, 2016

Ms. Annette Greely, Administrator
Park View Care Center
200 Park Lane
Buffalo, Minnesota 55313

Dear Ms. Greely:

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 9, 2016 the above facility is certified for or recommended for:

123 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 123 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2016

Ms. Annette Greely, Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: Project Number S5474026

Dear Ms. Greely:

On May 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 21, 2016. 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 June 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 17, 2016 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 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 9, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 21, 2016, effective May 9, 2016 and therefore remedies outlined in our letter to you dated May 2, 2016, 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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245474 (Y1)	A. Building B. Wing (Y2)	6/6/2016 (Y3)

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 05/09/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 05/09/2016	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 (INITIALS)** BF/kfd	**DATE** 6/14/2016	**SIGNATURE OF SURVEYOR** 10562	**DATE** 6/6/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 4/21/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245474	A. Building 01 - MAIN BUILDING 01 B. Wing	5/17/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 05/09/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 04/30/2016	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 (INITIALS) TL/kfd	DATE 6/14/2016	SIGNATURE OF SURVEYOR 34764	DATE 5/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/21/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245474	A. Building 02 - CHAPEL B. Wing	5/17/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 05/09/2016	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 (INITIALS) TL/kfd	DATE 6/14/2016	SIGNATURE OF SURVEYOR 34764	DATE 5/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/21/2016	☐ 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: DYL7

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 **04/21/2016** (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 **123** (L18)

13.Total Certified Beds **123** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	123			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Annette Truebenbach, HFE NE II 05/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/11/2016 (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.
00803
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 2, 2016

Ms. Annette Greely, Administrator
Park View Care Center
200 Park Lane
Buffalo, Minnesota 55313

RE: Project Number S5474026

Dear Ms. Greely:

On April 21, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 31, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 31, 2016 the following remedy will be imposed:

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

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.

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 21, 2016 (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 21, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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 electronic 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. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING _____ B. WING _____	04/21/2016

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.	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure shaving assistance was provided for 1 of 3 residents (R179) reviewed for activities of daily living and who were dependant on staff for care. Findings include: R179's quarterly Minimum Data Set (MDS) dated 4/15/16, indicated R179 had severe cognitive impairment and required extensive assistance from staff with personal hygiene.	F 312	It has been and remains the policy of Park View Care Center to assure that a resident who is unable or needs extensive or total assistance with personal facial hair care hygiene, receives the assistance needed from facility staff. Regarding cited resident #R179: R179 had her facial hair removed 4-21-16 and now has own personal razor for use. Actions taken to identify other potential	5/9/16

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

Electronically Signed | 05/09/2016

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F 312	Continued From page 1 R179's care plan dated 4/19/16, indicated R179 required extensive staff assistance with grooming. During observation on 4/18/16, at 11:56 a.m. R179 was seated in the dining room and was observed to have several, long white facial hairs on her lower. During follow up observations of R179 on 4/19/16, at 9:49 a.m. and 4/20/16, at 3:17 p.m., R179 continued to have several, long white facial hairs on her lower chin. During interview on 4/19/16, at 9:49 a.m. R179 stated the facial hair on her lower chin bothered her and, "Makes me feel terrible," and she wished staff would help her remove it because she couldn't do it herself. When interviewed on 4/20/16, at 1:33 p.m. trained medical aide (TMA)-A stated she had observed R179 to have facial hair in the past, however, the resident didn't have a razor, and the resident were responsible to supply their own razor at the facility as they did not have a community razor for all the residents to use. During interview on 4/20/16, at 2:04 p.m. registered nurse (RN)-A stated R179 required staff assistance to complete her grooming. RN-A had observed R179 with facial hair, however, RN-A was unaware what steps were being taken to ensure R179 would be provided assistance to remove the facial hair. An undated facility Facial Hair Care policy indicated, "Removal of facial hair is to be	F 312	facility residents having similar compliance concerns: a. an audit was completed 4-29-16 for all current residents of Park view Care Center regarding both facial hair care needs and individual resident razor availability/need. b. Social Services contacted individual resident family members regarding the need for a razor for identified residents without a razor having facial hair care needs. c. Prospective residents admissions/family members will receive information in their resident admissions packet regarding the need for individual razors for residents with facial hair care needs. d. A supply of disposable electric razors will be available in the facility for purchase by residents/family members to assure that facial hair care can be provided. Prioritization of audits: Resident #179 Current residents New resident admissions Measures put into place to ensure deficient practice does not reoccur: a. Staff Education: Nursing department staff education has been provided regarding the facility's facial hair care policy and procedure which has been updated to include the purchase/availability of disposable electric	

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F 312	Continued From page 2 assessed for all female residents on their regularly scheduled bath day ... In addition to bath day, facial hair is to be removed whenever it is noticeable (for some residents, this may be daily)."	F 312	razors for purchase. b. Licensed staff and unit managers will be instructed to monitor staff compliance throughout each shift and to address and assure follow up for any identified facial hair care need that shift. Effective Implementation of actions will be monitored by: a. Licensed staff and unit managers will monitor resident's facial hair care needs and compliance through daily observations during medication pass and dining times. The above auditors identifies care needs will be communicated to nursing staff for follow up care that shift. b. For the next 90 days or longer , per QAPI committee recommendations the unit manager for each nursing unit, evening supervisor and staff development coordinator will conduct and document at least weekly walk through observation audit to identify facial hair car need, assistance need and coordinate follow up care by nursing staff. The audit results will be presented to QAPI committee. Those responsible to maintain compliance are: a. Licensed staff, unit managers, evening supervisor and staff development/ infection control practitioner. b. the Director of Nursing will monitor to assure audit completion, staff re-instruction and compliance with facility policy and procedure. c. The QAPI committee through review of the audit reports submitted.	

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess the safe use of a mattress which did not properly fit the bed frame for 1 of 1 residents (R9) reviewed for accidents and hazards related to the large gap between the mattress and headboard. Findings include: R9's quarterly Minimal Data Set (MDS), dated 1/25/16, identified R9 was cognitively intact. The last annual MDS dated 5/1/15, indicated R9 was at risk for falls due to unsteadiness during transfers, and had diagnosis including Parkinson's disease, dementia with lewy bodies, and delusional disorder. R9's care plan dated 5/9/14, indicated, "Falls: Resident is at risk for falls related to weakness from Parkinson's with Lewy's bodies dementia OA [osteoarthritis] PVD [peripheral vascular disease] PAD [peripheral arterial disease] and lower body contractures; and requires assistance with transfers..." and "Psychotropic: Antipsychotic: Resident receives Seroquel [Antipsychotic medication] medication r/t [related to] diagnosis of	F 323	F323 Entrapment Risk Plan of Corrections Regarding cited resident R9: A spacer was created immediately to correct the gap issue. Per policy: Prevention of entrapment will include: a. Nursing and housekeeping will monitor mattresses for spaces larger than 4inches on sides, top and bottom of beds. b. Mattresses found out of compliance needs to be reported to Environmental Services for correction. c. New mattresses coming into the facility will be accessed by Environmental services before resident goes on the bed. Actions to be taken to identify other potential facility residents having similar concerns: a All housekeeping and nursing staff will monitor all mattresses for spaces more than 4 inches on mattresses. b. QAPI will review any concerns and	5/9/16

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F 323	Continued From page 4 delusions that are scary to resident." The care plan also included diagnosis of, "Memory deficit" directing staff to "Provide cues or reminders as needed." The care plan further noted on 1/5/16, R9's "Daughter has purchased a mattress for resident. Daughter to address any resident concerns and care related to mattress." On 4/19/16, at 9:30 a.m., R9 was observed lying on her right side in bed and was observed to have tremors to all extremities causing full body shaking while lying in bed. At that time, the head of the bed was slightly raised and a large gap, approximately 8" (inches), was noted between the end of R9's mattress and head board. During interview on 4/21/16, at 8:55 a.m., R9 stated she disliked the mattress and stated the mattress was far away from the head of the bed and stated, "They should make it [the mattress] so its a bed that fits." On 4/21/16, at 9:15 a.m., nursing assistant (NA)-A stated she had noticed the gap at the head of the bed between the mattress and the headboard, and she stated R9 always wanted the mattress pushed down to the foot of the bed which created a gap at the head. NA-A stated staff had been provided education on potential entrapment for residents related to side rails and gaps in the mattress, however, NA-A did not have concerns about R9 becoming entrapped in the gap. NA-A stated R9 required one staff to assist her into bed and was pretty independent once in bed with bed mobility, however, R9 did self-transfer without staff even though the resident was supposed to wait for staff assistance.	F 323	follow up for 90 days to ensure safety. Staff Education: a. Policy will be implemented in all communication books for nursing and housekeeping.	

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F 323	Continued From page 5	F 323		

During interview on 4/21/16, at 12:52 p.m. registered nurse (RN)-B stated the gap between the head board and mattress was just over 7", the gap between the end of the bed frame and mattress was about 5 1/2", and, with the head of the bed raised approximately 20 degrees, the gap between the headboard and mattress increased to 9". RN-B stated the mattress had been discussed during a care conference, and the family took responsibility for mattress maintenance, and did not have any concerns regarding entrapment because R9 was alert and oriented. RN-B stated maintenance was responsible for completing the entrapment assessment for the gap, while nursing completed entrapment assessments related to side rails.

On 4/21/16, at 1:30 p.m., the environmental director stated maintenance was not involved in assessing the mattress for resident safety.

During interview on 4/21/16, at 1:53 p.m. the administrator stated the expectation was for the facility's management and nursing to work together to assess the gap for entrapment risk, as well as to come up with a solution that wouldn't create a risk for the resident to get caught in the gap.

The U.S. Department of Health and Human Services Food and Drug Administration (FDA) guidance for Bed System Dimensional Assessment and Guidance to Reduce Entrapment, issued 3/10/06, defined vulnerable patients as those who have problems with memory, sleeping, incontinence, pain, or uncontrolled body movements, or those who get out of bed unsafely without assistance. Zone 7 identifies the area between the head board and

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F 323	Continued From page 6 mattress end as a potential zone of entrapment. The FDA guidelines recommended gaps within a bed system be less than 4 3/4" to reduce the risk of head entrapment. A policy on mattress safety/ entrapment was requested but not provided.	F 323		

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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 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 email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2016

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 <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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	K 000		

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K 000	Continued From page 2 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 123 and had a census of 119 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: On facility tour between 8 AM to 12:00 PM on 04/21/2016, during the review of all available documentation for the emergency generator, revealed the facility did not document the required cool down for the emergency generator. This deficient practices was confirmed by the Enviromental Manager (UP).	K 144	K144 - Documentation is now added to emergency generator log for the required cool down. This was completed on May 2, 2016. Monitoring: Facility Manager is responsible for correction and monitoring to prevent a reoccurrence of non compliance.	5/9/16
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	K 147		5/9/16

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K 147	Continued From page 3 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Findings include: On facility tour between 8 AM to 12:00 PM on 04/21/2016, revealed the following: 1) A multi-plug adapter in use in the laundry room plugging in a washing machine and other appliances, 2) A Microwave was not plugged into direct power, 3) All toasters were not being cleaned according to manufactures recommendations. This deficient practices was confirmed by the Enviromental Manager (UP).	K 147	K147 - Laundry washing machine is now plugged directly into the outlet. Microwave is now plugged directly into the outlet. Completion date for corrections May 2, 2016. Monitoring: Facility Manager will be responsible for correction of monitoring of compliance.	