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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: JD2K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00543

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245475**

2.STATE VENDOR OR MEDICAID NO.
(L2) **224840900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW HOME**
(L4) **102 COUNTY STATE AID HIGHWAY 9**
(L5) **BELVIEW, MN** (L6) **56214**

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 **1/21/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **30** (L18)

13.Total Certified Beds **30** (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
	30			
(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 :
Austin Fry, HFE NE II 1/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 2/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/11/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/12/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245475
February 25, 2015

Mr. Michael Stordahl, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, Minnesota 56214

Dear Mr. Stordahl:

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 January 10, 2015 the above facility is certified for or recommended for:

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 29, 2015

Mr. Michael Stordahl, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, Minnesota 56214

RE: Project Number S5475026

Dear Mr. Stordahl:

On December 9, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2014 that included an investigation of complaint number H5475004 which was found to be substantiated. 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 January 21, 2015, the Minnesota Department of Health and the Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2014 and a complaint investigation completed on December 1, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2014, effective January 10, 2015 and therefore remedies outlined in our letter to you dated December 9, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245475	A. Building B. Wing	1/21/2015

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **01/10/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **01/10/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/10/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/10/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **01/10/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **01/10/2015**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **01/10/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	1/29/2015	33925	1/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/4/2014			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 9, 2014

Mr. Michael Stordahl, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, Minnesota 56214

RE: Project Number H5475004

Dear Mr. Stordahl:

On December 1, 2014, an investigation was completed at your facility by the Minnesota Office of Health Facility Complaints 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 investigation found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the investigation date; and

<u>Informal Dispute Resolution</u> - 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:

Michelle Ness, RN, BS, PHN Supervisor
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. BOX 64970
St Paul, MN 55164-0970
Office 651-201-4217 Fax: 651-281-9796
General Info: 651-201-4201 Toll Free: 1-800-369-7994

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 investigation. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Office of Health Facility Complaints staff if your ePoC for the respective deficiencies 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 March 1, 2015 (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 investigation 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 June 1, 2015 (six months after the

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245475	A. Building B. Wing	1/21/2015

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	12/24/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KJ/MN	01/29/2015	33925	1/21/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/1/2014			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 9, 2014

Mr. Michael Stordahl, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, Minnesota 56214

Re: Enclosed State Nursing Home Licensing Orders - Complaint Number

Dear Mr. Stordahl:

A complaint investigation was completed on December 1, 2014. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 licensing 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 violation. 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 violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Michelle Ness, RN, BS, PHN Supervisor
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. BOX 64970
St Paul, MN 55164-0970
Office 651-201-4217 Fax: 651-281-9796
General Info: 651-201-4201 Toll Free: 1-800-369-7994

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

If you have questions or concerns you may call me at the number below.

Sincerely,

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 29, 2015

Mr. Michael Stordahl, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, Minnesota 56214

Re: Enclosed Reinspection Results - Complaint Number H5475004

Dear Mr. Stordahl:

On January 21, 2015 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on 12/1/2014. At this time these correction orders were found corrected.

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,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245475	A. Building B. Wing	1/21/2015

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	12/24/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By KJ/MN	Date: 01/29/2015	Signature of Surveyor: 33925	Date: 1/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/1/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING _____ B. WING _____	C 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	**102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214**

(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 An abbreviated standard survey was conducted to investigate complaint #H5475004. The following deficiency is issued:	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide personal cares to 1 of 1 residents (R1) in a dignified manner according to individual needs. R1 was found by family visitors in his room unclothed from the waist down, and soiled with feces and urine. The resident was cold and appeared to be distressed. R1 medical record was reviewed, R1 diagnoses included dementia, previous cerebral vascular accident (stroke), and chronic obstructive pulmonary disease (COPD). The resident had been admitted to the facility two days before. The admission history and physical dated 10/13/14 noted that R1 was confused and not able to make his/her needs known and that s/he had behaviors of urinating on the floor, and a history of falls. During an interview with the social worker on 11/21/14 at 2 p.m. she stated on the day following his/her admission, the social worker met with the	F 241		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING _____ B. WING _____	C 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	**102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214**

(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 241	Continued From page 1	F 241		

family and notified them that they were not able to care for R1 due to his/her behavior and confusion; and arrangements were made for a transfer to another facility.

The medical record included a 15 minute checks flow sheet that documented checks had been completed through 9 a.m. on 10/16/14, there was no signature or initials to identify which staff had completed checks. It was noted that R1 had voided at midnight, and that he/she was awake from 6 a.m. until 8 a.m.

Family member A was interviewed on 11/3/14 at 10:30 am and stated on the morning of 10/16/14, family member A and B came to R1's room at 9:15 a.m. They saw R1 on a mattress on the floor, family member A stated that he/she was naked from the waist down and the pajama bottoms were on a chair, he/she was laying in feces and urine. Family member A stated that the resident was very cold and had no covers on. Family member A stated that it was very upsetting, and he/she was crying. Family member A stated that R1 was not treated with dignity to be left this way in the room, and that R1 was cold and uncomfortable and this is not how R1 would wish to be treated.

Family member B was interviewed on 11/20/14 at 4:50 p.m. and stated that the t-shirt R1 was wearing was soaked in urine and there was an incontinence pad under him/her that was open with feces. Family member B noted that she was very upset and could not quickly locate staff to help. Family member B verified that the family had arrived at a pre-arranged time to bring R1 to a different nursing home. Family member B stated "I didn't feel he/she had been taken care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING _____ B. WING _____	C 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	**102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214**

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F 241	Continued From page 2 of, it was just wrong" Nursing assistant (NA) 1 was interviewed on 11/4/14 at 2 p.m. and stated she was working the day that R1 was discharged, she stated R1 had slept all night and had not had morning cares before family arrived. She verified that she had been trained that all residents should be treated individually and with respect. The director of nursing (DON) was interviewed on 11/21/14 at 2:03 p.m., she verified that she expected all residents to be treated with respect according to their individual needs and that all nursing staff had been trained on this. She was not able to identify which staff should have been responsible for assisting R1 that morning. She verified that there were 15 minute checks documented and was not sure if he had been given incontinence care or dressed that morning. The facility training was reviewed and included information that all residents were to be treated with respect, and to recognize each individual residents needs. The nursing staff had also been trained on the needs of individuals with dementia.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00543	A. BUILDING: _____ B. WING _____	C 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

(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: A complaint investigation was conducted to investigate complaint #H5475004. As a result the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota, 55164-0970.	2 000	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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to provide personal cares to 1 of 1	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00543	A. BUILDING: _____ B. WING _____	C 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214

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21805	Continued From page 2	21805		

residents (R1) in a dignified manner according to individual needs. R1 was found by family visitors in his room unclothed from the waist down, and soiled with feces and urine. The resident was cold and appeared to be distressed.

R1 medical record was reviewed, R1 diagnoses included dementia, previous cerebral vascular accident (stroke), and chronic obstructive pulmonary disease (COPD). The resident had been admitted to the facility two days before.

The admission history and physical dated 10/13/14 noted that R1 was confused and not able to make his/her needs known and that s/he had behaviors of urinating on the floor, and a history of falls.

During an interview with the social worker on 11/21/14 at 2 p.m. she stated on the day following his/her admission, the social worker met with the family and notified them that they were not able to care for R1 due to his/her behavior and confusion; and arrangements were made for a transfer to another facility.

R1 had an unwitnessed fall out of bed on 10/15/14 at 8 p.m. and was placed on a mattress on the floor with the family's knowledge to prevent further falls. R1 was also placed on fifteen minute checks for neurological and behavior monitoring.

The medical record included a 15 minute checks flow sheet that documented checks had been completed through 9 a.m. on 10/16/14, there was no signature or initials to identify which staff had completed checks. It was noted that R1 had voided at midnight, and that he/she was awake from 6 a.m. until 8 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21805	Continued From page 3 Family member A was interviewed on 11/3/14 at 10:30 am and stated on the morning of 10/16/14, family member A and B came to R1's room at 9:15 a.m. They saw R1 on a mattress on the floor, family member A stated that he/she was naked from the waist down and the pajama bottoms were on a chair, he/she was laying in feces and urine. Family member A stated that the resident was very cold and had no covers on. Family member A stated that it was very upsetting, and he/she was crying. Family member A stated that R1 was not treated with dignity to be left this way in the room, and that R1 was cold and uncomfortable and this is not how R1 would wish to be treated. Family member B was interviewed on 11/20/14 at 4:50 p.m. and stated that the t-shirt R1 was wearing was soaked in urine and there was an incontinence pad under him/her that was open with feces. Family member B noted that she was very upset and could not quickly locate staff to help. Family member B verified that the family had arrived at a pre-arranged time to bring R1 to a different nursing home. Family member B stated "I didn't feel he/she had been taken care of, it was just wrong" Nursing assistant (NA) 1 was interviewed on 11/4/14 at 2 p.m. and stated she was working the day that R1 was discharged, she stated R1 had slept all night and had not had morning cares before family arrived. She verified that she had been trained that all residents should be treated individually and with respect. The director of nursing (DON) was interviewed on 11/21/14 at 2:03 p.m., she verified that she expected all residents to be treated with respect according to their individual needs and that all	21805		

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21805	Continued From page 4 nursing staff had been trained on this. She was not able to identify which staff should have been responsible for assisting R1 that morning. She verified that there were 15 minute checks documented and was not sure if he had been given incontinence care or dressed that morning. The facility training was reviewed and included information that all residents were to be treated with respect, and to recognize each individual residents needs. The nursing staff had also been trained on the needs of individuals with dementia. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review pertinent policies and procedures. Revise as necessary and educate staff on facility policy. Then the director of nursing and/or designee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JD2K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00543

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245475**

2.STATE VENDOR OR MEDICAID NO.
(L2) **224840900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW HOME**
(L4) **102 COUNTY STATE AID HIGHWAY 9**
(L5) **BELVIEW, MN** (L6) **56214**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/04/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **30** (L18)

13.Total Certified Beds **30** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	30			
(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 :
Austin Fry, HFE NE II 12/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 01/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/12/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 16, 2014

Mr. Michael Stordahl, Administrator
Parkview Home
102 County State Aid Highway Nine
Belview, Minnesota 56214

RE: Project Number S5475026

Dear Mr. Stordahl:

On December 4, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 10, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 1, 2015 (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 June 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING _____ B. WING _____	12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME	**102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214**

(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 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		1/10/15

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

Electronically Signed | 12/24/2014

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

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F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide the appropriate liability notice of Medicare non-coverage for 4 of 12 resident (R34, R3, R6, R12) reviewed for demand bill and liability notices. Findings include: R34's Therapist Progress and Discharge Summary, dated 6/19/14, indicated she had met her goals for bed mobility, gait tasks, balance, and transfers, and was able to discharge to home. R34's Discharge Summary, dated 6/24/14, indicated she was admitted from the hospital on 6/9/14, and , "participated in ST [speech therapy] and PT [physical therapy] 3-5X/week [times a	F 156	It is the policy and goal of Parkview Home to notify beneficiaries by written and oral notice of Medicare non-coverage. For the residents that were affected, they have already discharged to home. To prevent future occurrences, CMS-10123 notification will be given to beneficiaries receiving skilled services that are being discharged from the facility to their home. If a resident is planning to stay in the facility, but is being discharged from skilled services they will be given a form called "Determination on Continued Stay" along with forms CMS-10055 and CMS-10123. These forms will highlight the reason for discharge from skilled	

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F 156	Continued From page 3 week]." R34 discharged to home on 6/20/14. There was no record of a Notice of Medicare Provider Non-coverage (CMS-10123) being given to R34 two days before discharge from therapy services. R3's Therapist Progress and Discharge Summary, dated 6/2/14, indicated, "Res [resident] has met all present PT goals." R3's Discharge Summary, dated 6/12/14, indicated she was admitted from the hospital on 5/3/14, and, "Placement is to be short term after goals are met with OT [occupational therapy] and PT." R3 discharged to home with home health care on 6/3/14. There was no record of a Notice of Medicare Provider Non-coverage (CMS-10123) being given to R3 two days before discharge from therapy services. R6's Therapist Progress and Discharge Summary, dated 10/8/14, indicated she met her goals for therapy, and was to be discharged back to her apartment. R6's Discharge Summary, dated 10/9/14, indicated she was admitted from the hospital on 8/21/14, and, "participated in OT and PT." R6 discharged to home on 10/9/14. There was no record of a Notice of Medicare Provider Non-coverage (CMS-10123) being given to R6 two days before discharge from therapy services. R12's Therapist Progress and Discharge Summary, dated 11/24/14, indicated she had met all of her goals for therapy, and was to be	F 156	services along with the options to appeal the facilities determination. These forms will be given by the DON or designee. It will be the responsibility of the business office manager or designee to audit compliance with proper paperwork being given to residents/families when discharging from skilled services. Audits will be done monthly and if positive results, the audits will be done quarterly thereafter. Any concerns with this process will be addressed at our Quality Assurance meetings.	

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F 156	Continued From page 4 discharged home. R12's Discharge Summary, dated 11/26/14, indicated she was admitted from the hospital on 10/22/14, and, "worked with OT and PT." R12 discharged to home on 11/25/14. There was no record of a CMS-10123 being given was located in R12's medical record. There was no record of a Notice of Medicare Provider Non-coverage (CMS-10123) being given to R12 two days before discharge from therapy services. During interview on 12/3/14 at 8:45 a.m., the business office manager (BOM) stated R34, R3, R6, and R12 all were admitted for short term placement, and discharged with remaining days in their Medicare beneficiary period. Further, the BOM stated none of the residents were given a CMS-10123 or any other notice of Medicare non-coverage, "We need to correct that." The BOM was unaware how long this practice had been occurring. When interviewed on 12/3/14 at 8:58 a.m., the director of nursing (DON) stated they only provide notices of Medicare non-coverage if the resident plans to remain in the facility after their skilled need (therapy) ends. A policy on liability notices was requested, but none was provided.	F 156		
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.	F 176		1/10/15

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F 176	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, care plan, and obtain physician orders for self administration of medication for 3 of 5 residents (R7, R14, R21) whom were observed during medication administration. Findings include: R7's Medication Administration Record (MAR) of 12/1/14 indicated licensed practical nurse (LPN)-A had administered a Tylenol #3 (a narcotic analgesic) at 10:40 a.m. R7 was observed on 12/1/14, at 11:30 a.m. sitting in his recliner in his room. Across the room there was a medication cup with a pill in it on a table. At 11:32 a.m. registered nurse (RN)-A verified this was the Tylenol #3, which should not have been left in R7's room. However, RN-A did not remove the medication, or administer it to R7, and left the room. When interviewed on 12/11/4, at 11:52 a.m. LPN-A stated R7 has some confusion and she should not have just left the medication in his room, without observing him take the narcotic analgesic. LPN-A went to R7 and found the medication cup, with the Tylenol #3 in it, in his pocket at this point. LPN-A then had R7 swallow the medication, 1 hour and 12 minutes after she had left it in his room. R7's physician order sheets dated 11/25/14, included, "Acetaminophen/Codeine (Tylenol #3)	F 176	It is the policy and goal of Parkview Home that residents receive medications safely. For residents #R7, R14, and R21, self-administration of medications was assessed and addressed on care plans and with physicians on 12/19/14. To prevent future occurrences, the Safety Assessment was updated to include self-administration of medications. All current residents with nebulizers and inhalers will be assessed for safety of medication administration - to determine if self-administration of medications is safe. Staff will be re-educated at an all-staff training on 1/7/15. It will be the responsibility of the DON or designee to audit compliance. Audits will be done on assessments of new admissions and staff performance audits done weekly for two months, if positive results, then monthly. Concerns will be addressed at QA and staff meetings.	

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F 176	Continued From page 6 Take 1 or 2 tabs [tablets] PRN [as needed]." The physician orders did not include an order that R7 could self administer medications. R7's Safety Assessment dated 11/28/14, included he had, "altered cognition." The safety assessment did not identify an assessment for self administration of medications. R7's Temporary Nursing Care Plan, dated 12/2/14, failed to identify if it was safe to leave medications in R7's room to have him self administer them or not. When interviewed on 12/3/14, at 1:15 p.m. the director of nursing (DON) stated she had assessed R7 for safety using the Safety Assessment form, and did not assess R7's safety to self administer medications as he had not requested to do so, and would not be safe to do so related to increased confusion. R14's quarterly Minimum Data Set (MDS), dated 10/8/14, indicated he had long and short term memory problems, and demonstrated behavioral symptoms 1 to 3 days during the review period. During observation on 12/2/14 at 3:56 p.m., R14 was seated in a recliner chair in his room. He was sleeping with his eyes closed, and had a nebulizer mask affixed to his face and the machine turned on. There were no staff present in the room or adjacent in the hallway to monitor R14 while he had the nebulizer mask on to ensure they received all the medication. When interviewed on 12/2/14 at 7:03 p.m., trained medication aide (TMA)-A stated she placed the nebulizer on R14 and left him alone with it on as is frequently done. R14 had	F 176		

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F 176	Continued From page 7	F 176		

episodes of removing the mask prior to the medication being completely dispensed in the past. Further, TMA-A was unsure how long R14 had the nebulizer mask left on after the medication had completed, but stated the nebulizer should have been removed and completed at a time when he was more alert and awake.

R14's Physician Orders Sheet, dated 9/4/14, indicated he received DuoNeb's (an inhaled medication used to treat COPD) three times a day. The physician orders did not indicate R14 was able to self administer his own nebulizer medications. R14's care plan, dated 7/7/14, lacked any indication R14 was safely able to self administer his own nebulizer medication. R14's Safety Assessment, dated 7/7/14, lacked any information or assessment regarding if R21 was safe to self administer his own nebulizer medications.

During interview on 12/3/14 at 1:31 p.m., licensed practical nurse (LPN)-C stated staff should be sitting with R14 during his nebulizer treatments. Further, LPN-C stated he should have had an assessment to determine if he was safe to self administer his own nebulizer's, and a physician order to do so.

When interviewed on 12/3/14 at 1:42 p.m., the director of nursing (DON) stated self administration of medication assessments are completed only if someone asks to do so. R14 is frequently left alone with his nebulizer's, and should not be. Further, the DON stated he should have had an assessment to determine if he was safe to self administer the nebulizer medications without staff present.

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F 176	Continued From page 8	F 176		

R21's quarterly Minimum Data Set (MDS), dated 8/26/14, indicated she had intact cognition, but displayed rejection of care behavior (including refusing medications) 4 to 6 days of the review period.

During observation on 12/1/14 at 2:12 p.m., R21 was seated in a recliner chair in her room. Her eyes were closed, and her head was resting on her left shoulder. She had a nebulizer mask affixed to her face, and the nebulizer machine was turned on. R21 awoke at 2:16 p.m., stood up, walked over to the machine and turned it off before removing the nebulizer mask. There were no staff were present in the room or adjacent hallway to monitor R21 while she had the nebulizer treatment to ensure they received all the medication.
R21's Physician Orders Sheet, dated 11/18/14, indicated she received DuoNeb's (an inhaled medication used to treat COPD) three times daily. The physician orders did not indicate R21 was able to self administer her own nebulizer medications. R21's care plan, dated 8/26/14, indicated her to be at risk for hospitalization due to her diabetes and history of pneumonia. Further, the care plan lacked any indication R21 was able to safely self administer her own nebulizer medications. R21's Safety Assessment, dated 12/1/14, lacked any information or assessment regarding if R21 was safe to self administer her own nebulizer medications.

When interviewed on 12/3/14 at 1:31 p.m., licensed practical nurse (LPN)-C stated staff should be sitting with R21 during her nebulizer treatments as she would likely try to remove it

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F 176	Continued From page 9 herself. Further, LPN-C stated residents that are able to self administer their own nebulizer's should have an assessment for their ability to do so, and have it listed in their care plan. During interview on 12/3/14 at 1:42 p.m., the director of nursing (DON) stated R21 was frequently left alone with her nebulizer on in her room. Further, the DON stated R21 should have an assessment to ensure safety with self administration of her nebulizer's, a physician order allowing her to self administer them, and have it identified in the care plan. A facility Self Administration of Medications by Residents policy, dated 8/1/11, indicated, "Self administration of any medication, prescription or non-prescription, must be written on physicians orders and renewed every month for skilled care..." Further, the policy indicated an assessment by the registered nurse (RN) should be completed.	F 176		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents	F 309	It is the policy and goal of Parkview Home to provide care and services for	1/10/15

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F 309	Continued From page 10 (R25) reviewed for wheel chair positioning, had their feet and trunk supported. Findings include: R25's significant change Minimum Data Set (MDS) dated 10/23/14, included a diagnosis of dementia with severe cognitive impairment. The MDS indicated R25 required total staff assistance with most activities of daily living (ADL's) , had limited range of motion of bilateral upper and lower extremities and utilized a wheel chair. R25's care plan dated 10/30/14, included an alteration in mobility and directed to staff to assist with all ADL's. The care plan also identified a risk for falls, and directed staff to, "Please do not leave me unattended in my w/c [wheel chair]." R25 was observed on 12/2/14, at 12:00 p.m. being propelled in her wheel chair to the dining room by trained medication aide (TMA)-B. R25's wheel chair was reclined approximately 30 degrees, and R25 was leaning to the right with her feet dangling not supported. R25 was assisted to eat her noon meal, while her feet were dangling, unsupported for the entire meal. On 12/3/14 R25 was observed at 8:48 a.m. during morning cares. Nursing assistant (NA)-D and licensed practical nurse (LPN)-B assisted her into her wheel chair via a mechanical lift. R25's chair was tilted back approximately 30 degrees and her feet dangled in the air off the floor	F 309	residents highest well-being. For resident #R25, orders for occupational therapy for wheel chair positioning were obtained on 12/17/14. The OT evaluation was done on 12/18/14. The care plan was updated and staff were educated that same day on when the use of leg rests on the wheel chair would be appropriate. To prevent future occurrences, all current residents with wheelchairs will be assessed for positioning by nursing and therapy staff if concerns noted. In addition, each resident will continue to be assessed for need of therapies upon admission, quarterly, and with significant changes. A wheel chair positioning policy will be developed. Staff will also be re-educated at an all-staff training session on 1/7/15. It will be the responsibility of the DON or designee to audit compliance weekly for one month then, if positive results will change to quarterly. Concerns will be addressed at QA and staff meetings.	

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F 309	Continued From page 11	F 309		

approximately 12 inches. R25 was wheeled to the dining room, where she was assisted to eat, her feet continued to dangled unsupported. LPN-B stated R25 was only up for meals and had never had any foot pedals for her wheel chair. They had never made a referral for wheel chair positioning for R25. At 9:00 a.m. NA-D stated she had checked with therapy and thought maybe the foot pedals for R25's wheel chair were, "in the garage." She stated that the resident [R25] used to pedal herself around the facility, but has not been doing this for, "a very long time." NA-D stated she had never reported a concern about R25 not having any support for her feet to anyone.

R25's Interdisciplinary Progress Notes dated 12/3/14, 11:00 a.m. included, "[name] is in w/c for short periods a time-she can be very spastic with movements jerks a lot-she will even flinch with touch even when you tell her what you are going to do before you do it. She has had open areas on her legs in the past as her legs jerk also..."

The director of nursing (DON) was interviewed on 12/3/14, at 9:41 a.m. and stated R25 had not been evaluated for wheel chair positioning, but her feet should be supported, not dangling in the air. R25 has little trunk strength and can only tolerate being up in the wheel chair for short periods, such as for meals.

When interviewed on 12/3/14, at 9:51 a.m. the activity director stated she has seen R25's legs dangling in the air, unsupported, but had never reported this to anyone.

Even though staff were aware R25 had poor trunk strength and that her feet dangled in the air, the

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F 309	Continued From page 12 facility failed to evaluate her positioning to ensure comfort. A policy was requested, but not provided by the facility.	F 309		
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 interview, and document review, the facility failed to complete routine lab work for	F 329	It is the policy and goal of Parkview Home that residents are free from	1/10/15

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F 329	Continued From page 13 medication monitoring for 2 of 5 residents (R14, R21) reviewed for unnecessary medication use. Findings include: R14's quarterly Minimum Data Set (MDS), dated 10/8/14, indicated he had a diagnosis of heart failure, short and long term memory problems, and took a diuretic medication (used to help the body get rid of unneeded water) daily. R14's Physician Orders Sheet, dated 9/4/14, indicated he took, "Lasix (a diuretic, which can deplete the body of potassium) 40 mg [milligrams] PO [by mouth] BID [twice a day]." The Physician Orders Sheet lacked any orders for potassium supplementation, or laboratory work to monitor R14's potassium level. R14's Medication Administration Records (MAR), dated 9/1/14 to 11/30/14, indicated he had received the Lasix medication as ordered. Review of R14's Laboratory Report, dated 12/6/13, indicated his last potassium level was 3.7 mMol/L (millimoles per liter), near the low end of a normal range. There was no indication that a potassium level has been completed since 2013, almost one year ago. When interviewed on 12/3/14 at 8:37 a.m., licensed practical nurse (LPN)-C stated R14 did not have any orders for potassium monitoring in his medical record. During interview on 12/3/14 at 1:40 p.m., the director of nursing (DON) stated laboratory monitoring was usually completed per R14's physician's preference, but there should be some orders in place to address routine lab work for	F 329	unnecessary drugs. For resident #R14, a potassium level was checked on 12/8/14. For #R21, and A1C was checked on 12/8/14. To prevent future occurrences, pharmacist consultant visit was done on 12/15/14 to review lab indications. Education and communication about lab work was held with nursing staff and consultant pharmacist on 12/5/14. All current resident medications will be reviewed to ensure that appropriate labs are being monitored. Consultant pharmacist rounds monthly and is available by fax or phone. A new policy will be developed to address the importance of lab values as the relate to medications. Nursing staff will be educated on an all-staff meeting on 1/7/15 to review labs during physician rounds and quarterly. It will be the responsibility of the DON or designee to audit monthly then, if positive result will change to quarterly.	

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F 329	Continued From page 14 medication monitoring. Review of R14's physican orders lacked any routine monitoring of R14's potassium levels. R21's quarterly MDS, dated 8/26/14, indicated she had a diagnosis of diabetes mellitus (a metabolic disease causing increased blood sugar levels), and intact cognition. R21's Physician Order Sheet, dated 11/19/14, identified the medication, "Metformin (Glucophage) [a medication used to treat high blood sugars] 250 mg 1 TAB [tablet] PO BID." Further, it indicated the following laboratory monitoring: "A1C [blood work used to indicate how well a patients diabetes mellitus is being managed] (due March 2014), BMP [basic metabolic panel] q [every] 6 months (due January 2014)." Review of R21's MAR, dated 9/1/14 to 11/30/14, indicated she took the Metformin as ordered. Review of R21's Laboratory Report, dated 3/5/14, indicated her A1C level was 6.2%, an abnormal value which is in the high range. The report lacked any physician orders of when to complete another A1C level, to monitor the effectiveness of the medication. During interview on 12/4/14 at 9:02 a.m., the DON stated she was unable to locate any further monitoring of R21's A1C, and it should have been completed in September 2014 according to her current orders. A policy on laboratory monitoring with medication use was requested, but none was provided.	F 329		

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F 428	Continued From page 15	F 428		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure irregularities regarding routine lab work monitoring for ordered medications for 2 of 5 residents (R14, R21) reviewed for unnecessary medication use, was identified by the consulting pharmacist. Findings include: R14's quarterly Minimum Data Set (MDS), dated 10/8/14, indicated he had a diagnosis of heart failure, short and long term memory problems, and took a diuretic medication (used to help the body get rid of unneeded water) daily. R14's Physician Orders Sheet, dated 9/4/14, indicated he took, "Lasix (a diuretic, which can deplete the body of potassium) 40 mg [milligrams] PO [by mouth] BID [twice a day]." The Physician Orders Sheet lacked orders for potassium supplementation, or laboratory work to monitor a potassium level. R14's Medication	F 428	It is the goal of Parkview Home and consultant pharmacist that resident drug regimen reviews and reports are done monthly. For resident #R14, a potassium level was checked on 12/8/14. For #R21 an A1C was checked on 12/8/14. To prevent future occurrences, pharmacist consultant visit was done on 12/5/14 to review lab indications. Education and communication about lab work was held with nursing staff and consultant pharmacist on 12/5/14. A new policy will be developed to address the importance of lab values as they relate to medication use. Nursing staff will also be educated at an all-staff meeting on 1/7/15. Consultant pharmacist will continue to round monthly and is available by fax or phone. All current resident medications and labs	1/10/15

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F 428	Continued From page 16 Administration Records (MAR), dated 9/1/14 to 11/30/14, indicated he had received the ordered Lasix medication as ordered. R14's Laboratory Report, dated 12/6/13, indicated his last drawn potassium level was 3.7 mMol/L (millimoles per liter), near the low end of a normal range. When interviewed on 12/3/14 at 8:37 a.m., licensed practical nurse (LPN)-C stated R14 did not have any orders for potassium monitoring in his medical record. During interview on 12/3/14 at 1:40 p.m., the director of nursing (DON) stated laboratory monitoring is done at the physician's preference, but orders to do so should be in place. R14's orders lacked indication on monitoring his potassium level. R14's Monthly Drug Therapy Review, dated 12/11/13 to 11/6/14, lacked identified concerns with R14's ongoing Lasix use or lack of laboratory monitoring. When interviewed on 12/4/14 at 9:02 a.m., the consulting pharmacist (CP) stated potassium levels should be drawn every quarter (3 months). Further, the CP stated R14 should be on potassium supplementation, and irregularities like that should have been identified during his monthly chart review. R21's quarterly MDS, dated 8/26/14, indicated she had a diagnosis of diabetes mellitus (a metabolic disease causing increased blood sugar levels), and intact cognition.	F 428	records will be reviewed to ensure appropriate monitoring is being done. It will be the responsibility of the DON or designee to audit monthly. Concerns will be addressed at QA and staff meetings.	

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F 428	Continued From page 17 R21's Physician Order Sheet, dated 11/19/14, indicated she took, "Metformin (Glucophage) [a medication used to treat high blood sugars] 250 mg 1 TAB [tablet] PO BID." Further, it indicated the following laboratory monitoring: "A1C [bloodworm used to indicate how well a patients diabetes mellitus is being managed] (due March 2014), BMP [basic metabolic panel] q [every] 6 months (due January 2014)." R21's MAR, dated 9/1/14 to 11/30/14, indicated she had received the medications as ordered. R21's Laboratory Report, dated 3/5/14, indicated her A1C level to be 6.2%, an abnormal value which is out of range (high). The report lacked orders when to next complete R21's A1C level. R21's Monthly Drug Therapy Review, dated 12/11/13 to 12/5/14, lacked identified concerns with R21's medication use or laboratory monitoring. During interview on 12/4/14 at 8:17 a.m., the DON stated she was unable to locate any further monitoring of R21's A1C, and it should have been drawn in September 2014 according to her orders. When interviewed on 12/4/14 at 9:02 a.m., the CP stated she only reviewed R21's chart to ensure the A1C level was drawn yearly, but her physician orders should be followed. A policy on laboratory monitoring with medication use, and pharmacy consultation was requested, but none was provided.	F 428		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		1/10/15

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F 431 SS=E	Continued From page 18 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 431	It is the goal and policy of Parkview	

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F 431	Continued From page 19 review, the facility failed to date a multidose vial of Tuberculin Skin Test (TST) when it was opened. In addition, the facility failed to ensure TST serum was expired when administered to 5 of 6 residents (R39, R40, R41, R42, and R43) who received the tuberculin skin test. Findings include: During observation of the medication storage room on 12/3/14, at 2:30 p.m. with licensed practical nurse (LPN)-B, the medication refrigerator contained an open, undated, vial of Tuberculin Purified Protein Derivative (aid in the detection of tuberculosis infection). The TST vial was filled on 10/20/14, Lot # 719477. During an interview on 12/3/14, at 2:35 p.m. licensed practical nurse (LPN)-B stated the TST vial was not dated when they opened the vial, and approximately 90% of the vial had been administered. LPN-B was unable to determine how long the vial had been opened in the refrigerator and stated the nurse that opened the vial should have dated it. Review of the manufacturer's package insert for Tuberculin Purified Protein Derivative, dated March 2013, indicated, " A vial of Tubersol which has been entered and in use for 30 days should be discarded." Package insert also specified, "Do not use after expiration date." During interview on 12/4/14, at 9:28 a.m. the director of nursing (DON) stated the multidose TST vial was not dated when opened and staff should be dating the vials when they are opened. In a further interview with DON on 12/4/14, at 9:39 a.m., the DON stated, "After a quick review,	F 431	Home to properly store and label drugs and biologicals. The vial of tuberculin in reference was disposed of on 12/4/14. Residents #R39, #R40, and #R42 will be re-administered. Resident #R41 will not be re-administered as he is receiving hospice services and declined. To prevent future occurrences, vial labels with "date opened" were purchased through Briggs corporation and will be used on all vials. The were received during the week of 12/18/14. A policy will be developed to address the process of labeling dating opened vials. Staff were educate at the time of arrival and will be educated at an all-staff meeting on 1/7/15. Staff will be re-educated about disposing of vials at 30 days of opening as well. It will be the responsibility of the DON or designee to complete audits biweekly for 3 months, if positive results, will change to quarterly. Concerns will be addressed at QA and staff meetings.	

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F 431	Continued From page 20 it [vial of Tubersol] was expired." Since the TST had expired, 30 days after it was opened, which was dispensed from the pharmacy on 10/20/14 identified four residents had received an expired dose of Tubersol. Review of the medical records identified the following residents received a first or second TST screening with the expired Tubersol. The residents were identified as follows: R39 received the second step TST on 11/26/14. R40 received the second step TST on 11/26/14. R41 received the first step TST on 11/24/14. R42 received the first step TST on 12/2/14. R43 received the first step TST on 11/27/14. Policy for dating multidose vials of medication was requested from DON on 12/4/14, but not provided.	F 431		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520		1/10/15

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F 520	Continued From page 21 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to consistently have the required number of members present during their Quality Assurance (QA) meetings. This had potential to affect all 19 residents whom resided in the facility, staff, and visitors. Findings include: A Parkview Homes QA Minutes form, dated 11/19/14, indicated staff whom attended the meeting included the following: medical doctor (MD), director of nursing (DON), administrator, a registered nurse (RN), and the consulting pharmacist (CP). The form did not identify the required number of staff members present (MD, DON, and at least 3 other facility staff) for the meeting. A Parkview Homes QA Minutes form, dated 9/11/14, indicated staff whom attended the meeting included the MD, DON, administrator, and dietary manager (DM). The form did not identify the required number of staff members	F 520	It is the goal of Parkview Home that the QAA committee members meet at least quarterly. A new policy will be developed for the QAA committee. This policy includes that meetings will be held a minimum of quarterly and includes that there must be at least 3 staff members present other than the MD and DON. If this is not possible, to have the correct number of staff, the meeting will be rescheduled within the quarter. This will be monitored by the DON or designee prior to the meeting or at the time the meeting. If the correct number of staff are unable to attend the meeting, the meeting will be rescheduled.	

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F 520	Continued From page 22 present for the meeting. An additional Parkview Homes QA Minutes form, dated 7/16/14, indicated staff whom attended the meeting included the MD, DON, administrator, licensed social worker (LSW), RN, and CP. The last time a QA meeting had been held with the required members present was 7/16/14. During interview on 12/4/14 at 9:28 a.m., the administrator stated the QA Minutes form(s) were accurate for the attendance of staff listed, and the facility tries to have the required number of people present for the meetings but is not always able to do so. A policy on QA, including the members whom attend and frequency of the meetings, was requested, but none was provided.	F 520		

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	245475	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 04, 2014. At the time of this survey, Parkview Home was found to be in 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. Parkview Home was constructed as follows: The original building was built in 1965, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The first addition was built in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The second addition was built in 1990, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The most recent addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. The facility has an automatic fire alarm system with smoke detection at all smoke barrier doors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 22 at time of the survey.	K 000		

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

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