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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ETL2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00406

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245553**
2.STATE VENDOR OR MEDICAID NO.
(L2) **104740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW MANOR NURSING HOME**
(L4) **308 SHERMAN AVENUE**
(L5) **ELLSWORTH, MN** (L6) **56129**

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 **02/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(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 :
Kathryn Serie, Unit Supervisor 02/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/06/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(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
01/28/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245553

March 6, 2015

Mr. Michael Werner, Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, Minnesota 56129

Dear Mr. Werner:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective January 23, 2015 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 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,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

February 12, 2015

Mr. Michael Werner, Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, Minnesota 56129

RE: Project Number S5553025

Dear Mr. Werner:

On December 31, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 18, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On February 12, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 9, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 23, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 18, 2014, effective January 23, 2015 and therefore remedies outlined in our letter to you dated December 31, 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,

Kamala Fike-Downing

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

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
245553	A. Building B. Wing	2/12/2015

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **01/23/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **01/23/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/23/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/23/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **01/23/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	02/12/2015	03048	02/12/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/18/2014

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
245553	A. Building 01 - MAIN BUILDING 01 B. Wing	2/9/2015

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **01/23/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	02/12/2015	19251	02/09/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/17/2014

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: ETL2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00406

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245553**

2.STATE VENDOR OR MEDICAID NO.(L2) **104740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW MANOR NURSING HOME**
(L4) **308 SHERMAN AVENUE**
(L5) **ELLSWORTH, MN** (L6) **56129**

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 **12/18/2014** (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 **37** (L18)

13.Total Certified Beds **37** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(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 :
Joseph Garvey, HFE NE II 01/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 31, 2014

Mr. Michael Werner, Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, Minnesota 56129

RE: Project Number S5553025

Dear Mr. Werner:

On December 18, 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. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 27, 2015, 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 December 18, 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 March 18, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING _____ B. WING _____	12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	**308 SHERMAN AVENUE ELLSWORTH, MN 56129**

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		1/23/15

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

Electronically Signed | 01/07/2015

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

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	245553	A. BUILDING _____ B. WING _____	12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	**308 SHERMAN AVENUE ELLSWORTH, MN 56129**

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to investigate and report potential neglect or abuse for 1 of 1 resident (R19) in the sample who had experienced an unwitnessed fall with significant injury. Findings include: An incident/accident report dated 7/5/14, indicated R19 had a fall at 10:45 p.m. where staff noted R19 to be on the floor next to her bed in her room with an alarm sounding. R19's left hip and left leg were noted to be rotated out and that left leg was noted shorter than right leg. R19 was transferred to the hospital and diagnosed with a fractured left hip. A nursing note dated 6/5/14 transcribed by licensed practical nurse (LPN)-B, indicated R19 received extensive assistance of one staff for transfers and ambulation. A nursing note from LPN-B, dated 6/24/14 at 6:10 a.m., indicated staff discovered R19 on the floor in her room and that R19 did not remember how the fall happened or	F 225	1. The system for VA reporting is in place with the initial complaint forms, internal investigation forms, and how to report and where. Incident reports are reviewed by the Administrator and Director of Nurses. Any fall that meets criteria of injury of unknown source will immediately be reported to the county and state. The Safety committee reviews all incident reports and safety committee findings are reviewed at Quarterly QA meetings. The incident was not thought to be of suspicious nature by the administrator and safety committee; but, the findings were not fully documented. A systematic change to fully document investigations will be done. The incident report will be changed to fully address the documentation of falls that are suspicious in nature; and, more specifically what the resident's response to an incident was, if	

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F 225	Continued From page 2 why she (R19) had gotten up by herself. A nursing note written by (LPN)-A at 2:00 p.m. on 7/1/14, indicated R19 was confused and had tried to get up numerous times to walk. R19's interdisciplinary care plan dated 6/2014 indicated in the problem/need area that R19 had dementia and depression. R19's care plan further indicated R19 was vulnerable and susceptible to abuse related to her inability to care for self and need for assist with transfers and ambulation. R19's quarterly Minimum Data Set (MDS) assessment, dated 6/28/14, indicated R19 had falls since admission or the prior assessment and had moderate cognitive impairment. R19 required extensive assistance of one staff for transfers and ambulation in her room. The MDS further indicated R19 was not steady and was only able to stabilize with staff assistance while moving from seated to standing position, walking, turning around and facing the opposite direction. The MDS also identified R19 needed staff assistance with moving on and off the toilet. A previous Care Area Assessment (CAA) related to falls dated 1/15/14, indicated R19 was at high risk for falls and had a history of falls. Internal risk factors identified for R19 included: decline in functional status, incontinence, cognitive impairment and impaired balance during transfers. Review of a Post-Fall assessment completed for R19 dated 7/5/14, indicated R19 had a history of falls and that the director of nursing (DON) had reviewed the fall and determined the root cause was lower extremity weakness and increasing confusion. During interview with the DON at 2:06 p.m., on 12/18/14, she stated she did not recall R19's transfer or ambulation status prior to the fall, or	F 225	any. The incident report will address if an internal investigation is necessary. 2. All incident reports will be reviewed for injuries of unknown origin. Any fall that meets criteria of injury of unknown source will immediately be reported to the county and State. If additional documentation other than root cause of fall is needed, the results of the investigation will be documented. 3. The incident report will be changed to systematically document if internal investigation is necessary. Licensed staff will be inserviced to assure understanding of injury of unknown source. The VA plan addresses the steps to be taken. Any fall that meets criteria of injury of unknown source will immediately be reported to the county and state. 4. The Administrator and the Director of Nurses will ensure that incident report forms are completed to ensure that investigations are documented. 5. The Administrator will monitor to assure the plan is sustained.	

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F 225	Continued From page 3 whether R19 had been able to state to staff how the fall on 7/5/14 had occurred. The administrator was interviewed at 1:28 p.m. on 12/18/14, and stated R19 had been experiencing confusion prior to the fall, and a Tabs alarm (an alarm attached to a resident's clothing that sounds when the resident attempts to get up) had been placed on R19. The administrator verified MDH had not been notified regarding the fall R19 had experienced on 7/5/14. The facility's Vulnerable Adult Protection Plan dated 11/10/14, included: "Injuries of Unknown Source: An injury that meets both of the following conditions: 1. as the source of the injury was not observed by any person or the source of the injury could not be reasonably explained by the resident, AND 2. the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. This includes an injury to a resident resulting in bruising, fractures, skin tears, lacerations, welts, etc." The policy also included directions for staff, "If staff become aware of a situation or incident where police, emergency medical services or protective services should be involved ASAP (as soon as possible), the facility should call 911 first, then report to MDH immediately."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		1/23/15

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F 226	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow their Abuse Prevention policy to report an incident of unknown origin promptly to the State agency, Minnesota Department of Health (MDH) for 1 of 1 resident (R19) who experienced a significant injury as a result of an unwitnessed fall. Findings include: The facility's Vulnerable Adult Protection Plan dated 11/10/14, included: "Injuries of Unknown Source: An injury that meets both of the following conditions: 1. as the source of the injury was not observed by any person or the source of the injury could not be reasonably explained by the resident, AND 2. the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. This includes an injury to a resident resulting in bruising, fractures, skin tears, lacerations, welts, etc." The policy also included directions for staff, "If staff become aware of a situation or incident where police, emergency medical services or protective services should be involved ASAP (as soon as possible), the facility should call 911 first, then report to MDH immediately. An incident/accident report dated 7/5/14, indicated R19 had a fall at 10:45 p.m. where staff noted R19 to be on the floor next to her bed in her room with an alarm sounding. R19's left hip and left leg were noted to be rotated out and that left leg was noted shorter than right leg. R19 was transferred to the hospital and diagnosed with a fractured left hip. A nursing note dated 6/5/14 transcribed by	F 226	1. The system for VA reporting is in place with the initial complaint forms, internal investigation forms, and how to report and where. Incident reports are reviewed by the Administrator and Director of Nurses. Any fall that meets criteria of injury of unknown source will immediately be reported to the county and state. The Safety committee reviews all incident reports and safety committee findings are reviewed at Quarterly QA meetings. The incident was not thought to be of suspicious nature by the administrator and safety committee; but, the findings were not fully documented. A systematic change to fully document investigations will be done. The incident report will be changed to fully address the documentation of falls that are suspicious in nature; and, more specifically what the resident's response to an incident was, if any. The incident report will address if an internal investigation is necessary. 2. All incident reports will be reviewed for injuries of unknown origin. Any fall that meets criteria of injury of unknown source will immediately be reported to the county and State. If additional documentation other than root cause of fall is needed, the results of the investigation will be documented. 3. The incident report will be changed to systematically document if internal investigation is necessary. Licensed staff will be inserviced to assure understanding of injury of unknown source. The VA plan	

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F 226	Continued From page 5 licensed practical nurse (LPN)-B, indicated R19 received extensive assistance of one staff for transfers and ambulation. A nursing note from LPN-B, dated 6/24/14 at 6:10 a.m., indicated staff discovered R19 on the floor in her room and that R19 did not remember how the fall happened or why she (R19) had gotten up by herself. A nursing note written by (LPN)-A at 2:00 p.m. on 7/1/14, indicated R19 was confused and had tried to get up numerous times to walk. R19's interdisciplinary care plan dated 6/2014 indicated in the problem/need area that R19 had dementia and depression. R19's care plan further indicated R19 was vulnerable and susceptible to abuse related to her inability to care for self and need for assist with transfers and ambulation. R19's quarterly Minimum Data Set (MDS) assessment, dated 6/28/14, indicated R19 had falls since admission or the prior assessment and had moderate cognitive impairment. R19 required extensive assistance of one staff for transfers and ambulation in her room. The MDS further indicated R19 was not steady and was only able to stabilize with staff assistance while moving from seated to standing position, walking, turning around and facing the opposite direction. The MDS also identified R19 needed staff assistance with moving on and off the toilet. Review of a Post-Fall assessment completed for R19 dated 7/5/14, indicated R19 had a history of falls and that the director of nursing (DON) had reviewed the fall and determined the root cause was lower extremity weakness and increasing confusion. During interview with the DON at 2:06 p.m., on 12/18/14, she stated she did not recall R19's transfer or ambulation status prior to the fall, or whether R19 had been able to state to staff how	F 226	addresses the steps to be taken. Any fall that meets criteria of injury of unknown source will immediately be reported to the county and state. 4. The Administrator and the Director of Nurses will ensure that incident report forms are completed to ensure that investigations are documented and injuries of unknown source are reported to the county and state. 5. The Administrator will monitor to assure the plan is sustained.	

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F 226	Continued From page 6 the fall on 7/5/14 had occurred. The administrator was interviewed at 1:28 p.m. on 12/18/14, and stated R19 was having confusion prior to the fall, and a tabs alarm (an alarm attached to a residents clothing that sounds when the resident attempts to get up) was placed on R19. The administrator verified MDH had not been notified regarding the fall R19 had experienced on 7/5/14.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the plan of care related to identifying new skin issues for 1 of 3 residents (R25) reviewed for non pressure related skin issues. Findings include: During observation/interview on 12/16/14, at 11:22 a.m. R25 was observed seated in his recliner in bedroom with red/purple bruising to fingers on both hands. R25 confirmed the bruising was not due to abuse but was unsure how the bruising had occurred. Review of the care plan, last reviewed 12/1/14, identified a risk for impaired skin integrity with interventions including: inspect skin daily and	F 282	1. R25's plan of care was updated to reflect slight bruising to hands. 2. All residents will have their plan of care updated to reflect problem of bruising if present. 3. Charge nurses were inserviced on need to identify those residents who have bruising present. The bruising will then be documented in nurses notes, monitored weekly, and care planned. 4. QA nurse will monitor care plans to assure problem is reflected on each residents plan of care. 5. Director of nurses will monitor to assure plan is sustained.	1/23/15

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F 282	Continued From page 7	F 282		

weekly skin assessment by licensed staff. The care plan further identified R25 "Bruises easily esp. (especially) hands". Review of the weekly bathing form titled, "Shower Day Worksheet/Body Audit" forms, dated 11/20/14, 11/27/14, 12/11/14, and 12/18/14 did not include identification of bruising to R25's fingers. Review of the nurses notes did not identify bruising to R25's fingers.

On 12/18/2014, at 10:30 a.m. R25 was observed with a purplish bruise on top of the right ring finger between the second and third knuckle and a fading purple bruise on top of the middle right finger near the knuckle on the hand; there was also a reddish/purple bruise on top of the left pinkie finger between the second and third knuckle that extended around the outer edge of the finger.

When interviewed on 12/18/2014, at 10:34 a.m. nursing assistant (NA)-E confirmed she had assisted R25 with cares earlier in the morning and and also assisted with his bath and trimmed his fingernails. NA-E reported not noticing bruising to the resident's fingers but stated when R25 was assisted with walking into the bathroom with his walker he would shut his eyes at times and would veer towards the side of the doorway and brush his hands across it which may have been the reason for the bruising.

When interviewed on 12/18/2014, at 2:14 p.m. LPN-A stated that resident's skin was monitored weekly on bath day by the NA who is giving the resident their shower. If a new skin issue was identified by the NA they would notify the nurse. LPN-A verified that a weekly skin assessment by licensed staff was not being completed unless a new skin issue was identified. LPN-A further

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F 282	Continued From page 8 confirmed that a weekly skin assessment by licensed staff had not been performed for R25.	F 282		
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 identify, assess, and monitor bruising on the hands for 1 of 3 residents (R25) reviewed for non-pressure related skin issues. Findings include: During observation/interview on 12/16/14, at 11:22 a.m. R25 was observed seated in his recliner in bedroom with red/purple bruising to fingers on both hands. R25 confirmed the bruising was not due to abuse but was unsure how the bruising had occurred. Review of the quarterly minimum data set (MDS) assessment dated 11/29/14 indicated R25 required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, personal hygiene, and locomotion on/off the unit. The brief interview for mental status (BIMS) scored 15 indicating intact cognition.	F 309	1. R25's slight bruising was assessed and documented in the nurses notes. A care plan was established addressing these issues. 2. All residents with bruises, will have areas assessed and documented. A plan of care will be established. 3. Nursing was inserviced on need for improved documentation of nonpressure related skin issues. CNA's will document areas on shower sheets and communicate areas of concern to charge nurse. Areas will be assessed and documented. A care plan will be established. 4. QA nurse will monitor skin to assure areas are being assessed, documented, and care planned. 5. Director of nurses will monitor to assure plan is sustained.	1/23/15

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F 309	Continued From page 9	F 309		

Review of the care plan last reviewed 12/1/14 identified a risk for impaired skin integrity with interventions including: inspect skin daily and weekly skin assessment by licensed staff. The care plan further identified R25 "Bruises easily esp. (especially) hands". Review of the weekly bathing form titled, "Shower Day Worksheet/Body Audit" forms dated 11/20/14, 11/27/14, 12/11/14, and 12/18/14 did not include identification of bruising to R25's fingers. Review of the nurses notes did not identify bruising to R25's fingers.

On 12/18/2014, at 10:30 a.m. R25 was observed with a purplish bruise on top of the right ring finger between the second and third knuckle and a fading purple bruise on top of the middle right finger near the knuckle on the hand; there was also a reddish/purple bruise on top of the left pinkie finger between the second and third knuckle that extended around the outer edge of the finger.

When interviewed on 12/18/2014, at 10:34 a.m. nursing assistant (NA)-E confirmed she had assisted R25 with cares earlier in the morning and and also assisted with his bath and had trimmed his fingernails. NA-E confirmed she had not noticed the bruising to the resident's fingers. NA-E stated that when staff assisted R25 with the use of the walker into the bathroom, R25 would shut his eyes at times and veer towards the side of the doorway, bumping his hands against the doorway which may have been the reason for the bruising.

When interviewed on 12/18/2014, at 11:10 a.m. the licensed practical nurse (LPN)-A stated when a new skin issue was identified it should be

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F 309	Continued From page 10 reported to the nurse; if unable to identify the cause, an incident report would be completed. The skin issue was then added to the Skin/Wound Tracking sheet located at the nurses desk and documented on weekly. While seated in the recliner in his room, the bruises were noted with the presence of LPN-A. LPN-A could not verify whether the bruising noted to the fingers was a new or chronic condition as the resident had bruises all the time. When LPN-A summoned the DON to observe the bruising noted to R25's fingers, the DON indicated she was unsure whether the bruising occurred recently but also stated the color of the bruises indicated they didn't appear to be recent. LPN-A stated the NA's were really good about identifying new skin issues. The DON stated a skin assessment was completed weekly on bath day to assure routine monitoring. When questioned whether the bruising/skin discolorations were documented anywhere in the record, the DON confirmed there was no documentation available for review so there was no baseline to determine whether the bruising was recently acquired or had been an ongoing skin condition. The DON further confirmed she expected staff to report newly acquired bruises so they could be monitored.	F 309		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 465		1/23/15

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F 465	Continued From page 11 Based on observation, interview and document review the facility failed to maintain a sanitary food service and preparation area in the kitchen which had the potential to effect 32 of 32 residents who received food from the kitchen. Findings include: During the initial kitchen tour on 12/15/14, at 6:15 p.m. with cook-A the following findings were observed in the kitchen: 1. The air exchange duct with a grated cover directly over the cook stove in the kitchen was observed to have a heavy dust build up with dust hanging down from the grate. The dust was thick enough that the air exchange openings in the grate were covered. 2. The commercial grade can opener attached to the food preparation counter in the kitchen was noted to have a sticky black substance and metal shavings in the void area between the cutting blade and the opener assembly. The cutting blade was noted to be sticky and was noted to have a black substance behind it. 3. A wall mounted fan located over the microwave in the kitchen was noted to be on and oscillating over the food preparation and service counter areas. The fan housing on the back side was noted to have heavy dust and grease build up. Ribbons of dust were observed to be drawn into the fan from the back and the fan and was noted to be oscillating directly into the food service and food preparation areas. During observation of the fan cook A stated,"I'm embarrassed, that's bad".	F 465	1. Dietary manager to perform inspection of kitchen conditions and address current needs immediately. 2. Housekeeping and Maintenance schedules have been adjusted by administrator to have plan in place to address needs on a timely basis. 3. Schedule adjusted to systematically review conditions so that sanitary conditions are maintained. 4. The dietary manager will be responsible to have list of needed duties for housekeeping staff and maintenance staff. Housekeeping staff are scheduled on timely basis to address needs. 5. The Dietary manager will assure plan is sustained.	

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	245553	A. BUILDING _____ B. WING _____	12/18/2014

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F 465	Continued From page 12	F 465		

4. On the wall directly behind the cooking stove there were pipes, pipe fittings, sprinkler lines and wall mounted speakers noted to have a heavy dust build up. The dust could easily be visualized from just walking in the kitchen. Cook-A verified all of the findings.

During interview with the dietary manager (DM) on 12/16/2014, at 1:59 p.m. the DM verified the fan blowing across the food service area had been neglected and that housekeeping staff were responsible for all cleaning above dietary staff reach. The DM further verified the commercial grade can opener was heavily soiled, but verified it was not on a routine cleaning schedule. The DM stated she would add disassembling the can opener and running it through the dishwasher to the routine cleaning schedule. The air exchange grate and pipes on the walls over the hood of the cook stove continued to be heavily soiled and the DM stated she was not sure when maintenance had last cleaned it. The DM verified all findings and acknowledged an understanding of the concerns with the lack of housekeeping in the kitchen.

During an additional kitchen tour with the environmental services director (ED) on 12/17/2014, at 1:56 p.m. the ED also acknowledged the findings. When asked, the ED verified it would be his responsibility to clean all of the areas identified. The ED stated he cleaned the air exchange grates quarterly but verified they may need to be cleaned more often. The ED further verified there was no definitive cleaning schedule for the high areas in the kitchen but stated dietary staff would let him know when specific areas needed to be cleaned. During review of the maintenance schedule and cleaning

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F 465	Continued From page 13 schedule from the ED, it was noted there was no periodic cleaning schedule for the above areas of concern.	F 465		

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	245553	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/17/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 17, 2014. At the time of this survey, Parkview Manor Nursing Home was found not to be 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/07/2015

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us Angela.kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Parkview Manor Nursing Home was constructed as follows: The original building was constructed in 1970, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type I (332) construction; The 1st Addition was constructed in 1980, is one-story in height, has no basement, and is fully fire sprinkler protected, and was determined to be of Type I (332) construction; The 2nd Addition was constructed in 1993. It consists of a Resident Room Addition and is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. The original 1970 building of Type I (332) construction is separated from the 1993 Addition of Type II (111) construction by a 2-hour fire wall assembly, with opening protectives consisting of a factory labeled, self-closing, positive latching, 90-minute fire rated double door assembly.	K 000		

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K 000	Continued From page 2 The 1980 Addition consists solely of an attached Generator Room, which is separated from the Nursing Home by a 2-hour fire wall, with no communicating openings. This room is accessible only from the building exterior. The facility has a fire alarm system with smoke detection located at smoke barrier doors and in spaces open to the corridors, which are monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with automatic smoke alarms. The facility has a capacity of 37 beds and had a census of 32 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in	K 029	1. Conduits in maintenance room and north will soiled utility room have been	1/23/15

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K 029	Continued From page 3 accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect 10 patients. Findings include: On facility tour between 8:00 AM and 11:00 AM on 12/17/2014 , observation revealed (2) Hazardous area rooms had penetrations around conduits on the corridor side wall not in accordance with section 19.3.2.1. These rooms were located: 1. The maintenance/storage room (which is over 50 sq. ft.), 2. The north wing soiled utility room. These deficient practices were verified by the Maintenance Supervisor at the time of the inspection.	K 029	sealed with fire rated caulk by maintenance staff. 2. Jan. 2, 2015 3. Maintenance supervisor responsible to monitor all wall penetrations to make sure are sealed properly.	