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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GY84

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00406

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/14/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 03/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245553

March 15, 2016

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

Dear Mr. Werner:

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

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

Effective March 4, 2016 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
March 15, 2016

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

RE: Project Number S5553026

Dear Mr. Werner:

On February 11, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 14, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 26, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 28, 2016, effective March 4, 2016 and therefore remedies outlined in our letter to you dated February 11, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245553 Y1	A. Building B. Wing Y2	3/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0242	Correction	ID Prefix F0280	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	02/26/2016	LSC	03/04/2016	LSC	02/26/2016
ID Prefix F0282	Correction	ID Prefix F0329	Correction	ID Prefix F0441	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.65	Completed
LSC	02/26/2016	LSC	02/26/2016	LSC	03/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	03/15/2016	03048	3/14/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/28/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245553 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/26/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0025	02/19/2016	LSC	K0029	02/19/2016	LSC	K0050	02/19/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0056	02/01/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	3/15/2016	35482	2/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
1/27/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GY84

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00406

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 02/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/10/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 11, 2016

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

RE: Project Number S5553026

Dear Mr. Werner:

On January 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 8, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 28, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING _____ B. WING _____	01/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess self-administration of medication for 1 of 1 resident (R15) who stored medications in her room. Findings include: R15's most recent quarterly Minimum Data Set (MDS) dated 10/17/15, indicated a Brief Interview for Mental Status (BIMS) score of 15/15, indicating cognition was intact.	F 176	1. Resident 15 has been assessed for self administration of medication. 2. Any resident who wishes to self administer medications will have assessments completed to determine cognitive and functional abilities. 3. Staff will be educated through in-service on self administration policy and assessment. 4. QA nurse will monitor quarterly to assure self administration policy is being followed. 5. Director of nurses will assure plan is	2/26/16

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

Electronically Signed | 02/19/2016

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 _____	01/28/2016

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 176	Continued From page 1 Review of the physician orders dated 1/21/16, indicated an order for aspercreme (pain relieving creme) 10% cream apply to affected areas as needed (PRN) R15 was observed on 1/25/16 at 3:48 p.m., to have a full-sized tube of aspercreme on the table beside the recliner where she was seated. R15 indicated she had a lot of pain in her right knee and leg as a result of "bone on bone" and therefore utilized the aspercreme as needed. The pharmacy label on the tube identified the medication as ordered for R15 and directed PRN use. When observed again on 1/25/16, at 6:30 p.m. the aspercreme remained located on the table beside R15's recliner. R15 indicated at this time she preferred to apply the creme to her right knee before she went to bed, but she would also use it during the day when needed. When questioned whether she applied the aspercreme herself, she responded affirmatively. R15 further confirmed that nursing staff leave the aspercreme in her room for her to apply independently. During intermittent observations made on 1/26/16 and 1/27/16, the aspercreme remained on the table beside R15's recliner. R15 stated she had been applying the creme at times during the day to her right knee but could not recall the times. During interview on 8/27/16 at 10:00 a.m. with licensed practical nurse (LPN)-A, indicated R15 did not have a self-administration of medication assessment completed for the use of the aspercreme. LPN-A further indicated she was unsure when and if the aspercreme had been used. Review of the January 2016 medication administration record (MAR) did not show any documentation of application of the aspercreme. During interview with the director of nursing	F 176	sustained by addressing at QA meeting.	

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F 176	Continued From page 2 (DON) on 1/27/16, at 10:21 a.m. verified a self-administration assessment nor physician order obtained for self-administration of the aspercreme for R15. The DON confirmed the interdisciplinary team had not been involved in the determination of it's safe use. The DON further indicated the aspercreme should be stored at the nurses station and observed/documented by the licensed nurse when used.	F 176		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accommodate bathing choices for 2 of 3 residents (R12, R30) reviewed for choices. Findings include: When interviewed on 1/25/16, at 4:10 p.m. R30 indicated she had been receiving a shower weekly but would prefer a bath. R30 also indicated the facility maintained a bathtub but was unsure whether it was being utilized by residents. Review of R30's significant change Minimum Data Set (MDS) dated 8/4/15, indicated giving	F 242	1. R12 and R30's bathing choices have been reviewed with residents. At present, on this date, both residents would like to have a bath; however, since our survey, these two resident's have changed their minds on the bath/shower/bed bath choice numerous times. 2. All residents will be offered bathing choices. 3. Staff will be educated through in-service on resident's options re: bathing choices. 4. Social service will assure resident's preferences/choices are being followed on	3/4/16

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F 242	Continued From page 3 R30 a choice of a tub bath, shower, bed bath or sponge bath to be very important. The facility untitled quarterly questionnaire form utilized by the licensed social worker (LSW) related to choices dated 10/29/15, included the following questions/answers: "Are you receiving a shower or bath each week? # of times each week?" R30's answer indicated: "Yes, 1 x/wk." (one time a week). "Are you satisfied with your current shower/bath schedule?" R30's answer indicated: "Yes". The form did not include a preference between taking a tub bath or a shower. When interviewed on 1/26/16, at 9:06 a.m. R12 stated receiving a shower once a week but would prefer more often; especially if she could have a tub bath. R12 indicated being unsure wether the bath tub was functional. R12's admission MDS dated 11/22/15, indicated being somewhat important for R12 to choose between a tub bath, shower, bed bath, or sponge bath. The facility untitled quarterly questionnaire form utilized by the licensed social worker (LSW) related to choices dated 11/16/15, included the following questions/answers: "Are you receiving a shower or bath each week? # of times each week?" R12's answer indicated: "Shower 1 x/wk." "Are you satisfied with your current shower/bath schedule?" R12's answer indicated: "Yes". The form did not include a preference between taking a tub bath or a shower. When interviewed on 1/27/16, at 1:09 p.m. the LSW confirmed asking residents the questions as	F 242	a quarterly basis. She will use a form entitled "Resident Preferences". 5. Director of nurses will assure plan is being sustained and to assure no psychological stress is brought to residents who choose to have a shower on an ongoing basis.	

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F 242	Continued From page 4	F 242		

written on the untitled form related to choices quarterly. When the LSW was questioned whether a functional bath tub was available for resident use, the LSW responded that to her knowledge there was one available but the director of nursing (DON) could confirm this question.

When interviewed on 1/27/16, at 1:25 p.m. the DON confirmed a new whirlpool bathtub in working order was available but could not state exactly the date of installation. DON further confirmed the tub had not yet been used by residents due to staffing issues and further more, staff hadn't been trained yet on how to use the tub. The DON also indicated she was uncertain whether the company from which the tub was purchased had been contacted and an Inservice scheduled yet.

When interviewed on 1/28/16, at 9:30 a.m. the administrator confirmed the bath tub was fully functional and knew there had been some resistance to using it. The administrator confirmed there had been an "instructional" related to use of the tub and was aware that some of the staff had been trained on how to use it. During a subsequent interview at 10:45 a.m., the administrator confirmed the facility had the new whirlpool bath tub since 8/20/15. The administrator stated the tub came with an instructional video and reiterated that some of the staff had viewed the video. The administrator stated being unaware that the tub had not been used, though was aware of staff resistance.

When interviewed on 1/28/16, at 11:55 a.m. nursing assistant (NA)-A confirmed staff only offer showers to the residents and had not been

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F 242	Continued From page 5 instructed to use the new bathtub nor had they been trained on how to use the tub. When interviewed on 1/28/16, at 12:24 p.m. NA-B confirmed residents were given showers and baths were not offered. When interviewed on 1/28/16, at 3:15 p.m. the DON confirmed the new whirlpool bathtub was functional but was not being offered as an option to residents at this time. DON further stated giving a bath took twice as long as a shower and would take up more of staff's time.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		2/26/16

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F 280	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the plan of care to reflect interventions for falls for 1 of 1 (R28) who was reviewed for accidents. Findings include: Review of the significant change Minimum Data Set (MDS) dated 12/5/15, identified R28 as having a brief interview for mental status (BIMS) score of 14 indicating intact cognition and diagnosis including polymyalgia rheumatica, atrial fibrillation, and chronic obstructive pulmonary disease. The Care Area Assessment (CAA) dated 12/8/15 identified R28 as being at risk for falls. Review of the medical record indicated R28 had falls on 9/18/15, 12/12/15, 12/28/15 and 1/8/15. Review of the incident reports identified that two of the falls were due to the resident having his reclining chair up too high and sliding out of the chair. The safety committee notes for the falls on 9/18/15 and 12/12/15 identified the root cause of the falls as lower extremity weakness. The interventions were to remind resident to not put chair in such a high position. R28 was identified as being independent with transfers. Review of the care plan dated 9/4/15, did not identify that R28 needed to be reminded to not put recliner in high position due to previous falls related to this nor did the care plan reflect the use of the alarm in the recliner. During observations of R28 on 1/26/16, at 1:30 p.m., 1/26/16, at 2:30 p.m., 1/26//16 at 3:30 p.m.	F 280	1. R28's plan of care was revised prior to survey teams exit. 2. All resident's care plans will be revised as need arises dependent on their health condition. 3. Staff will be educated through in-service on assuring that interventions are reflected in the resident's plan of care. 4. QA nurse will monitor and review care plans on a quarterly basis to assure care plans are updated timely. 5. Director of nurses will monitor to assure plan is sustained on an ongoing basis.	

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F 280	Continued From page 7 and 1/27/16, 6:05 a.m. resident was observed sitting in his recliner chair with feet elevated and a tabs alarm attached. On 1/27/16, at 6:30 a.m. R28 remained in the recliner with feet elevated and tabs alarm on. On 1/28/2016, at 8:29 a.m. R28 stated, "I don't try to do it myself anymore (get up on his own). I had my chair up too high and I slid out. Now I know I can't wind it too high! During interview with nursing assistant (NA-C) on 1/28/2016, at 8:34 a.m. she stated that R28 is now transferred with an EZ lift as he needs more assistance and is no longer walking. She states he is very good about waiting for help to get out of the recliner now. She stated he has an alarm on while in his recliner. During interview with the director of nursing (DON) on 1/28/16, at 10:17 a.m. she stated that any interventions needed after a fall should be added to the care plan. She verified the care plan had not been updated to reflect the interventions of a personal alarm while in recliner and that R28 would raise the recliner too high and needed to be reminded to not put the recliner in the highest position related to falls from chair.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 282	1. R12's nonpressure skin concern was	2/26/16

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F 282	Continued From page 8 review the facility failed to follow the plan of care related to identifying and reporting new skin concerns for 1 of 3 residents (R12) reviewed for non pressure related skin concerns. Findings include: R14 was admitted on 4/121/15 with diagnoses that included: From MD (medical doctor)order sheet in paper record; hypertension, hyperlipidemia, right drop foot with right leg weakness secondary to brain surgery, osteoporosis, lumbar spinal stenosis and cerebral vascular accident (CVA). Review of the care plan dated 5/13/15, indicated a problem of potential for altered skin integrity with a Braden Risk score of 13 (<=16 is at risk for breakdown). Interventions included; 1.) inspect skin daily 2.) weekly skin assessment 3.) weekly wound progress assessment/documentation by nurse 4.) treatment as ordered. During observation on 1/26/16, at 9:04 a.m. R14 was noted to have a large purple colored bruise 3.0 cm x 2.0 cm on the mid-shin of her right leg. In addition; a smaller dark red/purple area was noted to the right of this bruise and measured 2.0 cm x 2.0 cm. Extending around the lateral aspect and onto the back of the right leg had a brownish discoloration. R14 had a 2.0 cm x 2.0 cm dressing on the inner aspect of the right calf. During interview on 1/26/16, at 9:04 a.m. R14 indicated uncertainty as to when the bruise had occurred, but stated she thought it was the result of staff holding onto her right leg when she was being transferred with the EZ sling lift. R14 indicated the staff were not attempting to harm her. R14 further indicated she was unaware of the reason for the dressing located on the inner	F 282	identified and documented prior to survey teams exit from the facility (measurements utilized in the survey teams "findings" are Parkview's measurements, please give credit). 2. All non-pressure skin concerns will be identified and documented. 3. Staff will be in-serviced on identifying non-pressure skin concerns and reporting areas of concern to the charge nurse. 4. QA nurse will conduct skin and chart audits on a quarterly basis to assure plan is followed and that non-pressure related skin concerns are identified and documented. 5. Director of nurses will assure plan is being sustained on an ongoing basis.	

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F 282	Continued From page 9 aspect of her right calf. On 1/27/16, at 1:15 p.m. R14 was observed being transferred from her wheelchair (w/c) to bed by nursing assistants (NA)-A and NA-C . The NAs were observed to guide grip R14's right lower leg and guide both legs around the lift stand, positioning for being lowered into bed. R14 indicated this was the usual procedure followed for transferring from the w/c to bed. Review of the weekly skin assessments, the wound clip board, in addition to the written nursing notes for January 2016 did not indicate any skin issues/bruises documented for R14's lower extremities. In addition there was no indication listed for use of the dressing located on R14's right inner calf area. An interview was conducted with the director of nursing (DON) on 1/27/16, at 12:56 p.m. R14's right calf area was viewed and the DON confirmed this was an area she would have expected to be reported to the charge nurse for assessment, documented on the weekly/bath skin assessment and documented in the record with appropriate notifications. The DON indicated the dressing located on R14's right inner calf was for protection of her skin as she tended to develop skin issues in this area. Review of the the facility policy Bruises/Skin tears Parkview Manor Nursing Home dated 1/2015 included; 1.) NA's will report bruises, open areas, skin tears, etc. to charge nurse. 2) NA's will document these areas on the shower sheets or verbally report to charge nurse. 3) Charge nurses will document area of concern in the nurses notes. 4) Area of concern should be added to Skin/Wound charting flowsheet. 5) The day charge nurse is responsible to check this sheet daily to assure that day's documentation is	F 282		

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F 282	Continued From page 10 complete. 6) The area of concern should be documented on weekly; until healed. 7) Be sure that "a cause" for the area of concern is included in the nurses notes; and 9) Continue to document bruising, skin tears, thin skin, fragile skin, etc. in plan of care.	F 282		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 329	1. R34's medications have been	2/26/16

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F 329	Continued From page 11 review the facility failed to insure dose reductions were addressed for 1 of 5 residents (R34) reviewed for unnecessary medications. Findings include: R34 was admitted on 3/30/15, with diagnoses obtained from the physician order sheet which included: Dementia with behavioral disturbances, upper respiratory infection, atrial fibrillation, hypertension, osteoarthritis and weakness. Review of the medication administration record indicted R34 was receiving two psychotropic medications which required assessment for gradual dose reduction (GDR) interventions. (1.) Risperidone 1 milligram (mg) by mouth (PO) every (Q) Day(D) at bedtime(HS) and 0.25 mg PO Q morning (AM).(antipsychotic ordered 3/30/15), and (2.) Lorazepam 1.5 mg PO QHS (antianxiety ordered 3/30/15). Multiple observations were made of R34 during the period of 1/26/16 and 1/27/16: On 1/26/16, at 2:58 p.m. R34 was observed lying in bed with eyes closed, mouth open and breathing softly. The bed was in the low position and a gray mat was on the floor beside the bed. On 1/26/16, at 3:11 p.m. R34 was seated in a high back wheelchair (w/c) with tab alarm attached and positioned in the lounge area facing the TV. R34's eyes remained closed, mouth open and breathing softly. At 3:30 p.m. R34 continued to remain in the same position in front of the TV. At 4:08 p.m. R34 remained seated in the high backed w/c with tab alarm and no other persons interacting with him. R34 appeared comfortable and did not engage in	F 329	reviewed by his physician. Additional documentation has been added to substantiate need for "unnecessary medications". 2. All residents receiving "unnecessary medications" will have meds reviewed by pharmacy and if the physician deems necessary will have a dose reduction trialed. 3. Staff is educated through in-service training regarding "unnecessary drugs" and need to insure dose reductions versus need for continuation of such medications. 4. Pharmacy will monitor monthly to assure "unnecessary medications" are reviewed timely, to assure continued need, and to assure adequate documentation exists to support need for "unnecessary medications'. 5. Director of nurses will assure plan is sustained on an ongoing basis.	

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F 329	Continued From page 12 activity occurring around him. On 1/27/16, at 7:12 a.m. R34 was again observed seated in a high back w/c positioned in the lounge area in front of the TV. Eyes were open and R34 appeared to be observing persons moving around the area. At 7:36 a.m. R34 remained in the w/c facing the TV with eyes closed, mouth open and breathing softly. 7:50 a.m. R34 was transported into the dining room and positioned at the feeding assist table. At 9:00 a.m. R34 was again seated in his w/c located in the lounge area. Activity "World News" took place and resident sat with eyes closed and indicated no interest in the activity occurring around him. At 10:00 a.m. resident was observed lying on his back in bed and appeared to be resting quietly. At 11:16 a.m. R34 was observed back up in the high backed w/c and positioned by table in the lounge area with a newspaper on the table. No occurrences of the documented behaviors were noted during the period of observation. During interview on 1/26/16, at 2:46 p.m. nursing assistant (NA)-C stated R34 does not participate in activities and at times he will talk, but usually what is said is not appropriate to what is being discussed. NA-C also indicated R34 is on a list for a sensory group, but a lot of times is very sleepy so doesn't attend. NA-C indicated R34 is total care with dressing, grooming, toileting, and is incontinent. NA-C indicated R34 does display behaviors of "feisty" hitting out, or shaking fist, or will grab hold of caregiver and not let go. NA-C indicated behaviors occur on an average 3 days a week and when they occur the intervention is to allow R34 to calm down and then reattempts. NA-D was interviewed on 1/26/16, at 3:35 p.m.	F 329		

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	245553	A. BUILDING _____ B. WING _____	01/28/2016

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F 329	Continued From page 13	F 329		

and indicated R34 displayed anxiety at times and is resistive to repositioning. NA-D indicated R34 does display behaviors and on good days is cooperative, but on bad days is anxious and attempts to scoot out of his recliner or chair and when staff attempt to assist/intervene he becomes angry and will at times hit out. NA-D further started R34's usual behavior if angry is to yell out and call names and staff attempt redirection by bringing up things resident likes, and if this is ineffective will leave and attempt again at a later time.

Review of January 2016 behavior monitoring were noted: Physical abuse-hitting/kicking-4 times; Resistive with cares-8 times; easily angered/agitated-9 times; wandering-0; anxious-12 times.

Pharmacy Consultant Reviews were provided with the following recommendations and physician (MD) responses:

(1) 6/18/15-recommendation-review of psychotropic meds for a possible gradual dose reduction (GDR)-MD response dated 6/18/15, and subsequent orders dated 6/18/15- PRN Lorazepam discontinued (DC) ed.

(2) 8/17/15-pharmacist recommendation: GDR of psychotropic medications-Risperdal 0.25 mg QAM, 1 mg QHS; Haldol 1 mg Q 4 H prn (used 18 times April; 4 x May; 1 x June; 0 x July) Ativan 1.5 mg qHS; Depakote sprinkles 250 mg PO BID; No MD response to recommendation.

(3) 10/15/15-pharmacist recommendation: review psychotropic meds. MD response 10/15/15-continue with current psychotropic

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F 329	Continued From page 14 medications. (4) 12/7/15-pharmacist recommendation: unused prn Haldol order. MD response dated 12/17/15-DC PRN Haldol. On 1/28/16, at 2:34 p.m. the consultant pharmacist was interviewed via telephone and stated she was not certain how the MD had responded related to the requested GDR, but according to the notes reviewed with her, (Consultant Pharmacist Report), agreed the requested GDR for the scheduled Risperdone and Ativan had not been addressed by the MD. A follow up letter was received dated 1/29/16, after the pharmacist had reviewed her documentation and indicated, " I sent 2 psychotropic reviews within the first 6 months of admit, not including the note requesting discontinuation of the unused prn order for Haldol. I also monitored behaviors within the first few months of admit along with need for Haldol and Ativan prn initially as resident 'settled in' to nursing home care. My letters to the doctor did include wording to 'review the medications listed for the possibility of a trial dose reduction or taper to discontinuation and document reasoning in your progress note'. According to the notes I made to myself, it appears that the doctor addressed the psychotropic medications as 'continue current medications for dementia with behavioral issues which is under good control currently'. The consultant pharmacist further indicated she planned to address the need for documentation of need and risk versus benefit of continued use of psychotropic medications with the MD.	F 329		

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F 441	Continued From page 15	F 441		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		3/4/16

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure proper hand hygiene was used by staff while feeding residents for 6 of 6 residents (R1, R7, R34, R24, R20, R43) observed during meals. Findings include: During observation of the breakfast meal on 1/27/16, at 8:00 a.m. nursing assistant (NA)-A was observed feeding R1 bacon. NA-A picked up the piece of bacon with her bare hands while feeding R1. NA-A was observed to touch R1's mouth to get the bacon in her mouth. NA-A then gave R20 his toast to eat using the same hand she had fed R1 with. NA-A did not wash her hands between feeding R1 and R20. On 1/27/16, at 8:03 a.m. NA-C was observed to be feeding R24 and R34. NA-C was observed to use a spoon to feed R24 toast and bacon. When feeding R24, NA-C was observed to use her bare hand to put the food from the spoon into R24's mouth. NA-C then picked up R34's toast with the same hand, put jelly on it and folded it over and then handed it to R34 to eat. NA-C did not wash her hands between feeding R24 and R34. On 1/28/16, at 7:50 a.m. NA-A was observed feeding R7 and R43 breakfast. NA-C fed R7 toast with her bare hands touching R7's mouth. NA-A then picked up R43's toast with the same hand and handed it to him. This continued through breakfast with finger foods. NA-A did not wash her hands between feeding R7 and R43.	F 441	1.Proper hand hygiene is being utilized during meals when feeding residents R1, R7, R34, R24, R20, and R43. 2. Proper hand hygiene is being utilized by all CNA's while feeding residents during meals. 3. Staff will be educated through in-service training regarding proper hand hygiene with particular focus on feeding multiple residents at the same time to avoid cross contamination. 4. QA nurse will monitor CNA's during meals for one week to assure proper hand hygiene is being practiced during meals. 5. Director of nurses will assure plan is sustained on an ongoing basis.	

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F 441	Continued From page 17 During interview on 1/28/2016, at 2:23 p.m. NA-A verified she had not washed her hands between feeding R1 and R20 and R7 and R43, and used the same hand to feed both residents. During interview on 1/28/16, at 2:27 p.m. NA-C verified that she had not washed her hands between feeding R24 and R34 and used the same hand to feed both residents. During interview on 1/28/2016, at 10:27 a.m. the director of nursing (DON) verified that NA-A and NA-C should have washed their hands between feeding the residents. Review of the policy Assistance with Eating dated 6/2010, indicated if a NA (nursing assistant) is feeding two residents at the same time, the NA should use the same hand when feeding residents finger foods and such to avoid cross contamination. Frequent hand washing may be necessary to avoid cross contamination between residents.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 27, 2016. At the time of this survey, Parkview Manor Nursing Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2016

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

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

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K 000	Continued From page 2 a factory labeled, self-closing, positive latching, 90-minute fire rated double door assembly. The 1980 Addition consists solely of an attached Generator Room, which is separated from the Nursing Home by a 2-hour fire wall, with no communicating openings. This room is accessible only from the building exterior. The facility has a fire alarm system with smoke detection located at smoke barrier doors and in spaces open to the corridors, which are monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with automatic smoke alarms. The facility has a capacity of 37 beds and had a census of 34 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barrier wall in accordance with	K 025	1. Inspect all fire smoke barriers. Seal all penetrations with sheet rock, fire caulk	2/19/16

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K 025	Continued From page 3 the following requirements of 2000 NFPA 101, Section 19.3.7.3, 8.3.2 and 8.3.6. The deficient practice could affect 25 out of 34 residents. Findings include: On facility tour between 10:30 AM and 1:30 PM on 01/27/2016, observation revealed that the smoke barriers on the east and west corridor have open penetrations above smoke barrier doors above the lay in ceiling. NOTE: All smoke barriers need to be checked from exterior wall to exterior wall. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 025	and fire rated foam. 2. 2-19/16 3. Mike Werner, administrator responsible for monitoring compliance.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain a hazardous area door in accordance with NFPA 101 (00), Chapter 19, Section 19.3.2.1	K 029	1. All door hold open devices not connected to fire alarm system are removed. All doors have door closers.	2/19/16

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K 029	Continued From page 4 and 19.3.6.3.2, and Chapter 8, Section 8.2.3.2.3.2. In a fire emergency, this deficient practice could adversely affect 20 of 34 patients. FINDINGS INCLUDE: On 01/27/16 at 11:50 AM, observation revealed the following Hazardous Areas need self closing doors to latch into the door frames: Storage Room North Hallway,Maintenance/Storage Room, Kitchen, Soiled Linen Room. Doors were observed being held open by magnetic devices not connected into to Fire Alarm System. This finding was confirmed with the chief building engineer.	K 029	Hold open devices connected to these doors in the future will be connected to fire alarm system. 2. 2-19/16 3. Mike Werner, administrator responsible for monitoring compliance.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2.	K 050	1. Schedule made out by Administrator and maintenance director for fire drill and insure completion on timely basis. 2. 2-19/16 3. Mike Werner, administrator responsible for monitoring compliance.	2/19/16

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K 050	Continued From page 5 Findings include: On facility tour between 11:00 AM and 1:30 PM on 01/27/2016, the review of the fire drill documentation revealed that no fire drill was conducted 3rd quarter (Jul-Sep) day shift. This deficient practice was confirmed by the Director of Facility Maintenance at the time of discovery.	K 050		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7. The deficient practice could affect 15 out of 56 residents. FINDINGS INCLUDE:	K 056	1. Maintenance person inspected entire system. Total Fire of Brandon, SD here and inspected entire system. Connected sprinkler system to rooms that were missed. All rooms connected on 1/28/2016. Curtains in shower in shower room replaced on 2/1/16. 2. 2-1-16	2/1/16

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K 056	Continued From page 6 On facility tour between 11:00 AM and 1:30 PM on 01/27/2016, observation revealed: 1.) Fire sprinkler piping was not attached/connected to the main fire sprinkler supply line for Rooms 10 and 14 in the West Hallway. 2.) Fire sprinkler heads were impeded by solid curtains in both shower rooms. The entire fire sprinkler system needs to be checked to ensure system has been installed and is being maintained properly. that in the 1976 addition, the main entrance vestibule does not have a fire sprinkler protection. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 056	3. Mike Werner, administrator responsible for monitoring compliance.	

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
February 11, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5553026

Dear Mr. Werner:

The above facility was surveyed on January 25, 2016 through January 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 contact Kathryn Serie at (507) 476-4233.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00406	A. BUILDING: _____ B. WING _____	01/28/2016

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) COMPLETE DATE
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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On January 25, 26, 27, 28, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the plan of care related to identifying and reporting new skin concerns for 1 of 3 residents (R12) reviewed for non pressure related skin concerns. Findings include: R14 was admitted on 4/121/15 with diagnoses that included: From MD (medical doctor)order sheet in paper record; hypertension, hyperlipidemia, right drop foot with right leg weakness secondary to brain surgery, osteoporosis, lumbar spinal stenosis and cerebral vascular accident (CVA). Review of the care plan dated 5/13/15, indicated a problem of potential for altered skin integrity with a Braden Risk score of 13 (<=16 is at risk for breakdown). Interventions included; 1.) inspect skin daily 2.) weekly skin assessment 3.) weekly wound progress assessment/documentation by nurse 4.) treatment as ordered.	2 565	Corrected.	2/26/16

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2 565	Continued From page 3 During observation on 1/26/16, at 9:04 a.m. R14 was noted to have a large purple colored bruise 3.0 cm x 2.0 cm on the mid-shin of her right leg. In addition; a smaller dark red/purple area was noted to the right of this bruise and measured 2.0 cm x 2.0 cm. Extending around the lateral aspect and onto the back of the right leg had a brownish discoloration. R14 had a 2.0 cm x 2.0 cm dressing on the inner aspect of the right calf. During interview on 1/26/16, at 9:04 a.m. R14 indicated uncertainty as to when the bruise had occurred, but stated she thought it was the result of staff holding onto her right leg when she was being transferred with the EZ sling lift. R14 indicated the staff were not attempting to harm her. R14 further indicated she was unaware of the reason for the dressing located on the inner aspect of her right calf. On 1/27/16, at 1:15 p.m. R14 was observed being transferred from her wheelchair (w/c) to bed by nursing assistants (NA)-A and NA-C . The NAs were observed to guide grip R14's right lower leg and guide both legs around the lift stand, positioning for being lowered into bed. R14 indicated this was the usual procedure followed for transferring from the w/c to bed. Review of the weekly skin assessments, the wound clip board, in addition to the written nursing notes for January 2016 did not indicate any skin issues/bruises documented for R14's lower extremities. In addition there was no indication listed for use of the dressing located on R14's right inner calf area. An interview was conducted with the director of nursing (DON) on 1/27/16, at 12:56 p.m. R14's right calf area was viewed and the DON confirmed this was an area she would have expected to be reported to the charge nurse for	2 565		

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2 565	Continued From page 4 assessment, documented on the weekly/bath skin assessment and documented in the record with appropriate notifications. The DON indicated the dressing located on R14's right inner calf was for protection of her skin as she tended to develop skin issues in this area. Review of the the facility policy Bruises/Skin tears Parkview Manor Nursing Home dated 1/2015 included; 1.) NA's will report bruises, open areas, skin tears, etc. to charge nurse. 2) NA's will document these areas on the shower sheets or verbally report to charge nurse. 3) Charge nurses will document area of concern in the nurses notes. 4) Area of concern should be added to Skin/Wound charting flowsheet. 5) The day charge nurse is responsible to check this sheet daily to assure that day's documentation is complete. 6) The area of concern should be documented on weekly; until healed. 7) Be sure that "a cause" for the area of concern is included in the nurses notes; and 9) Continue to document bruising, skin tears, thin skin, fragile skin, etc. in plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility follow care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision	2 570		2/26/16

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2 570	Continued From page 5 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the plan of care to reflect interventions for falls for 1 of 1 (R28) who was reviewed for accidents. Findings include: Review of the significant change Minimum Data Set (MDS) dated 12/5/15, identified R28 as having a brief interview for mental status (BIMS) score of 14 indicating intact cognition and diagnosis including polymyalgia rheumatica, atrial fibrillation, and chronic obstructive pulmonary disease. The Care Area Assessment (CAA) dated 12/8/15 identified R28 as being at risk for falls. Review of the medical record indicated R28 had falls on 9/18/15, 12/12/15, 12/28/15 and 1/8/15. Review of the incident reports identified that two of the falls were due to the resident having his reclining chair up too high and sliding out of the chair. The safety committee notes for the falls on	2 570	Corrected.	

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2 570	Continued From page 6 9/18/15 and 12/12/15 identified the root cause of the falls as lower extremity weakness. The interventions were to remind resident to not put chair in such a high position. R28 was identified as being independent with transfers. Review of the care plan dated 9/4/15, did not identify that R28 needed to be reminded to not put recliner in high position due to previous falls related to this nor did the care plan reflect the use of the alarm in the recliner. During observations of R28 on 1/26/16, at 1:30 p.m., 1/26/16, at 2:30 p.m., 1/26//16 at 3:30 p.m. and 1/27/16, 6:05 a.m. resident was observed sitting in his recliner chair with feet elevated and a tabs alarm attached. On 1/27/16, at 6:30 a.m. R28 remained in the recliner with feet elevated and tabs alarm on. On 1/28/2016, at 8:29 a.m. R28 stated, "I don't try to do it myself anymore (get up on his own). I had my chair up too high and I slid out. Now I know I can't wind it too high! During interview with nursing assistant (NA-C) on 1/28/2016, at 8:34 a.m. she stated that R28 is now transferred with an EZ lift as he needs more assistance and is no longer walking. She states he is very good about waiting for help to get out of the recliner now. She stated he has an alarm on while in his recliner. During interview with the director of nursing (DON) on 1/28/16, at 10:17 a.m. she stated that any interventions needed after a fall should be added to the care plan. She verified the care plan had not been updated to reflect the interventions of a personal alarm while in recliner and that R28 would raise the recliner too high and needed to be reminded to not put the recliner in the highest position related to falls from chair.	2 570		

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2 570	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of	21390		3/4/16

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21390	Continued From page 8 products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure proper hand hygiene was used by staff while feeding residents for 6 of 6 residents (R1, R7, R34, R24, R20, R43) observed during meals. Findings include: During observation of the breakfast meal on 1/27/16, at 8:00 a.m. nursing assistant (NA)-A was observed feeding R1 bacon. NA-A picked up the piece of bacon with her bare hands while feeding R1. NA-A was observed to touch R1's mouth to get the bacon in her mouth. NA-A then gave R20 his toast to eat using the same hand she had fed R1 with. NA-A did not wash her hands between feeding R1 and R20. On 1/27/16, at 8:03 a.m. NA-C was observed to be feeding R24 and R34. NA-C was observed to use a spoon to feed R24 toast and bacon. When feeding R24, NA-C was observed to use her bare hand to put the food from the spoon into R24's mouth. NA-C then picked up R34's toast with the same hand, put jelly on it and folded it over and then handed it to R34 to eat. NA-C did not wash her hands between feeding R24 and R34. On 1/28/16, at 7:50 a.m. NA-A was observed feeding R7 and R43 breakfast. NA-C fed R7 toast with her bare hands touching R7's mouth.	21390	Corrected.	

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21390	Continued From page 9 NA-A then picked up R43's toast with the same hand and handed it to him. This continued through breakfast with finger foods. NA-A did not wash her hands between feeding R7 and R43. During interview on 1/28/2016, at 2:23 p.m. NA-A verified she had not washed her hands between feeding R1 and R20 and R7 and R43, and used the same hand to feed both residents. During interview on 1/28/16, at 2:27 p.m. NA-C verified that she had not washed her hands between feeding R24 and R34 and used the same hand to feed both residents. During interview on 1/28/2016, at 10:27 a.m. the director of nursing (DON) verified that NA-A and NA-C should have washed their hands between feeding the residents. Review of the policy Assistance with Eating dated 6/2010, indicated if a NA (nursing assistant) is feeding two residents at the same time, the NA should use the same hand when feeding residents finger foods and such to avoid cross contamination. Frequent hand washing may be necessary to avoid cross contamination between residents. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21390		

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21426	Continued From page 10	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure tuberculin skin tests (TST's) were accurately documented for 5 of 5 employees (E1,E2, E3, E4 and E5) and 3 of 5 residents (R12, R25, and R31), and failed to complete a baseline screening to assess for current symptoms of active tuberculosis (TB) and patient risk factors for 1 of 5 residents (R25), per current Center for Disease Control and Prevention (CDC) recommendations and per facility policy. In addition the facility failed to complete a facility TB risk assessment every 2	21426	Corrected.	2/26/16

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21426	Continued From page 11 years per Minnesota Department of Health (MDH) regulation guidelines. Findings include: Employee (E)-1 had a hire date of 12/31/15. A second step TST was placed on 1/19/16, and read on 1/21/16. The documentation did not include the time the TST was placed nor read; the surveyor could not determine if the test was read between a 48-72 hour time period. E-2 had a hire date of 12/22/15. A first step TST was placed on 12/22/15 and read on 12/24/15. A second step TST was placed on 1/11/16 and read on 1/13/16. The documentation did not include the time either TST was placed nor read; the surveyor could not determine if the tests were read between a 48-72 hour time period. E-3 had a hire date of 10/5/15. A first step TST was placed on 10/6/15 and read on 10/8/15. A second step TST was placed on 1/21/16 and read on 1/23/16. The documentation did not include the time either TST was placed nor read; the surveyor could not determine if the tests were read between a 48-72 hour time period. E-4 had a hire date of 8/4/15. A first step TST was placed on 8/4/15 and read on 8/6/15. A second step TST was placed on 8/19/15 and read on 8/21/15. The documentation did not include the time either TST was placed nor read; the surveyor could not determine if the tests were read between a 48-72 hour time period. E-5 had a hire date of 8/7/15. A second step TST was placed on 8/24/15 and read on 8/26/15. The documentation did not include the time the TST was placed nor read; the surveyor could not	21426		

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21426	Continued From page 12 determine if the test was read between a 48-72 hour time period. R12 was admitted to the facility on 11/10/15. A second step TST was placed on 11/24/15 at 1400 (2:00 p.m.). There was no documented evidence to support that the TST result had been read. R25 was admitted to the facility on 9/21/15. The Baseline TB Screening Tool for Patients (a form that assess's current symptoms of active TB disease and patient's risk factors) dated 9/21/15 had not been completed for R25. A first step TST was placed on 9/21/15 and read on 9/23/15; neither the time placed or read was documented. A second step TST was read on 10/9/15 at 1330 (1:30 p.m.) though the documentation did not include what date and time the second step TST had been placed. The surveyor could not determine if the tests were read between a 48-72 hour time period. R31 was admitted to the facility on 9/16/15. A first step TST was placed on 9/16/15 and read on 9/18/15. A second step TST was placed on 9/30/15 and read on 10/2/15. The documentation did not include the time either TST was placed nor read; the surveyor could not determine if the tests were read between a 48-72 hour time period. The facility Tuberculosis (TB) risk assessment worksheet dated 6/2/09, indicated the facility was at a low risk. The form included handwritten dates on the bottom of the first page indicating the form was reviewed yearly by staff; the last review dated 11/15 indicated, "no changes". When interviewed on 1/28/16, at 2:35 p.m. the director of nursing (DON) confirmed the facility	21426		

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21426	Continued From page 13 TB risk assessment, though reviewed yearly, had not been completed since 6/2/09. DON confirmed the TST results for the identified employees and residents did not include the time the TST's were placed or read making it unable to determine if read between the 48-72 hour time period. The Tuberculosis Control Policy dated 12/2009, included: "3. All residents will have a Mantoux skin test 3 months prior to admission or within 72 hours of admission ad, if negative, the Mantoux will be repeated in 2 weeks. The Mantoux skin tests are read 48-72 hours after administration." "8. All paid and unpaid healthcare workers will have a Mantoux skin test upon hire to the facility. If negative, the Mantoux skin test will be repeated in 2 weeks. The Mantoux skin tests are read 48-72 hours after administration." The MDH Regulations for Tuberculosis Control in Health Care Settings dated July 2013 includes: "All health care settings in Minnesota should perform an initial facility TB risk assessment. Medium-risk settings should update their assessment yearly; low-risk settings should update theirs every other year." SUGGESTED METHOD FOR CORRECTION: The DON or administrator could review and update procedures and educate staff to ensure that current CDC recommendations for Tuberculosis are practiced. TIME PERIOD FOR CORRECTION: Seven (7) days.	21426		

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21535	Continued From page 14	21535		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to insure dose reductions were addressed for 1 of 5 residents (R34) reviewed for unnecessary medications. Findings include: R34 was admitted on 3/30/15, with diagnoses obtained from the physician order sheet which included: Dementia with behavioral disturbances,	21535	Corrected.	2/26/16

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21535	Continued From page 15 upper respiratory infection, atrial fibrillation, hypertension, osteoarthritis and weakness. Review of the medication administration record indicted R34 was receiving two psychotropic medications which required assessment for gradual dose reduction (GDR) interventions. (1.) Risperidone 1 milligram (mg) by mouth (PO) every (Q) Day(D) at bedtime(HS) and 0.25 mg PO Q morning (AM).(antipsychotic ordered 3/30/15), and (2.) Lorazepam 1.5 mg PO QHS (antianxiety ordered 3/30/15). Multiple observations were made of R34 during the period of 1/26/16 and 1/27/16: On 1/26/16, at 2:58 p.m. R34 was observed lying in bed with eyes closed, mouth open and breathing softly. The bed was in the low position and a gray mat was on the floor beside the bed. On 1/26/16, at 3:11 p.m. R34 was seated in a high back wheelchair (w/c) with tab alarm attached and positioned in the lounge area facing the TV. R34's eyes remained closed, mouth open and breathing softly. At 3:30 p.m. R34 continued to remain in the same position in front of the TV. At 4:08 p.m. R34 remained seated in the high backed w/c with tab alarm and no other persons interacting with him. R34 appeared comfortable and did not engage in activity occurring around him. On 1/27/16, at 7:12 a.m. R34 was again observed seated in a high back w/c positioned in the lounge area in front of the TV. Eyes were open and R34 appeared to be observing persons moving around the area. At 7:36 a.m. R34 remained in the w/c facing the TV with eyes closed, mouth open and breathing softly. 7:50 a.m. R34 was transported into the dining room and positioned at the feeding	21535		

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21535	Continued From page 16	21535		

assist table. At 9:00 a.m. R34 was again seated in his w/c located in the lounge area. Activity "World News" took place and resident sat with eyes closed and indicated no interest in the activity occurring around him. At 10:00 a.m. resident was observed lying on his back in bed and appeared to be resting quietly. At 11:16 a.m. R34 was observed back up in the high backed w/c and positioned by table in the lounge area with a newspaper on the table. No occurrences of the documented behaviors were noted during the period of observation.

During interview on 1/26/16, at 2:46 p.m. nursing assistant (NA)-C stated R34 does not participate in activities and at times he will talk, but usually what is said is not appropriate to what is being discussed. NA-C also indicated R34 is on a list for a sensory group, but a lot of times is very sleepy so doesn't attend. NA-C indicated R34 is total care with dressing, grooming, toileting, and is incontinent. NA-C indicated R34 does display behaviors of "feisty" hitting out, or shaking fist, or will grab hold of caregiver and not let go. NA-C indicated behaviors occur on an average 3 days a week and when they occur the intervention is to allow R34 to calm down and then reattempts.

NA-D was interviewed on 1/26/16, at 3:35 p.m. and indicated R34 displayed anxiety at times and is resistive to repositioning. NA-D indicated R34 does display behaviors and on good days is cooperative, but on bad days is anxious and attempts to scoot out of his recliner or chair and when staff attempt to assist/intervene he becomes angry and will at times hit out. NA-D further started R34's usual behavior if angry is to yell out and call names and staff attempt redirection by bringing up things resident likes, and if this is ineffective will leave and attempt

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21535	Continued From page 17 again at a later time. Review of January 2016 behavior monitoring were noted: Physical abuse-hitting/kicking-4 times; Resistive with cares-8 times; easily angered/agitated-9 times; wandering-0; anxious-12 times. Pharmacy Consultant Reviews were provided with the following recommendations and physician (MD) responses: (1) 6/18/15-recommendation-review of psychotropic meds for a possible gradual dose reduction (GDR)-MD response dated 6/18/15, and subsequent orders dated 6/18/15- PRN Lorazepam discontinued (DC) ed. (2) 8/17/15-pharmacist recommendation: GDR of psychotropic medications-Risperdal 0.25 mg QAM, 1 mg QHS; Haldol 1 mg Q 4 H prn (used 18 times April; 4 x May; 1 x June; 0 x July) Ativan 1.5 mg qHS; Depakote sprinkles 250 mg PO BID; No MD response to recommendation. (3) 10/15/15-pharmacist recommendation: review psychotropic meds. MD response 10/15/15-continue with current psychotropic medications. (4) 12/7/15-pharmacist recommendation: unused prn Haldol order. MD response dated 12/17/15-DC PRN Haldol. On 1/28/16, at 2:34 p.m. the consultant pharmacist was interviewed via telephone and stated she was not certain how the MD had responded related to the requested GDR, but according to the notes reviewed with her, (Consultant Pharmacist Report), agreed the	21535		

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21535	Continued From page 18 requested GDR for the scheduled Risperdone and Ativan had not been addressed by the MD. A follow up letter was received dated 1/29/16, after the pharmacist had reviewed her documentation and indicated, " I sent 2 psychotropic reviews within the first 6 months of admit, not including the note requesting discontinuation of the unused prn order for Haldol. I also monitored behaviors within the first few months of admit along with need for Haldol and Ativan prn initially as resident 'settled in' to nursing home care. My letters to the doctor did include wording to 'review the medications listed for the possibility of a trial dose reduction or taper to discontinuation and document reasoning in your progress note'. According to the notes I made to myself, it appears that the doctor addressed the psychotropic medications as 'continue current medications for dementia with behavioral issues which is under good control currently'. The consultant pharmacist further indicated she planned to address the need for documentation of need and risk versus benefit of continued use of psychotropic medications with the MD. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could establish procedures, educate staff and audit to ensure that residents drug regimen is free of irregularities and contraindications and appropriate monitoring is being completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		2/26/16

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21565	Continued From page 19 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess self-administration of medication for 1 of 1 resident (R15) who stored medications in her room. Findings include: R15's most recent quarterly Minimum Data Set (MDS) dated 10/17/15, indicated a Brief Interview for Mental Status (BIMS) score of 15/15, indicating cognition was intact. Review of the physician orders dated 1/21/16, indicated an order for aspercreme (pain relieving creme) 10% cream apply to affected areas as needed (PRN) R15 was observed on 1/25/16 at 3:48 p.m., to have a full-sized tube of aspercreme on the table beside the recliner where she was seated. R15 indicated she had a lot of pain in her right knee and leg as a result of "bone on bone" and therefore utilized the aspercreme as needed. The pharmacy label on the tube identified the medication as ordered for R15 and directed PRN use. When observed again on 1/25/16, at 6:30 p.m. the aspercreme remained located on the table beside R15's recliner. R15 indicated at this time she preferred to apply the creme to her right knee before she went to bed, but she would also	21565	Corrected.	

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use it during the day when needed. When questioned whether she applied the aspercreme herself, she responded affirmatively. R15 further confirmed that nursing staff leave the aspercreme in her room for her to apply independently.

During intermittent observations made on 1/26/16 and 1/27/16, the aspercreme remained on the table beside R15's recliner. R15 stated she had been applying the creme at times during the day to her right knee but could not recall the times.

During interview on 8/27/16 at 10:00 a.m. with licensed practical nurse (LPN)-A, indicated R15 did not have a self-administration of medication assessment completed for the use of the aspercreme. LPN-A further indicated she was unsure when and if the aspercreme had been used. Review of the January 2016 medication administration record (MAR) did not show any documentation of application of the aspercreme. During interview with the director of nursing (DON) on 1/27/16, at 10:21 a.m. verified a self-administration assessment nor physician order obtained for self-administration of the aspercreme for R15. The DON confirmed the interdisciplinary team had not been involved in the determination of it's safe use. The DON further indicated the aspercreme should be stored at the nurses station and observed/documented by the licensed nurse when used.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or desigee ensure the appropriate assessments are conducted to ensure the safe administration of medications. The DON could ensure the staff were educated on the importance of the assessment process. The DON or designee could randomly audit resident records to ensure adequate monitoring

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21565	Continued From page 21 and documentation was in place. The DON could could random audits to ensure medication is not left with residents unless deemed safe by the interdisciplinary TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a	21830		3/4/16

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family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county

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21830	Continued From page 23 social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to accommodate bathing choices for 2 of 3 residents (R12, R30) reviewed for choices. Findings include: When interviewed on 1/25/16, at 4:10 p.m. R30 indicated she had been receiving a shower weekly but would prefer a bath. R30 also indicated the facility maintained a bathtub but was unsure whether it was being utilized by residents. Review of R30's significant change Minimum Data Set (MDS) dated 8/4/15, indicated giving R30 a choice of a tub bath, shower, bed bath or sponge bath to be very important. The facility untitled quarterly questionnaire form utilized by the licensed social worker (LSW) related to choices dated 10/29/15, included the	21830	Corrected.	

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21830	Continued From page 24 following questions/answers: "Are you receiving a shower or bath each week? # of times each week?" R30's answer indicated: "Yes, 1 x/wk." (one time a week). "Are you satisfied with your current shower/bath schedule?" R30's answer indicated: "Yes". The form did not include a preference between taking a tub bath or a shower. When interviewed on 1/26/16, at 9:06 a.m. R12 stated receiving a shower once a week but would prefer more often; especially if she could have a tub bath. R12 indicated being unsure wether the bath tub was functional. R12's admission MDS dated 11/22/15, indicated being somewhat important for R12 to choose between a tub bath, shower, bed bath, or sponge bath. The facility untitled quarterly questionnaire form utilized by the licensed social worker (LSW) related to choices dated 11/16/15, included the following questions/answers: "Are you receiving a shower or bath each week? # of times each week?" R12's answer indicated: "Shower 1 x/wk." "Are you satisfied with your current shower/bath schedule?" R12's answer indicated: "Yes". The form did not include a preference between taking a tub bath or a shower. When interviewed on 1/27/16, at 1:09 p.m. the LSW confirmed asking residents the questions as written on the untitled form related to choices quarterly. When the LSW was questioned whether a functional bath tub was available for resident use, the LSW responded that to her knowledge there was one available but the director of nursing (DON) could confirm this question.	21830		

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 _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21830	Continued From page 25 When interviewed on 1/27/16, at 1:25 p.m. the DON confirmed a new whirlpool bathtub in working order was available but could not state exactly the date of installation. DON further confirmed the tub had not yet been used by residents due to staffing issues and further more, staff hadn't been trained yet on how to use the tub. The DON also indicated she was uncertain whether the company from which the tub was purchased had been contacted and an Inservice scheduled yet. When interviewed on 1/28/16, at 9:30 a.m. the administrator confirmed the bath tub was fully functional and knew there had been some resistance to using it. The administrator confirmed there had been an "instructional" related to use of the tub and was aware that some of the staff had been trained on how to use it. During a subsequent interview at 10:45 a.m., the administrator confirmed the facility had the new whirlpool bath tub since 8/20/15. The administrator stated the tub came with an instructional video and reiterated that some of the staff had viewed the video. The administrator stated being unaware that the tub had not been used, though was aware of staff resistance. When interviewed on 1/28/16, at 11:55 a.m. nursing assistant (NA)-A confirmed staff only offer showers to the residents and had not been instructed to use the new bathtub nor had they been trained on how to use the tub. When interviewed on 1/28/16, at 12:24 p.m. NA-B confirmed residents were given showers and baths were not offered. When interviewed on 1/28/16, at 3:15 p.m. the	21830		

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21830	Continued From page 26 DON confirmed the new whirlpool bathtub was functional but was not being offered as an option to residents at this time. DON further stated giving a bath took twice as long as a shower and would take up more of staff's time. SUGGESTED METHOD OF CORRECTION: The director of nurses could inservice the staff on the use of the tub and follow up with residents to ensure they are involved in the choices related to their personal care. An audit could be developed to ensure resident participation in care planning is implemented and the results could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		