Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 10, 2025

Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, MN 56129

RE: CCN: 245553
Cycle Start Date: March 27, 2025

Dear Administrator:

On June 9, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 10, 2025

Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, MN 56129

Re: Reinspection Results
Event ID: EOVV12

Dear Administrator:

On June 9, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2025

Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, MN 56129

RE: CCN: 245553
Cycle Start Date: March 27, 2025

Dear Administrator:

On March 27, 2025, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 27, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by September 27, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2025

Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, MN 56129

Re: State Nursing Home Licensing Orders
Event ID: EOVV11

Dear Administrator:

The above facility was surveyed on March 24, 2025 through March 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2025**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/26/2025. At the time of this survey, Parkview Manor Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/18/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2025**

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
K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

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, is fully fire sprinkler protected, and was determined to be of Type I (332) construction;

The 2nd Addition was constructed in 1993. It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2025**

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
K 000	Continued From page 2 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 facility has a capacity of 36 beds and had a census of 29 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/26/2025**

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
K 920	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 03/26/2025 between 10:00 AM and 1:00 PM, it was revealed by observation that a multi-plug adapter cord was being used in the boiler room to power two water pumps. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	1. On 03/27/2025 the multi-plug adaptor cord was disconnected and removed. 2. The cords that had been plugged into the multi-plug adapter cord were plugged directly into electrical receptacles. 3. Multi-plug adaptor cords will no longer be used as a permanent power supply within the facility. 4. The Maintenance Director will be responsible for compliance.	

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 _____	03/27/2025

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
E 000	Initial Comments On 3/24/25 through 3/27/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/24/25 through 3/27/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		5/31/25

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

Electronically Signed | 04/21/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING _____ B. WING _____	03/27/2025

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 558	Continued From page 1 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (R5) had been appropriately assessed for wheelchair size by therapy. Findings include: R5's 1/3/25, annual Minimum Data Set (MDS) assessment identified she had admitted to the facility in January of 2022, with intact cognition. She had no psychosocial behaviors, and required extensive assistance from staff to complete Activities of Daily Living (ADL). R5 had diagnoses of severe morbid obesity, arthritis, and reduced mobility. She had pain that occasionally interfered with her ADL and had a stage II pressure ulcer (characterized by partial-thickness skin loss). R5 was not receiving any therapy. Observation and interview on 3/24/25 at 2:57 p.m., of R5 in her room, identified she was seated in a recliner with her legs elevated. R5 identified she has asked for a new wheelchair. She reported she does not go to any activities or leave her room "for anything". She would like to take part in activities but "I'm stuck in here" because it was "so painful" to sit in her wheelchair. Interview on 3/26/25 at 2:24 p.m., with the activity aid (AA)-A identified R5 used to come out for activities but then started refusing, she said its	F 558	The facility will ensure residents receive services with reasonable accommodation of their needs and preferences except when to do so would endanger the health or safety of the resident or other residents. On 3/28/2025, the DON submitted a referral to the contracted therapy dept. to measure the resident for a w/c that will accommodate, and be comfortable for, the resident. On 04/03/2025 the DON was informed by the contracted therapy dept. that a third-party company will assess and measure the resident for a w/c on 04/22/25. The DON will monitor that the assessment/measurement is completed on that date. The DON will then work with the resident, the third-party company, and facility Administration to obtain the recommended w/c as soon as possible. The DON will keep the resident informed of the status and expected arrival of the w/c that is ordered. Upon arrival, the DON and therapy dept. will fit the w/c to the resident to ensure it meets the resident's needs and is comfortable. The DON and nursing staff will monitor	

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 _____	03/27/2025

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 558	Continued From page 2 painful to sit in her wheelchair so she cant come to activities. AA-A identified she had reported the concern to the director of nursing but did not know if anything had been done. Interview on 3/26/25 at 2:28 p.m., with the nursing assistant (NA)-A identified she was aware R5 does not come out of her room because her wheelchair is uncomfortable. NA-A identified she had reported the refusals and the reason given to the director of nursing. Interview on 3/26/25 at 3:52 p.m., with the registered nurse (RN)-A identified she knew R5 refused to come out of her room but was not aware of the reason. She reports "she thought that was her normal", she could not recall anyone telling her that it was because of her wheelchair being uncomfortable. R5's current, undated care plan identified R5: 1) Was at risk for feelings of powerlessness related to (r/t) her inability to regain strength and independence to return to her home as she had hoped on admission and was unable to take care of herself independently. R5 was noted to have preferred to stay in her room; resident expresses that she is fearful of falling; at times resident states/seems fearful of motion/movement in lift and in wheelchair. One of R5's goals was she would "spend time out of her room as she feels up to it". 2) Was noted to be at risk for impaired individual coping r/t NH placement, impaired mobility, and at times would appear fearful of motion/movement with EZ-stand and when she was in her wheelchair as resident will scream, yell, and/or cry when staff is assisting her in EZ-stand and in her wheelchair, with an	F 558	the resident's use of the w/c on an ongoing basis and will submit a referral for a new assessment/measurement should it be required due to a change in condition or needs of the resident. Referrals for new w/c assessments/measurements will be brought to QAPI for review and compliance.	

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F 558	Continued From page 3 intervention to discuss resident fears with resident and inform the charge nurse when R5 was upset, screaming, yelling and/or crying. 3) Has little or no activity involvement r/t disinterest and immobility and physical limitations. Staff were to establish and record R5's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary and required assistance/escort to activity functions. 4) has ADL self-care performance deficit r/t activity intolerance, morbid obesity, impaired mobility. 5) Chronic Pain r/t osteoarthritis, impaired mobility, and morbid obesity with a goal to not have an interruption in normal activities due to pain. Staff were to monitor/document for probable cause of each pain episode and remove/limit causes where possible and monitor resident's existing conditions which may increase pain and or discomfort. 6) has impairment to skin integrity r/t chronic peripheral edema (swelling of limbs),decreased mobility, obesity and refusals to be repositioned every 2 hours. Staff were to identify/document potential causative factors and eliminate/resolve where possible. R5 required a pressure relieving cushion to protect the skin while up in her chair. Review of R5's progress notes and medical record identified there was no mention if R5 had been assessed per the care plan above as to why she refused to be repositioned, or why she declined to be seated in her wheelchair. There was also no indication therapy had been notified to assess R5 for appropriate wheelchair size.	F 558		

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F 558	Continued From page 4 Interview on 3/26/25, at 3:56 p.m., with the licensed practical nurse (LPN)-A reported R5 "has the right to refuse". She identified she had never asked her why she refused to come out of her room, but she recalled her being uncomfortable sitting on the commode and states "she is almost always uncomfortable". Interview on 3/27/25 at 1:54 p.m., with the administrator identified he agreed the facility had not reached out to R5's physician to request an assessment by therapy for an appropriate wheelchair and had no documentation identifying that they had attempted any interventions to improve R5's comfort while sitting in her wheelchair. The administrator identified he would have expected nursing to update R5's physician and request an order for her to be evaluated by therapy. Therapy was unavailable for interview. Review of the facilities undated Accommodation of Needs policy identified the facility would assist the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. Staff attitudes and behaviors must be directed towards assisting the resident in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes.	F 558		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		5/31/25

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F 625	Continued From page 5 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the resident and/or their responsible party, in writing, of the facility's bed hold policy, including potential costs included with the bed hold, at the time of transfer to the hospital for 4 of 4 residents (R1, R8, R15 and R18). Findings include:	F 625	The facility will provide the Bed-Hold Notice Policy to a resident or their representative before the resident transfers to a hospital or the resident goes on therapeutic leave. Copies of the Bed-Hold Notice Policy were placed in a folder in a drawer at the nurse station.	

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F 625	Continued From page 6 R1's 3/5/25, end of PPS stay Minimum Data Set (MDS) assessment identified his cognition was intact and he required assistance of 1-2 staff for activities of daily living (ADLS). R1 utilized a wheelchair for mobility and had a chronic indwelling catheter. He had diagnosis of spinal stenosis, kidney failure, peripheral venous insufficiency, weakness and chronic pain. R1's 1/31/25 at 9:29 a.m., progress noted identified a call had been received from the MD that R1 had an elevated WBC and CRP and she would like him evaluated in the emergency department. R18's 2/7/25, quarterly MDS assessment identified her cognition was intact, and she required extensive assistance of 2 staff members for ADLS. She was non-ambulatory and had pressure reducing devices in her bed and chair. R18 utilized a wheelchair for mobility and had experienced a fall due to attempting to self-transfer from her chair to bed. R18's diagnosis list included heart failure, vitamin B12 deficiency, congestive heart failure (CHF), anxiety disorders, high blood pressure (HTN) and hypokalemia. R18's 11/26/24 at 8:03 a.m., progress notes identified an unidentified nursing assistant (NA) had gone to get R18 up for the day and found her unresponsive. R18's respirations were labored, she opened her eyes when spoken to, but was unable to verbally respond. Appropriate notifications were completed with a plan for transfer via ambulance to the ED for evaluation. R18 was admitted to acute care with a diagnosis of CHF exasperation, until she returned on 11/29/24.	F 625	On 03/27/2025 education was given to the nurses by the DON of the need to have a Bed-Hold Notice Policy signed by the resident or their representative before the resident transfers to a hospital or goes on therapeutic leave. In the event of an emergency transfer when it may not be possible to have the Bed-Hold Notice Policy signed prior to transfer, attempts will be made to have it signed by the resident or their representative as soon as practicable. The Administrator or designee will monitor and ensure the Bed-Hold Notice Policy is signed by the resident or their representative before the resident transfers to a hospital or goes on therapeutic leave or as soon as practicable in the event of an emergency transfer. Resident transfers to a hospital or therapeutic leaves will be brought to QAPI for review of Bed-Hold Notice Policy compliance.	

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F 625	Continued From page 7 Review of R1 and R18's medical record identified there was no documentation of a bed hold provided to either the resident or his family members. Interview on 3/27/25 at 12:00 p.m., with the administrator confirmed the facility had not been providing bed holds to residents who were hospitalized and he was in the process of finding forms to be used for this process. R8's 2/21/25, significant change Minimum Data Set (MDS) assessment identified her cognition was intact, she had diagnosis of bi-polar disorder, post-traumatic stress disorder, anxiety, spinal stenosis, hallucinations, and diabetes mellitus. R8 was dependent on staff for transfers, dressing, and hygiene, and used a wheelchair for mobility. Review of R8's hospital course of stay summary identified she was admitted to the hospital on 3/18/25, with a diagnosis of a urinary tract infection and was discharged back to the facility on 3/24/25. Review of R8's medical record identified there was no documentation oto support a bed hold notice had been provided. . R15's 12/20/24, quarterly Minimum Data Set (MDS) assessment identified her cognition was severely impaired, she was dependent on staff for all activities of daily living (ADL)'s, and had diagnosis of hemiplegia (one sided paralysis due to a stroke), dementia, and oropharyngeal dysphagia (impairment in the ability to swallow).	F 625		

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F 625	Continued From page 8 R15's 12/8/24, nursing progress note identified she had increased rapid respirations, sounded congested and was coughing. Her physician was notified and R15 was transferred to the hospital via ambulance for evaluation and treatment. R15's medical record lacked documentation a bed hold had been offered to the resident representative. Interview on 3/26/25 at 4:19 p.m., with the administrator identified he agreed with the above findings, and he would expect staff to offer a bed hold to either the resident or the resident representative prior to discharge or transfer to the hospital. Review of the facilities 11/20/19, Notice of Bed Hold policy identified they would provide a bed hold notice to the resident or the responsible party upon admission and at the time of leave.	F 625		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the hospice plan of care had been integrated with the facility	F 684	The facility will ensure that residents receive treatment and care in accordance with professional standards of practice,	5/31/25

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F 684	Continued From page 9 care plan for 2 of 2 residents (R14 and R131) to delineate services provided between the facility and hospice. Findings include: R14's 2/7/25, significant change Minimum Data Set (MDS) assessment identified her cognition was severely impaired and she was dependent on staff to complete all activities of daily living (ADL)'s. R14 had diagnosis of heart failure, arthritis, Alzheimer's disease, chronic pain, and lymphedema. She had vocal indicators of pain, received scheduled pain medication, and had a life expectancy of less than 6 months. Review of R14's current care plan identified she would receive visits from hospice. The care plan lacked any indication when the visits would occur and did not identify what services the facility was to provide nor services the hospice agency was to provide. R131's 3/12/25, admission Minimum Data Set (MDS) identified he had a diagnosis of cancer and was admitted to the facility on hospice with a life expectancy of less than 6 months. Review of R131's care plan identified he was receiving hospice services and had a focus of comfort. The care plan lacked any delineation of what care the hospice agency was to provide verses what care the facility was to provide. Interview on 3/24/25 at 3:15 p.m., with the hospice registered nurse, identified they typically fax the hospice care plan to the facility within 48 hours. She identified they had some communication concerns with the facility staff	F 684	the comprehensive person-centered care plan, and the residents' choices. The residents care plans are online in PCC. The hospice care plans are in a binder located at the nurse station. On 04/01/2024 the DON discussed the facilitys and hospice care plans with the facilitys nurse who develops the plan of care for residents. The The remaining hospice resident's facility care plan was updated to include adjusting provision of ADL's to compensate for resident's changing abilities; assessing resident's coping strategies and respecting resident's wishes; encouraging resident to express feelings, listen with non-judgmental acceptance and compassion; encouraging support system of family and friends; following hospice orders for care of resident; hospice RN visits 2X/week and PRN, hospice aide 2X/week and PRN, Social Worker 1-2X/month and PRN; keeping the environment quiet and calm, keeping linens clean, dry and wrinkle free, keeping lighting low and familiar objects near; observing resident closely for signs of pain, administering pain medications as ordered and notifying physician immediately if there is breakthrough pain; referring for psychiatric/psychogeriatric consult if indicated; reviewing resident's Living Will and ensure it is followed; supporting resident and family in their grief processes while psychologically and emotionally preparing for end of life; addressing symptoms problematic to pain	

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F 684	Continued From page 10 recently and had to explain to the aids that the bath hospice provides must be in addition to the bathing provided by the facility staff. She also reported the facility aids are responsible for assisting the hospice aid with positioning and dressing when they are at the facility providing a bath, however, at times there are no staff available to assist. Review of the 2016 Comprehensive Person Centered Care Plan policy identified the facility would describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, Incorporate identified problem areas, incorporate risk factors associated with identified problems, reflect the resident's expressed wishes regarding care and treatment goals, and identify the professional services that are responsible for each element of care. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition.	F 684	to maintain optimal quality of life; working cooperatively with hospice team to ensure resident's spiritual, emotional, intellectual, physical and social needs are met; and working with nursing staff to provide maximum comfort for the resident. The DON or designee will audit facility/hospice care plans once weekly for one month, then twice monthly for one month, then monthly as needed. Results of all audits will be brought to QAPI and reviewed for compliance or the need for continued monitoring.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		5/31/25

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F 689	Continued From page 11 by: Based on observation and interview the facility failed to avoid the potential risk of burns from 1 of 1 unattended Bunn brand coffee warmer used in the dining room. Findings include: Observation on 3/26/25 at 11:30 a.m., as an unknown dietary staff member entered the dining room and switched on the heating elements on a Bunn double element coffee warmer. The warmer was used to place glass coffee pots on during meals to keep the coffee hot. The coffee warmer with glass pots was positioned on a counter within easy reach of a resident walking or in a wheelchair. The warmer was observed to be very hot when a hand was held an inch above the surface, in addition to the glass coffee pots which held hot coffee. Neither dietary or nursing staff were consistently in the dining room, and no one was observed monitoring the coffee to ensure a resident did not attempt to serve themselves. Interview on 3/26/25 at 11:33 a.m. with the certified dietary manager (CDM), reported the Bunn coffee warmer was turned on prior to meals to allow it to become hot before the glass coffee pots were placed on it for service during the meal. She acknowledged the potential for burns if a resident attempted to self-serve coffee or touched the hot plate surface. The CDM reported she would make a change to utilize a pump type coffee server to eliminate the risk of a resident being burned. Interview on 3/26/25 at 11:55 a.m., with the administrator acknowledged the potential hazard the coffee warmer and glass coffee pots	F 689	The facility will ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. On 03/24/2025 the Bunn coffee warmer appliance was removed from the dining room and placed in storage outside of the building. A pump style air pot will be used for service and to keep coffee warm. At breakfast the air pot will remain in the kitchen until a CNA comes to get it for service. At lunch and supper it will be placed on a cart utilized by dietary staff to serve beverages to residents at their table so that it's not setting on the counter unattended. The CDM or designee will audit the use and placement of the air pot at each meal service for one week, then one meal per day for one week, then 3 meals for one week. Results of all audits will be brought to QAPI and reviewed for compliance or the need for continued monitoring.	

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F 689	Continued From page 12 presented. He reported this was the system that had been utilized, but he had not identified the potential hazard. The administrator reported the facility would need to utilize a different method for serving coffee in the dining room and acknowledged the CDM had replaced the warmer and glass pots with a pump type pot for safety following the observation. A policy for safety in the dining room was requested, but not provided prior to survey exit.	F 689		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		5/31/25

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F 758	Continued From page 13 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to obtain informed consents for the use of psychotropic medications for 6 of 6 residents, (R7, R8, R10, R18, R22 and R28). The facility also failed to act upon pharmacy reviews and provide justification for not attempting a gradual dose reduction (GDR) for 2 of 5 residents (R8 and R10) reviewed for unnecessary medications. Findings include: R10's 1/10/25 quarterly Minimum Data Set (MDS) assessment identified her cognition was intact, she was able to make choices to attend activities but required extensive assistance of 1 staff	F 758	The facility will obtain signed Informed Consents from residents or their representative for the use of psychotropic medications. The DON will review the care plan of residents currently on psychotropic medications and will obtain signed Informed Consents from those residents or their representative at their next scheduled Care Conference. The DON will monitor and ensure all residents who have or receive an order for, or have a change of dosage of,	

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F 758	Continued From page 14 person for activities of daily living (ADLs). R10 had diagnosis of heart failure, high blood pressure, and major depressive disorder. R10's current physician orders identified an order for Venlafaxine (anti-depressant medication) extended release (ER) tablet 150 milligrams (mg) by mouth (PO) daily for major depressive disorder with a start date of 2/20/24. The 2/13/25 physician 60-day routine visit documented a pharmacy concern regarding her Venlafaxine (Effexor) dose, but the family had requested it not be changed. No GDR had been attempted, nor rational documented as clinically contraindicated. R10's paper and electronic medical record failed to provide documentation of the risk's verses benefit of the psychotropic medication to the resident and/or family and no consent for administration of the medication was provided. R18's 2/7/25 quarterly MDS assessment identified her cognition was intact, and she required extensive assistance of 2 staff persons for her ADLs. R18 had pressure reducing devices for both her bed and chair and mobility was via wheelchair due to limited mobility on one side. R18 had diagnosis of congestive heart failure, high blood pressure, arthritis, and anxiety disorder. R18's current physician orders identified an order for Cymbalta DR 30 mg PO every (Q) morning for neuropathy (a condition that affects the nerves, causing damage or dysfunction), depression and anxiety. 12/6/24 was identified as the start date for this medication and the medical record failed to provide documentation of the risk's verses	F 758	psychotropic medications will be presented the Informed Consent form for signature. The Pharmacy does GDR's two times per year of admission or upon starting a psychotropic medication then annually thereafter unless contraindicated. The DON or designee will audit the care plans or residents on psychotropic medications to ensure there is a signed Informed Consent once weekly for one month, then twice monthly for one month, then monthly as needed. Results of all audits will be brought to QAPI and reviewed for compliance or the need for continued monitoring.	

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F 758	Continued From page 15 benefit of the psychotropic medication to the resident and/or family and no consent for administration of the medication was provided. R22's 2/7/25 quarterly MDS identified his cognition was intact, he required moderate to extensive assistance with ADLS, and used a walker or wheelchair for mobility. R22 had an indwelling catheter, and received scheduled pain, insulin, antidepressant, anticoagulant, and diuretic medications. He had diagnosis of Type I diabetes, chronic pain, depression, polyneuropathy, urine retention, blood clots of his right lower extremity, swelling, malaise, and a fracture of the leg. R22's current physician orders identified an order for Cymbalta (anti-depressant) 30 mg PO QD started on 3/15/24 for depression/chronic pain syndrome. The medical record failed to provide documentation of the risk's verses benefit of the psychotropic medication to the resident and/or family and no consent for administration of the medication was provided. Interview on 3/26/25 at 2:47 p.m., with the director of nursing (DON), identified there were no consents obtained for residents who received psychotropic medications, and she was not aware this was required. She further reported the facility did not have a policy regarding consents for psychotropic medications. R8's 2/21/25, Significant Change Minimum Data Set (MDS) assessment identified her cognition was intact, she had diagnosis of bi-polar disorder, post-traumatic stress disorder, anxiety, and hallucinations. R8 was dependent on staff for	F 758		

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F 758	Continued From page 16	F 758		

transfers, dressing, and hygiene, she used a wheelchair for mobility. R8 took an antipsychotic and an antidepressant on a routine basis.

R8's current, undated medication administration record (MAR) identified she was administered Abilify (anti-psychotic) 15mg oral tablet at bedtime and duloxetine HCl (antidepressant) 60 mg oral tablet daily in the morning.

R8's medical record identified no documentation that a gradual dose reduction had been attempted since March of 2024. The medical record did not include any documentation that the resident or the resident representative had been educated on the risks and benefits of using psychotropic medications.

R28's 2/27/25 admission Minimum Data Set (MDS) assessment identified his cognition was moderately impaired and he required extensive assistance from staff to complete activities of daily living (ADL)'s. R8 had diagnosis of atrial fibrillation, hypertension, and arthritis, but did not have any psychiatric mood disorders. R8 was being administered an antipsychotic on a routine basis.

Review of R28's March 2025, medication administration record identified he was being administered quetiapine (antipsychotic) 25 milligrams orally twice daily for disorientation. R28's medical record lacked any documentation of an appropriate diagnosis for the use of an antipsychotic.

Interview on 3/26/25 at 1:11 p.m., with the director of nursing identified she does not monitor or review medication for the need of a gradual dose

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F 758	Continued From page 17 reduction, she also has not completed any informed consents including an explanation of the risks and benefits of using psychotropic medication. she reports that the gradual dose reductions are done by the contracted pharmacist consultant. Interview on 3/27/25 at 11:16 a.m., with the pharmacist consultant identified that she reviewed R8 and R28's medications monthly, she agreed that R8 would be appropriate for a recommendation to have a gradual dose reduction.She also agreed that R28 does not have an appropriate diagnosis documented for the use of an antipsychotic and reports that she must have "missed it". She identified she would expect the facility to provide education on risks and benefits to the resident and have that documented in the medical record. Interview with the administrator on 3/27/25, at 3:00 p.m., with the administrator agreed with the above findings and identified he would expect the facility to notify the primary physician when a gradual dose reduction is appropriate. He would also expect the nursing department to ensure residents and/or their representatives were informed of the risks and benefits and alternative treatments available to taking a antipsychotic medication and to ensure residents have an appropriate diagnosis for the use of psychotropic medications. R7's annual Minimum Data Set (MDS) dated 1/24/25, indicated severe cognitive impairment without hallucinations or delusions. R7 had diagnoses of neurocognitive disorder with Lewy bodies, Parkinson's disease with dyskinesia,	F 758		

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F 758	Continued From page 18 bipolar disorder, mild dementia, major depressive disorder, and anxiety disorder. R7's physicians orders indicated the following psychotropic medication orders: quetiapine dated 1/9/25 (an antipsychotic). Informed consents regarding risks versus benefits of these medications were not found in the resident record. During interview on 3/25/25 at 4:54 p.m., Director of Nursing (DON) stated she was unaware of the requirement, and this had not been completed. DON stated understanding of the importance of residents and their representatives being aware of the risks verses benefits of the psychotropic medications being prescribed. There was no policy provided related to medication by the end of the survey.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		5/31/25

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F 812	Continued From page 19 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 exhaust vent located above the gas stove was free from accumulation of dirt and grease that had the potential to contaminate food being prepared and served. This had the potential to affect all 28 residents who received food prepared in the facility kitchen. Findings include: Observation and interview on 3/24/25 at 10:45 a.m., during the initial kitchen tour with the certified dietary manager (CDM). identified a large rectangular vent positioned in the wall above the stove. The vent was covered with a black, thick grease-like substance. The CDM reported the vent had been cleaned by maintenance a couple of months previously and she thought the black substance was likely rust and dust. She also reported she had not noticed how it appeared, but stated it needed to be cleaned. Interview on 3/24/25 at 11:30 a.m., with the Maintenance Supervisor (MS) reported he had replaced the vent a couple of months ago due to rust and paint chipping, but he did not realize how much more dirt and grease had accumulated. He reported he was not able to wipe off the black buildup but had to utilize a heavy degreaser to remove it and would need to put it on his maintenance schedule for regular cleaning.	F 812	The facility will store, prepare, distribute and serve food in accordance with professional standards for food service safety. The grille of the exhaust vent is located in the ceiling above a shelf that overhangs the cooking surface of the stove which would prevent dust, dirt or debris from falling directly onto the cooking surface. On 03/25/2025 the Maintenance Director cleaned the grille of the exhaust vent and has added cleaning of the grille to his monthly to-to list. The Administrator or designee will monitor and ensure the grille is cleaned monthly. The Administrator's or designee's findings will be brought to QAPI for review of compliance.	

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F 812	Continued From page 20 A policy on cleaning of vents and equipment in the kitchen was requested but not provided.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		5/31/25

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F 880	Continued From page 21 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the use of appropriate personal protection equipment (PPE) was utilized during blood glucose testing, and subsequent insulin administration for 2 of 2 residents (R7 and R22). In addition, the facility failed to ensure mechanical lifts were regularly	F 880	The facility will ensure the use of appropriate personal protection equipment (PPE) when administering medications and especially when the administration involves contact with blood. The facility will also ensure the cleaning, disinfecting or sterilizing of reusable or	

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F 880	Continued From page 22 cleaned and/or disinfected between resident use. Findings include: Observation on 3/25/25 at 11:30 a.m., as licensed practical nurse (LPN)-A prepared to check R7's BS and administer his lunch time insulin. She retrieved the necessary supplies from the medication cart, retrieved a BS strip from the bottle and placed it into the meter, then went to the dining room and informed R7 she needed to check his BS and administer his insulin. R7 voiced agreement and was transported from the dining room to the tub room for privacy. LPN-A asked which finger he would like to use to test. R7 then held up a finger. With her un-gloved hands, she proceeded to use an alcohol wipe to wipe his finger, then dried it with a cotton ball, picked up the automatic lancet, and lanced R7's finger to obtain a drop of blood. LPN-A then took the meter with the strip in place and touched the drop of blood to the strip, then placed the cotton ball on R7's finger. Still using her un-gloved hands, LPN-A picked up the used lancet, cotton ball, and monitor strip and placed them into the left side pocket of her scrub top. LPN-A continued with her un-gloved hands and picked up the insulin pen, applied the needle, dialed the pen to 2 units, primed the pen, then dialed to the ordered 10 units of insulin and administered the dose in R7's left lower quadrant. LPN-A recapped the pen and placed it into the same scrub top pocket with the used blood glucose items. LPN-A transported R7 back to the dining room, and then returned to the medication cart, applied hand sanitizer, and removed the items from her pocket and disposed of the used lancet, cotton ball, and glucose strip into the sharp's container. She placed the meter on the top of the	F 880	durable medical equipment (DME) between residents. The DON will give one-to-one education to the nurses on the use of appropriate personal protection equipment (PPE) when administering medications and especially when the administration involves contact with blood as stated in the Administering Medications policy. The education will be completed by 04/25/2025. The DON will have the nurses and aides review the Cleaning and Disinfection of Resident-Care Items and Equipment policy and sign off they have reviewed the policy. The DON or designee will audit the nurses use of PPE when administering medications two times per day for two weeks, then once per day for one week, then randomly on an on-going basis. The DON or designee will audit the disinfecting of lifts between use on residents two times per day for two weeks, then once per day for one week, then randomly on an on-going basis. The results of the audits will be brought to QAPI for review of compliance or if further monitoring is required	

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F 880	Continued From page 23 cart, with un-gloved hands, took the insulin pen from her pocket, removed the needle from the pen and disposed in the sharps container. She then obtained a purple labeled Sani wipe, applied gloves and wiped the surface of the meter for disinfection, wrapped the wipe around the meter and identified it would remain on the meter until dry. LPN-A did sanitize her hands after the conclusion of the deficient practice. Observation on 3/25/25 at 11:39 a.m. with LPN-A identified she reported she also needed to administer insulin to R22. LPN-A transported R22 from the dining room to the tub room for privacy, prepared his insulin pen by wiping the tip with alcohol, attaching the needle, priming with 2 units, then dialing the pen to a total of 14 units. R22 requested the insulin be administered into his right upper arm. With her un-gloved hands, she administered the insulin. LPN-A recapped the insulin pen placed it into her scrub top pocket, transported R22 back to the dining room, and returned to the medication cart. She then she removed the used needle from the insulin pen, disposed in the sharps container and returned the insulin pen to the medication cart drawer. She then cleansed her hands with hand sanitizer. Interview on 3/25/25 at 11:43 a.m., with LPN-A reported she should have been wearing gloves and performed hand hygiene, but stated was nervous at being observed and had "forgotten". Interview on 3/25/25 at 11:55 a.m., with the director of nursing (DON) identified her expectation for all staff to follow infection control measures including appropriate use of PPE when administering medications, and especially when the administration involved contact with blood.	F 880		

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F 880	Continued From page 24 She agreed putting contaminated supplies and pens in her scrub pockets and placing contaminated insulin pens back into the medication carts would contaminate any item the pens came into contact with. Review of the 2001 MED-PASS, Inc (revised April 2019) Administering Medications policy identified staff were to follow infections control policies and procedures (handwashing, antiseptic technique, gloves, and any precautions identified) for all medications being administered. LIFTS Observation on 3/25/25 at 9:04 a.m., CNA in training (CNAT) identified CNAT pushed a Hoyer (total mechanical lift) into a resident room. The door was open as CNAT conversed with the resident and placed the residents designated sling beneath him while he waited for another staff member to assist with the transfer. When another staff member arrived, the door was closed to provide privacy during the transfer from wheelchair to recliner. After the transfer was completed, the residents door was opened and CNAT was observed pushing the hoyer lift out of residents room and down the hall, and into another residents room. The door was again closed while assisting the resident. Interview on 3/25/25 at 9:15 a.m., CNAT confirmed the lift was not cleaned between residents. He stated he was trained to complete cleaning of lifts at the end of each shift, and believed this was their policy. CNAT confirmed neither resident was on EBP. Interview on 3/25/25 at 3:59 p.m., with the director of nursing (DON) who was also the	F 880		

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F 880	Continued From page 25 Infection Preventionist, identified lifts were to be cleaned and disinfected between residents regardless of their precaution status. DON stated new staff were trained to clean and disinfect them after each resident use. DON also stated CNAT had received a lot of information all at once, and she had clarified this expectation earlier when CNAT asked her about it. Review of the 2001 MED-PASS, Inc (revised October 2018) Cleaning and Disinfection of Resident-Care Items and Equipment policy identified staff were to clean and disinfect or sterilize reusable or durable medical equipment (DME) between residents.	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/24/25 through 3/27/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00406	A. BUILDING: _____ B. WING _____	03/27/2025

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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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 exhaust vent located above the gas stove was free from accumulation of dirt and grease that had the potential to contaminate food being prepared and served. This had the potential to affect all 28 residents who received food prepared in the facility kitchen. Findings include: Observation and interview on 3/24/25 at 10:45 a.m., during the initial kitchen tour with the certified dietary manager (CDM). identified a large rectangular vent positioned in the wall above the stove. The vent was covered with a black, thick grease-like substance. The CDM reported the vent had been cleaned by maintenance a couple of months previously and she thought the black substance was likely rust and dust. She also reported she had not noticed how it appeared, but stated it needed to be cleaned.	21015	Corrected	5/10/25

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21015	Continued From page 3 Interview on 3/24/25 at 11:30 a.m., with the Maintenance Supervisor (MS) reported he had replaced the vent a couple of months ago due to rust and paint chipping, but he did not realize how much more dirt and grease had accumulated. He reported he was not able to wipe off the black buildup but had to utilize a heavy degreaser to remove it and would need to put it on his maintenance schedule for regular cleaning. A policy on cleaning of vents and equipment in the kitchen was requested but not provided. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		5/10/25

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21375	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the use of appropriate personal protection equipment (PPE) was utilized during blood glucose testing, and subsequent insulin administration for 2 of 2 residents (R7 and R22). In addition, the facility failed to ensure mechanical lifts were regularly cleaned and/or disinfected between resident use. Findings include: INSULIN Observation on 3/25/25 at 11:30 a.m., as licensed practical nurse (LPN)-A prepared to check R7's BS and administer his lunch time insulin. She retrieved the necessary supplies from the medication cart, retrieved a BS strip from the bottle and placed it into the meter, then went to the dining room and informed R7 she needed to check his BS and administer his insulin. R7 voiced agreement and was transported from the dining room to the tub room for privacy. LPN-A asked which finger he would like to use to test. R7 then held up a finger. With her un-gloved hands, she proceeded to use an alcohol wipe to wipe his finger, then dried it with a cotton ball, picked up the automatic lancet, and lanced R7's finger to obtain a drop of blood. LPN-A then took the meter with the strip in place and touched the drop of blood to the strip, then placed the cotton ball on R7's finger. Still using her un-gloved hands, LPN-A picked up the used lancet, cotton ball, and monitor strip and placed them into the left side pocket of her scrub top. LPN-A continued with her un-gloved hands and picked up the insulin pen, applied the needle, dialed the pen to 2 units, primed the pen, then dialed to the	21375	Corrected	

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21375	Continued From page 5 ordered 10 units of insulin and administered the dose in R7's left lower quadrant. LPN-A recapped the pen and placed it into the same scrub top pocket with the used blood glucose items. LPN-A transported R7 back to the dining room, and then returned to the medication cart, applied hand sanitizer, and removed the items from her pocket and disposed of the used lancet, cotton ball, and glucose strip into the sharp's container. She placed the meter on the top of the cart, with un-gloved hands, took the insulin pen from her pocket, removed the needle from the pen and disposed in the sharps container. She then obtained a purple labeled Sani wipe, applied gloves and wiped the surface of the meter for disinfection, wrapped the wipe around the meter and identified it would remain on the meter until dry. LPN-A did sanitize her hands after the conclusion of the deficient practice. Observation on 3/25/25 at 11:39 a.m. with LPN-A identified she reported she also needed to administer insulin to R22. LPN-A transported R22 from the dining room to the tub room for privacy, prepared his insulin pen by wiping the tip with alcohol, attaching the needle, priming with 2 units, then dialing the pen to a total of 14 units. R22 requested the insulin be administered into his right upper arm. With her un-gloved hands, she administered the insulin. LPN-A recapped the insulin pen placed it into her scrub top pocket, transported R22 back to the dining room, and returned to the medication cart. She then she removed the used needle from the insulin pen, disposed in the sharps container and returned the insulin pen to the medication cart drawer. She then cleansed her hands with hand sanitizer. Interview on 3/25/25 at 11:43 a.m., with LPN-A reported she should have been wearing gloves	21375		

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21375	Continued From page 6 and performed hand hygiene, but stated was nervous at being observed and had "forgotten". Interview on 3/25/25 at 11:55 a.m., with the director of nursing (DON) identified her expectation for all staff to follow infection control measures including appropriate use of PPE when administering medications, and especially when the administration involved contact with blood. She agreed putting contaminated supplies and pens in her scrub pockets and placing contaminated insulin pens back into the medication carts would contaminate any item the pens came into contact with. Review of the 2001 MED-PASS, Inc (revised April 2019) Administering Medications policy identified staff were to follow infections control policies and procedures (handwashing, antiseptic technique, gloves, and any precautions identified) for all medications being administered. LIFTS Observation on 3/25/25 at 9:04 a.m., CNA in training (CNAT) identified CNAT pushed a Hoyer (total mechanical lift) into a resident room. The door was open as CNAT conversed with the resident and placed the residents designated sling beneath him while he waited for another staff member to assist with the transfer. When another staff member arrived, the door was closed to provide privacy during the transfer from wheelchair to recliner. After the transfer was completed, the residents door was opened and CNAT was observed pushing the hoyer lift out of residents room and down the hall, and into another residents room. The door was again closed while assisting the resident.	21375		

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21375	Continued From page 7 Interview on 3/25/25 at 9:15 a.m., CNAT confirmed the lift was not cleaned between residents. He stated he was trained to complete cleaning of lifts at the end of each shift, and believed this was their policy. CNAT confirmed neither resident was on EBP. Interview on 3/25/25 at 3:59 p.m., with the director of nursing (DON) who was also the Infection Preventionist, identified lifts were to be cleaned and disinfected between residents regardless of their precaution status. DON stated new staff were trained to clean and disinfect them after each resident use. DON also stated CNAT had received a lot of information all at once, and she had clarified this expectation earlier when CNAT asked her about it. Review of the 2001 MED-PASS, Inc (revised October 2018) Cleaning and Disinfection of Resident-Care Items and Equipment policy identified staff were to clean and disinfect or sterilize reusable or durable medical equipment (DME) between residents. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure appropriate disinfection between resident use and PPE use is completed. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21)	21375		

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21375	Continued From page 8 days.	21375		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (R5) had been appropriately assessed for wheelchair size by therapy. Findings include: R5's 1/3/25, annual Minimum Data Set (MDS) assessment identified she had admitted to the facility in January of 2022, with intact cognition. She had no psychosocial behaviors, and required extensive assistance from staff to complete Activities of Daily Living (ADL). R5 had diagnoses of severe morbid obesity, arthritis, and reduced mobility. She had pain that occasionally interfered with her ADL and had a stage II pressure ulcer (characterized by partial-thickness skin loss). R5 was not receiving any therapy. Observation and interview on 3/24/25 at 2:57 p.m., of R5 in her room, identified she was seated	21810	Corrected	5/10/25

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21810	Continued From page 9 in a recliner with her legs elevated. R5 identified she has asked for a new wheelchair. She reported she does not go to any activities or leave her room "for anything". She would like to take part in activities but "I'm stuck in here" because it was "so painful" to sit in her wheelchair. Interview on 3/26/25 at 2:24 p.m., with the activity aid (AA)-A identified R5 used to come out for activities but then started refusing, she said its painful to sit in her wheelchair so she cant come to activities. AA-A identified she had reported the concern to the director of nursing but did not know if anything had been done. Interview on 3/26/25 at 2:28 p.m., with the nursing assistant (NA)-A identified she was aware R5 does not come out of her room because her wheelchair is uncomfortable. NA-A identified she had reported the refusals and the reason given to the director of nursing. Interview on 3/26/25 at 3:52 p.m., with the registered nurse (RN)-A identified she knew R5 refused to come out of her room but was not aware of the reason. She reports "she thought that was her normal", she could not recall anyone telling her that it was because of her wheelchair being uncomfortable. R5's current, undated care plan identified R5: 1) Was at risk for feelings of powerlessness related to (r/t) her inability to regain strength and independence to return to her home as she had hoped on admission and was unable to take care of herself independently. R5 was noted to have preferred to stay in her room; resident expresses that she is fearful of falling; at times resident states/seems fearful of motion/movement in lift and in wheelchair. One of R5's goals was she	21810		

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21810	Continued From page 10 would "spend time out of her room as she feels up to it". 2) Was noted to be at risk for impaired individual coping r/t NH placement, impaired mobility, and at times would appear fearful of motion/movement with EZ-stand and when she was in her wheelchair as resident will scream, yell, and/or cry when staff is assisting her in EZ-stand and in her wheelchair, with an intervention to discuss resident fears with resident and inform the charge nurse when R5 was upset, screaming, yelling and/or crying. 3) Has little or no activity involvement r/t disinterest and immobility and physical limitations. Staff were to establish and record R5's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary and required assistance/escort to activity functions. 4) has ADL self-care performance deficit r/t activity intolerance, morbid obesity, impaired mobility. 5) Chronic Pain r/t osteoarthritis, impaired mobility, and morbid obesity with a goal to not have an interruption in normal activities due to pain. Staff were to monitor/document for probable cause of each pain episode and remove/limit causes where possible and monitor resident's existing conditions which may increase pain and or discomfort. 6) has impairment to skin integrity r/t chronic peripheral edema (swelling of limbs),decreased mobility, obesity and refusals to be repositioned every 2 hours. Staff were to identify/document potential causative factors and eliminate/resolve where possible. R5 required a pressure relieving cushion to protect the skin while up in her chair. Review of R5's progress notes and medical	21810		

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21810	Continued From page 11 record identified there was no mention if R5 had been assessed per the care plan above as to why she refused to be repositioned, or why she declined to be seated in her wheelchair. There was also no indication therapy had been notified to assess R5 for appropriate wheelchair size. Interview on 3/26/25, at 3:56 p.m., with the licensed practical nurse (LPN)-A reported R5 "has the right to refuse". She identified she had never asked her why she refused to come out of her room, but she recalled her being uncomfortable sitting on the commode and states "she is almost always uncomfortable". Interview on 3/27/25 at 1:54 p.m., with the administrator identified he agreed the facility had not reached out to R5's physician to request an assessment by therapy for an appropriate wheelchair and had no documentation identifying that they had attempted any interventions to improve R5's comfort while sitting in her wheelchair. The administrator identified he would have expected nursing to update R5's physician and request an order for her to be evaluated by therapy. Therapy was unavailable for interview. Review of the facilities undated Accommodation of Needs policy identified the facility would assist the resident in maintaining and/or achieving safe independent functioning, dignity and well-being. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. Staff attitudes and behaviors must be directed towards assisting the resident in maintaining independence, dignity and well-being	21810		

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21810	Continued From page 12 to the extent possible and in accordance with the residents' wishes. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or should develop, review, and /or revise policies and procedures to ensure all residents are appropriately assessed for mobility devices. The DON or designee should educate staff to those changes and perfoem meaurable audits and report findings to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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	24G454	A. BUILDING **01** B. WING _____	**02/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAWSON ICFMR	**2974 192ND STREET** **DAWSON, MN 56232**

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K 000	INITIAL COMMENTS FIRE SAFETY E-SCORE: +5 = IMPRACTICAL An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/11/2025. At the time of this survey, Dawson ICFMR was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.470(j), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33 Existing Residential Board and Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000		

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

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 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info This 2-story building was constructed in 1971 and determined to be of Type II (111) construction. It has a full basement and is sprinkler protected throughout. The facility has a fire alarm system with detection in all areas. The facility also has automatic smoke detection in all sleeping rooms. The facility has a licensed capacity of 6 beds and had a census of 3 at the time of the survey. The requirements at 42 CFR, Subpart 483.470(j), are NOT MET as evidenced by.	K 000		

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	24G454	A. BUILDING **01** B. WING _____	**02/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAWSON ICFMR	**2974 192ND STREET** **DAWSON, MN 56232**

(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
K0345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on a review of available documentation, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 33.2.3.4.1, 9.6, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, and 14.4.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/11/2025 between 9:30 and 10:30 AM, it was revealed during a review of available documentation at the time of inspection that there was no documentation for the sensitivity testing of the smoke detectors. An interview with the Program Director verified this deficient finding at the time of discovery.	K0345		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with	K0353		

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K0353	Continued From page 3 NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant	K0353		

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K0353	Continued From page 4 sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 33.2.3.5.3, and 9.7.5, and NFPA 25 (2011 eidtion), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2, and 5.2.5. These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 02/11/2025, between 9:30 and 10:30 AM, it	K0353		

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K0353	Continued From page 5 was revealed by review of available documentation that quarterly inspections of the fire sprinkler system have not been occurring. 2. On 02/11/2025, between 9:30 and 10:30 AM, it was revealed by observation that the sprinkler head in the main floor storage room was covered in lint and dust. An interview with the Program Manager verified these deficient findings at the time of discovery.	K0353		
K0511	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical systems per NFPA 101 (2012 edition), Life Safety Code, sections 33.2.5.1 and 9.1.2, and NFPA 70, (2011 edition), National Electrical Code, section 400.8. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 02/11/2025 between 9:30 and 10:30 AM, it was revealed by observation that a white extension cord was being used to plug in a multiplug adapter that was being used to provide power to a fan and a laptop charger in the lower level office.	K0511		

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K0511	Continued From page 6 An interview with the Program Manager verified this deficient finding at the time of discovery.	K0511		