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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K3IK

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 **01/26/2017** (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 :
Bruce Melchert, HFE NE II 06/04/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 06/04/2018 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/02/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245475 June 4, 2018

Mr. Thomas Goeritz, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

Dear Mr. Goeritz:

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 16, 2018 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. 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 4, 2018

Mr. Thomas Goeritz, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

RE: Project Number S5475029

Dear Mr. Goeritz:

On December 21, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 7, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 26, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 26, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 7, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 16, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 7, 2017, effective January 16, 2018 and therefore remedies outlined in our letter to you dated December 21, 2017, 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 related to thsi electronic notice.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 4, 2018

Mr. Thomas Goeritz, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

Re: Reinspection Results - Project Number S5475029

Dear Mr. Goeritz:

On January 26, 2018, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 7, 2017, with orders received by you on December 29, 2017. At this time these orders were found to be 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K3IK

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 **12/07/2017** (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
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Bruce Melchert, HFE-NE II — 01/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 01/31/2018 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 21, 2017

Mr. Thomas Goeritz, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

RE: Project Number S5475029

Dear Mr. Goeritz:

On December 7, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (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 16, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 16, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 7, 2018 (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 7, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

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 _____	12/07/2017

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 12/5/17 through 12/7/17, during a recertification survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.	E 006		1/16/18

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

Electronically Signed | 01/02/2018

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 _____	12/07/2017

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
E 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively develop emergency preparedness policies and procedures,based on the facility and community risks assessments and communication plans, for all required and facility-identified hazards. This had the potential to affect all 23 residents currently residing in the facility. Findings include: The facility's Emergency Management Plan, Parkview Senior Living, dated 8/1/17, was reviewed. The facility's current plan identified key potential hazards, including tornados and other kinds of sever weather, utility outages, fire, armed intruder and. The document failed to include missing residents within the emergency plan as a potential hazard. When interviewed on 12/7/17 at 1:55 p.m., the administrator stated specific policies or directions were not developed for each of the hazards identified, and added he did not think "we have all the scenarios worked out." The administrator also acknowledged that each of the identified	E 006	PLAN BASED ON ALL HAZARDS RISK ASSESSMENT: Facility failed to comprehensively develop emergency policies and procedures based on the risk assessment and communication plan for all hazards that were identified. The plan also did not include missing residents within the emergency plan. ACTION: Facility will review the risk assessment and specifically address each identified risk with an action plan to al all parties involved. Missing residents were not identified as a possible hazard and that will be addressed in the development of policies in EO13. COMPLETION DATE: 1/16/18 RESPONSIBLE PERSON: Administrator/Leadership Team - Plan to be reviewed annually.	

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 _____	12/07/2017

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
E 006	Continued From page 2 emergencies, such as blizzard or material spill, could include components of evacuation and or sheltering in place, and stated the lack of plans for each left facility emergency plan "incomplete."	E 006		
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and	E 013		1/16/18

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E 013	Continued From page 3 procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop emergency preparedness policies and procedures,based on the facility and community risks assessments and communication plans, for all assessed potential hazards identified by the facility. This had the potential to affect all 23 residents currently residing in the facility. Findings include: In review of the Emergency Management Plan, Parkview Senior Living, dated 8/1/17, the facility identified the following potential hazards: tornado, fire, hazardous material/spills, hail/severe thunderstorm, blizzards, bomb threats, utility emergencies, workplace violence/threat of violence and armed intruder. The document provided detail about fire drills and evacuation preparedness, and also contained analysis of how the facility responded to and evacuated from the facility, following a tornado several years prior. The document also identified "evacuation" and "sheltering" and indicated basic steps the facility would take to undertake these possible scenario, should an emergency event	E 013	Development of policies, procedures and communication plan for each identified hazard is needed. Hazards were identified and a general emergency plan was developed. The plan lacked detail for each hazard identified. ACTION: The revised plan will include specific policy/procedure to address severe weather, bomb threats, workplace violence and armed intruders and any other hazards that may need more clarity or definition. The facility will address provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. This will include food, water, medical and pharmaceutical supplies. Alternative sources of energy to maintain temperature, emergency lighting (we noted that we have a generator that will support the entire facility, not just emergency areas), fire systems, and sewage disposal.	

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E 013	Continued From page 4 occur; but the current plan provided no details of how this would be implemented. The current facility emergency plan document lacked policies and procedures that aligned with their identified hazards from the facility risk assessment, which included: hazardous material spills, other kinds of severe weather, bomb threats, workplace violence and armed intruders. The current facility emergency plan document also lacked policies and procedures for the following requirements which address: -The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place and include, but are not limited to: food, water, medical and pharmaceutical supplies; and alternate sources of energy to maintain: temperatures (to protect patient health and safety, and for the safe and sanitary storage of provisions); emergency lighting; fire detection, extinguishing and alarm systems; and sewage disposal. -A system to track the location of on-duty staff and sheltered patients during emergency care; and if staff are relocated during an emergency, the specific name and location of the receiving facility, or other location. -Safe evacuation from the facility, including the care and treatment needs of the evacuees; staff responsibilities; transportation; identification of the evacuation locations; and primary and alternate means of communication. -A means to shelter in place for patients, staff and volunteers who remain in the facility.	E 013	We will develop a system to track all on-duty staff and sheltered residents, as well as tracking staff and residents if they are relocated to another facility. (Again, I think it is important to remember that this is a facility with two hallways, no steps, no elevator, no basement, and a dining room, with a census of 22 and probably 7 staff in the building at any given time.) We will comply with the correction orders in full detail but we appreciate some reasonable judgment in application of standards to a unique facility. Thank you. We will develop a safe evacuation plan from the facility for all residents. We will better address transportation and identification of the evacuation locations. (we have 7 signed mutual aid agreements) We will develop a policy to have more complete information on the specific relocation facility. We will also address the primary and secondary means of communication. We will develop a means to better shelter in place for residents, staff and volunteers who remain in the facility. (Please forgive my comments, but again we have 22 residents, and we would transfer them to other facilities as there would not be an issue or reason for staff and volunteers to stay at the facility.) However, knowing it might happen for some reason, we will write a policy in the event this should happen, and brainstorm on other "what ifs" as there may be something we have missed.	

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E 013	Continued From page 5 -A system of medical documentation that preserves patient information; protects confidentiality of patient information; and secures and maintains availability of records. -The use of volunteers during an emergency or other staffing strategies, including a process for integrating State and Federal designated health care professional to address needs during an emergency. -The role of the facility under a wavier declared by the Secretary in the provision of care and treatment at an alternated care site identified by emergency management officials. When interviewed on 12/7/17 at 1:55 p.m., the administrator stated specific policies or directions were not developed for each of the hazards identified, and added he did not think "we have all the scenarios worked out." The administrator also acknowledged that each of the identified emergencies, such as blizzard or material spill, could include components of other identified emergencies, like evacuation and or sheltering in place, and stated the lack of plans for each left facility emergency plan "incomplete."	E 013	We will further develop a system/policy to better document and preserve resident information in the case of relocation. We did share with the survey team that we have an EMR (electronic medical record) Point, Click, Care and can access that from any remote location. We will better review specific internal steps to take in the case of evacuation. This will include more detail for specific staff, and specific actions for them to follow. This would include containers for resident's personal items, medications and medical record. We will be more specific in the role of volunteers in the case of an emergency, and will identify what they might be able to help with, and how to use them most effectively. We had listed the county emergency coordinator as a primary contact. We will be sure to list his number on all phases of emergency plans that are developed. The team suggests state and federal designated professionals be contacted. FEMA may be useful after the incident has occurred and we will list them. We believe our county emergency personnel would be our best source of assistance and will expand on that as we improve our emergency plan. We will better describe the role of the facility if an alternate care site is identified by emergency management officials. In our present plan, we did say that our staff would be assigned to those facilities that we would end up sending residents to should they need additional help. We can expand on that plan to improve the detail.	

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E 013	Continued From page 6	E 013	In trying to keep things simple, we failed to have enough detail per the survey feedback. COMPLETION DATE: 1/16/18 RESPONSIBLE PERSON: Administrator	
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively develop an emergency-preparedness communication plan. This had the potential to affect all 23 current residents in the facility. Findings include: The facility's Emergency Management Plan, Parkview Senior Living, dated 8/1/17, was reviewed. Under the notification section, the plan indicated the facility would use weather service and portable radio and TV to get alerts. The plan listed one emergency contact, the facility phone number. The plan indicated "key staff" would be contacted by the person in charge, who in turn would contact their own staff, and other staff could be contacted using a phone tree. Residents would be informed of a crisis via a phone/radio system. The plan further indicated the facility phone was not working, staff would	E 029	The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated annually. The facility plan stated that key staff (department heads and administration) would be contacted by the person in charge and they in turn would contact their staff. The plan also indicated that if the phone lines were not working, they would use cell phones as a backup. Staff could also literally drive to an alternate location to communicate with other staff when necessary. (Many staff live in town or within 8 miles of town). This detail was deemed insufficient during the survey. ACTION: Facility will expand the plan to include all staff names and contact information. We will include physicians,	1/16/18

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E 029	Continued From page 7 use personal cell phones; and as a back up, staff could drive to meet other staff a home, and local police could be contact. The facility plan, however lacked further detail. The facility plan, addressing communication during an emergency with residents and other stakeholders, also lacked detail with policy and procedure to: -Include names and contact information for: staff; entities providing services under arrangement; patients' physicians; other facilities; and volunteers. -Include contact information for Federal, State, tribal, regional and local emergency preparedness staff; State licensing agency; the Office Long-Term Care Ombudsman and other contacts as identified in the emergency plan. -Provide a primary and alternate means for communicating with staff; and federal, tribal, regional, and local emergency management agencies. -Describe a method for sharing information and medical documentation for patient care with other providers as needed; and a means to release patient information about resident condition and location as needed for continuity of care; a means to release information in event of evacuation; a means of providing information about the general condition and location of patients under the facility's care. -Include a means of providing information about the facility's occupancy, needs and its ability to provide assistance, to the authority having its	E 029	volunteers and other facilities phone numbers and preferred method of communication. Contact information of Federal, State, Tribal, regional, and local emergency preparedness staff, state licensing agencies, the office of the Ombudsman, and other important contacts will be listed. Will review primary and alternate means for communicating with staff, Federal, State, Tribal, regional and local emergency contacts. We thought regular phones and cell phones were sufficient, but will be certain to emphasize this for each hazard we identify. We will also check with other facilities to see what other means of communication they used in their plans. We will better describe the means of sharing medical information with other providers as necessary in case of evacuation. We will better describe the means of sharing the location of residents during the specific emergency. We will expand on our procedure as to how we will share information. We stated that Point, Click, Care EMR was available from any remote location, but we will expand on that. We will describe in better detail how the resident's belongings, medical record and medications will be transferred with the residents. Location of residents will be handled by the Director of Social Services or designee. We will expand on this process as well.	

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E 029	Continued From page 8 jurisdiction; and -A means for sharing information from the emergency plan that the facility has determined appropriate with residents, their families and or representatives. During interview on 12/7/17 at 2:06 p.m., the facility administrator talked about communication during emergency, stated he felt the current plan had sufficient information. The administrator stated the facility had not developed policies, procedures or directions for each of the requirements. Staff would use radios inside the building, and an Internet connection for "Point Click Care" (the electronic health record) remotely if there was evacuation. The administrator said the fire department (FD) likely had satellite radios, but stated while there was agreement with FD for evacuation, he had not thought about use of FD phones during emergency. The administrator stated he realized "the breadth" of a plan, voiced understanding that communication was a necessity of readiness, and stated our emergency plan "could be more thorough."	E 029	We will develop a system where we share information from the emergency plan with residents, families and resident representatives. In doing so, they will have access to the complete emergency preparedness plan if desired. This is all part of being more detailed and inclusive with the emergency plan. As we revise the communication plan, we will expand on this detail to make it more understandable. COMPLETION DATE: 1/16/18 RESPONSIBLE PERSON: Administrator	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must	E 036		1/16/18

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E 036	Continued From page 9 be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an emergency-preparedness training and testing program, based on the facility's risk assessments. This had the potential to affect all 23 current residents of the facility. Findings include:	E 036	The facility emergency plan was reviewed. The plan lacked sufficient documentation of staff training and testing. The plan referred to non-fire emergencies but could have been more detailed with regard to training. ACTION: When the revised emergency plan is completed, training and testing of	

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E 036	Continued From page 10 The facility's Emergency Management Plan, Parkview Senior Living, dated 8/1/17, was reviewed. The current facility emergency preparedness plan lacked documentation of staff training and testing program which addressed: -Training in emergency preparedness policies and procedures to all new and existing staff, and other individuals providing services under arrangement; and -Maintained documentation of all emergency preparedness training; and that staff -Demonstrated knowledge of emergency procedures. During interview on 12/7/17 at 10:55 a.m., licensed practical nurse (LPN)-A stated she was "unaware" of "emergency training." LPN-A stated the facility conducted fire drills, and would do weather drills, but stated she had not been instructed on what to do if there was a building evacuation, for example. LPN-A stated there was and she had training on various topics like "infection control" or "how to talk" with residents with dementia, but had not received specific training on handling facility emergencies. When interviewed on 12/7/17 at 12:47 p.m., the director or nursing (DON) stated the administrator had been working on the emergency plan, but was not aware of any specific training regarding emergency procedures for staff. In addition, the current plan lacked documented evidence the facility participated in any community-involved emergency preparedness drill, or completed a table-top emergency-simulation exercise, as required.	E 036	all new and current staff will be done. All training will be documented in regard to emergency preparedness. Staff will be expected to show knowledge and demonstrate competency in regard to all emergency procedures. This will include additional training and testing. Table-top meetings will be held and documented with the County Emergency Preparedness Director. This will include simulated emergencies. We will participate in the next scheduled county/community planned emergency preparedness drill. The facility will also see if a specific facility-wide evacuation drill can be conducted. We will also work with our local volunteer fire department, first response team, local ambulance services to review emergency procedures and participate in any training they may be able to provide. COMPLETION DATE: 1/16/18 RESPONSIBLE PERSON: Administrator We feel this plan of correction will meet the expectations of the survey team and more completely comply with the requirements of the Department of Health. In trying to keep things more simple, we were not as detailed as we should have been. We feel the new plan will meet all acceptable standards.	

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E 036	Continued From page 11 When interviewed on 12/7/17 at 2:06 p.m., the facility administrator stated the facility had not participated in a community drill, and also that no simulation, "table-top" exercise had been completed by the facility. The administrator stated the emergency plan was a newer, on-going project and still incomplete. The administrator stated the facility has planned a table top simulation, set up for a couple of weeks from now, on December 21st. The administrator stated, to date, facility staff or other nursing home staff had not completed any kind of emergency preparation drill, outside of the usual fire and weather drills. "We have not done that." The administrator stated there was no specific training provided for staff regarding emergencies, like the identified risks, "other than what we currently do" with the fire drills.	E 036		
F 000	INITIAL COMMENTS A recertification survey was conducted 12/5/17 through 12/7/17. 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. 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	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		1/16/18

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F 656	Continued From page 12	F 656		

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care

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F 656	Continued From page 13 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, document review and interview, the facility failed to comprehensively develop resident care plans for 1 of 12 residents (R19) whose care plans were reviewed. Findings include: R19's diagnoses, as identified on physician's orders dated 12/4/17, included chronic obstructive pulmonary disease, pain in the right shoulder, hypothyroidism, generalized arteriosclerosis, and spondylosis (a degeneration of the spine). The Annual Minimum Data Set (MDS), dated 11/09/17, indicated R19 was cognitively intact, received extensive assistance with most of her activities of daily living (ADLs), was on a pain management regimen, and had hypothyroidism. Two care area assessments (CAAs), for activities of daily living and Pain, undated, indicated R19's mobility and mood were affected by pain. During observation on 12/6/17 at 4:54 p.m., R19 completed a nebulizer treatment, and was assisted to her wheel chair by a licensed practical nurse (LPN)-A before the evening meal. R19 displayed facial grimacing, and once in the wheel chair, sighed relief. LPN-A asked R19 to rate her pain, to which resident stated her knees and back were stiff, and rated it a 3 (0 no pain and 10 being excruciating pain). R19 did not wish any medication intervention at that time. R19's physician's orders, last reviewed on	F 656	The facility failed to comprehensively develop care plans for 2 of 12 residents whose care plans were reviewed. It is the policy of Parkview Home to ensure that all residents have care plans developed that address all necessary care areas, current diagnoses, and any other health concerns relevant to their ongoing well-being. Resident R19 was identified during the survey as being affected by this deficiency due to no existing care plan related to pain management and management of her hypothyroidism. Resident R15 was identified during the survey as potentially being affected by this deficiency due to no existing care plan related to his current preventive skin care interventions currently in place. Although Resident R15 did not have any current skin issues or concerns, the interventions presently in place should be care planned accordingly. ACTION: To prevent future occurrences, the DON, MDS Coordinator and RN Manager met to discuss the care planning process. The MDS Coordinator was instructed to develop care plans for the residents identified as being affected by the deficiency. In the future, upon	

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	245475	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 14 12/6/17, indicted R19 received acetaminophen 650 milligrams (mg) four times a day for pain (started 7/13/17), and OxyCODONE HCL (a narcotic) 5 mg twice a day, and may have it two more times as needed (started 9/13/17). R19's pain assessment, dated 8/13/17, indicated R19 was experiencing frequent moderate pain, with interventions of acetaminophen, warm packs and physical therapy. In a more recent pain assessment, dated 11/05/17, indicated that in addition to acetaminophen and warm packs, OxyCODONE had been added for pain management. In this assessment, R19 indicated pain of 5 out of 10 (10 being excruciating pain). In review of R19's care plan, undated, the care plan did not address any of R19's pain issues or have interventions for this identified concern. In review of R19's labs it was noted that this resident's thyroid stimulating hormone (TSH - used to determine medication management of thyroid dysfunction) were the following: > On 6/5/17 R19's TSH results = 6.056 High - reference range of 0.358-3.740 milli-international units per milliliter (uIU/ml) A physician order dated 6/5/17, ordered R19's levothyroxine (medication used to manage thyroid dysfunction) dose change to 88 micrograms (mcg), and to recheck TSH in 2 months. > On 8/2/17 R19's TSH results = 9.414 High - reference range of 0.358-3.740 uIU/ml A physician order dated 8/2/17, ordered R19's levothyroxine dose changed to 125 mcg, and to recheck TSH in 8 weeks.	F 656	admission, each resident will be assessed to ensure that all care areas and pertinent diagnoses that are being treated are appropriately care planned. All residents will be assessed to determine the need for specific care plan areas, including skin care, skin breakdown prevention, pain management, etc. The DON will develop a specific care planning policy outlining the necessary components of facility care plans, timelines for development in accordance with current MDS requirements, and the procedure for development of the care plan. The DON or designee will routinely audit all care plans for 4 weeks, and then monthly to ensure that facility care plans are developed according to facility policy and contain all components needed to effectively care for each resident. The QA Committee will be provided with a report at each quarterly QA Meeting. The QAPI Committee will be provided with a report at each monthly QAPI meeting to ensure that the changes and audits are completed and that care plans are developed as required. COMPLETION DATE: 1/16/18 RESPONSIBLE PERSON: Director of Nursing	

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F 656	Continued From page 15 > On 9/27/17 R19's TSH results = 1.122 Normal - reference range of 0.358-3.740 uIU/ml A physician order dated 9/27/17, ordered R19's levothyroxine dose to remain at 125 mcg. In review of R19's care plan, undated, the care plan did not address R19's fluctuating TSH and his identified thyroid concerns. On 12/07/17 at 12:07 p.m., registered nurse (RN)-A stated that during the time of the last comprehensive assessment, a part-time RN was filling in for the MDS/Care Plan RN. RN-A stated she was uncertain why R19's pain and thyroid issues had not been addressed in resident's care plan. In an interview on 12/07/17 12:34 p.m., the director of nursing (DON) stated that any health issue that a resident being treated for "should be addressed" in their care plan. A policy regarding care plan development was requested, but not received. R15's diagnoses, as identified on the Admission Record dated 12/7/17, included cardiovascular disease (a disease affecting the blood vessels of the brain) and spastic hemiplegia affecting the dominant side. R15's quarterly Minimum Data Set (MDS), dated 10/19/17, indicated impaired cognition, with modified independence with decision making process. The MDS also indicated R15 required extensive assistance with activities of daily living (ADLs). During observation on 12/6/17 at 6:45 p.m., nursing assistant (NA)-B and NA-C provided evening cares for R15. R15 had yellow/purple bruising covering his right shoulder, which	F 656		

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F 656	Continued From page 16	F 656		

extended down his right arm and chest. During cares, R15 indicated a week ago he fainted in the bathroom and fractured his right arm and wore a sling to support his right arm. NA-B and NA-C transferred R15 into bed, lifting R15 using a mechanical lift and a sling. Staff completed the transfer without bumping or jarring R15's right arm. Once in bed, NA-B and NA-C completed cares, which included removing a foam boot and a compression stocking from R15's right foot. R15's right foot and leg had no signs of redness, skin breakdown, irritation or infection. NA-B and NA-C positioned R15 in bed in a side-lying position, with pillows placed for additional support.

When interviewed on 12/6/17 at 6:55 p.m., NA-B stated the foam boot was used to protect R15's foot from skin breakdown. During the same interview, NA-C stated the compression sleeve on the leg worked well for R15's swelling.

R15's care plan, dated 10/30/15, did not identify use of foam boot or compression hose to right foot/leg. Further, R15's care plan did not identify any injuries related to recent fracture and interventions for pain and transfers. A physician order, initiated on 1/5/17, identified R15 was to have edema wear to right leg on in the morning and off in the evening.

During interview on 12/6/17, at 12:40 p.m., registered nurse (RN)-B stated she was unable to find the information regarding implementation of interventions of compression hose and foam boot. RN-B stated R15's right foot was padded with foam boot to protect form potential injuries, related to contracture. RN-B stated the care plan did not address skin care, but that it should.

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F 656	Continued From page 17 A policy regarding care plan development was requested, but not received.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to comprehensively assess and provide interventions for skin irritations for 1 of 1 residents (R11) reviewed for non-pressure related skin concerns. Findings include: R11's diagnoses, as listed on the admission record face sheet dated 12/7/17, including bronchiectasis (a condition which affects the respiratory system which causes cough and mucous secretions), cerebral infarction (stroke), and diabetes. A significant change MDS dated 10/3/17, identified R11 had noted cognitive impairment and required extensive assistance of one to two staff with ADL's. During observation on 12/5/17, at 11:02 a.m. R11 was noted to have an abrasion on left side of the chin, approximately 0.75 centimeter (cm) in	F 684	Facility failed to comprehensively assess and provide interventions for skin irritation for 1 of 1 residents reviewed for non-pressure related skin concerns. It is the policy of Parkview Home to ensure that all residents with the potential for skin irritation, skin breakdown and skin concerns are properly assessed and that care planning is developed to aid in the timely identification and prevention of skin problems. Resident R11 was identified during the survey as being affected by this deficiency due to having an apparent abrasion on her left chin area that was not appropriately addressed by nursing staff or receiving any current treatment. Although resident R11 had recent changes related to her eating utensils as	1/16/18

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F 684	Continued From page 18	F 684		

diameter, with no surrounding redness, with scab in center. R11 was unable to state what happened to her chin when asked.

During interview on 12/6/17, at 6:40 p.m. registered nurse (RN)-A stated she had first noted the area on R11's chin during the evening meal tonight. RN-A stated she would initiate a treatment to this area, which would include gentle cleansing followed by an application of bacitracin (an antibiotic ointment) per standing orders. RN-A stated this should be identified in the narrative progress notes.

During a follow up interview on 12/6/17, at 7:00 p.m., NA-A and NA-B stated they were unaware of R11's skin irritation prior to this evening.

During observation at 12/0/17, at 12:37 p.m. R11 was in the dining room following the evening meal and drinking coffee. The area below R11's chin was scabbed over, and the outer edge of the scab appeared slightly pink. R11 was noted to have some food debris present around lips and chin.

During interview on 12/7/17, at 1:15 p.m., NA-A stated R11 required assistance to complete basic cares. NA-A stated she did not recall seeing an area on R11's chin. NA-A stated when any areas of skin breakdown were noted, a nurse should be informed to assess the area.

During interview on 12/7/17, at 2:09 p.m. RN-B stated R11 recently had a change in silverware on 12/4/17 as was noted to have problems with smearing food on her face. RN-B stated R11 has had excessive drooling related to her history of cerebral infarction (onset date of diagnosis

well, this was also not addressed in her care plan. Resident R11's care plan also did not address any current treatments in use for prevention of future skin concerns. Resident R11 has a history of current skin irritations and problems.

ACTION: To prevent future occurrences, the DON, MDS Coordinator and RN Manager met to discuss the current care planning process. The MDS Coordinator was instructed to update resident R11's current care plan to include the current skin condition and treatments presently in place. A skin assessment was completed on Resident 11. Her care plan was changed and updated to include scheduled skin assessments, all treatments used for the areas prone to skin irritation and other interventions. All residents, and especially those residents with a history of skin irritations or problems, will be assessed and care plans will be developed to ensure skin problems and concerns are addressed accordingly. Preventive skin care plans will be developed and put in place for all residents at risk for any skin problems/breakdown. The DON will develop a specific skin care policy to ensure that resident are appropriately assessed and necessary care plans are put in place. All licensed nurses will be educated on 1/15/18 regarding skin assessment, documentation, treatment and skin care policies to ensure that any skin concerns are promptly identified and treated appropriately. The DON or designee will routinely audit resident

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F 684	Continued From page 19 10/1/15 per Admission Record), with increased problems noted with her health decline over the past two months. R11 had a historic irritation noted on her chin with a prescription in place for cortisone cream as needed. RN-B stated the area of irritation had been relayed by evening nurse in the communication book on 12/6/17, however, had not documented this information in the medical record. RN-B stated the treatment should be placed on the treatment sheet or the medication administration record. During a subsequent interview on 12/7/17 at 2:23 p.m., RN-B reviewed R11's care plan, initiated on 10/5/17, and identified although the resident had the potential for impairment in skin integrity related to declining condition, it did not address history of skin irritation related to increased oral secretion and difficulty in self feeding, resulting in presence of food debris on lips and chin. The care plan did not identify the need for prompt facial cleansing after meals to decrease the potential for irritation or the availability of cortisone cream as needed (PRN) to treat these areas of irritation. RN-B stated it would be appropriate to address both the recurrent irritation of the chin, use of alternate silverware, cleansing of face promptly after meals, and PRN cortisone cream on the care plan. Review of R11's 5-day Medicare coverage Minimum Data Set (MDS) assessments dated, 9/18/17, and significant change MDS of 10/3/17 did not identify any area of skin breakdown. R11 was identified as having used applications of ointment/medications noted as noted under skin and ulcer treatment. A review of narrative notes from the past 30 days did not identify any problems with irritation or skin breakdown even though R11 had a history of skin irritation on her	F 684	treatments and care plans related to skin concerns/breakdown prevention weekly X 4, then monthly to ensure that skin concerns are identified and care planned appropriately according to facility policy and contain all components to effectively care for residents with skin concerns, and prevent future occurrences. The QAPI Committee will be provided with a report at each monthly meeting and the QA Committee with a report at each quarterly meeting to ensure that the changes put in place are maintained. COMPLETION DATE: 1/16/18 RESPONSIBLE PERSON: Director of Nursing	

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F 684	Continued From page 20 chin from oral secretions. Even though R11 had a history of skin irritations, these were not assessed or a plan provided to help reduce the risk of these skin irritations. A policy regarding assessment of skin condition and care plan development was requested, but not received.	F 684		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey the Parkview Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/02/2018

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

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Parkview 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.	K 000		

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K 000	Continued From page 2 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. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1. (1). This deficient practice could affect 22 of 22 residents by allowing smoke to propagate from	K 372	The smoke barrier near room 23 and near the physical therapy room were observed to have some spots where caulk was missing where the wall and ceiling meet. The caulking had not held and thus created a potential smoke barrier	12/29/17

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K 372	Continued From page 3 one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Findings include: On facility tour between 11:00 AM and 2:00 PM on 12/06/2017, penetrations were observed above the ceiling tiles at the smoke barrier near resident room #23 and the smoke barrier near the physical therapy department. NOTE; All smoke barriers and 2 hour fire separations need to be checked to ensure compliance. These deficient practices were verified by the Facility Maintenance Director.	K 372	penetration. ACTION: Maintenance has repaired the areas where caulking was identified to be gone and checked the other smoke barriers in the facility for additional open penetrations due to released caulking or other issues. COMPLETION DATE: All penetrations have been checked and repaired if needed. 1/2/18 RESPONSIBLE PERSON: The maintenance director is responsible for any repairs needed and will monitor all smoke barriers on a biannual schedule and report to the administrator.	
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety	K 926		12/29/17

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	245475	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2017**

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
K 926	Continued From page 4 guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This deficient practive could effect 22 of 22 residents. FINDINGS INCLUDE: During documentation review between 11:00 AM and 2:00 PM on 12/06/2017, documentation could not be located to show that all staff that handle gas cylinders have received safety training guidelines and usage requirements of gas cylinders. This deficient practice was verified by the Facility Maintenance Director.	K 926	During review of documentation on 12/6/17, documentation could not be located to show that all staff that handle gas cylinders have received safety training guidelines and usage requirements of gas cylinders. It is the policy of Parkview Home that all licensed nursing staff and other staff who are required to handle gas (oxygen) cylinders are tested for competency in handling the cylinders, applying the cylinders, and administering oxygen to residents. It is the policy of Parkview Home to ensure that annual training on oxygen administration and safety is completed by all licensed nursing staff. ACTION: To prevent future occurrences of this, licensed staff and other staff will be provided with training regarding oxygen administration and handling of gas cylinders annually. All new licensed nursing staff and others will be tested to competency with the use of oxygen, gas cylinders and oxygen administration upon hire. Mandatory inservice training will be completed here on 1/17/18 by the DON to ensure that all current staff have received adequate training regarding safety training guidelines and usage requirements of gas cylinders.	

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K 926	Continued From page 5	K 926	COMPLETION DATE: 1/17/18 RESPONSIBLE PERSON: Director of Nursing	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 21, 2017

Mr. Thomas Goeritz, Administrator
Parkview Home
102 County State Aid Highway 9
Belview, MN 56214

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5475029

Dear Mr. Goeritz:

The above facility was surveyed on December 5, 2017 through December 7, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Unit Supervisor Brenda Fischer at brenda.fischer@state.mn.us or (320) 223-7338.

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

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
	00543	A. BUILDING: _____ B. WING _____	12/07/2017

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/5/17 to 12/7/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observations, document review and interview, the facility failed to comprehensively develop resident care plans for 2 of 12 residents (R19, R15) whose care plans were reviewed. Findings include: R19's diagnoses, as identified on physician's orders dated 12/4/17, included chronic obstructive pulmonary disease, pain in the right shoulder, hypothyroidism, generalized arteriosclerosis, and spondylosis (a degeneration of the spine). The Annual Minimum Data Set (MDS), dated 11/09/17, indicated R19 was cognitively intact, received extensive assistance	2 570	CORRECTED	12/29/17

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2 570	Continued From page 3 with most of her activities of daily living (ADLs), was on a pain management regimen, and had hypothyroidism. Two care area assessments (CAAs), for activities of daily living and Pain, undated, indicated R19's mobility and mood were affected by pain. During observation on 12/6/17 at 4:54 p.m., R19 completed a nebulizer treatment, and was assisted to her wheel chair by a licensed practical nurse (LPN)-A before the evening meal. R19 displayed facial grimacing, and once in the wheel chair, sighed relief. LPN-A asked R19 to rate her pain, to which resident stated her knees and back were stiff, and rated it a 3 (0 no pain and 10 being excruciating pain). R19 did not wish any medication intervention at that time. R19's physician's orders, last reviewed on 12/6/17, indicted R19 received acetaminophen 650 milligrams (mg) four times a day for pain (started 7/13/17), and OxyCODONE HCL (a narcotic) 5 mg twice a day, and may have it two more times as needed (started 9/13/17). R19's pain assessment, dated 8/13/17, indicated R19 was experiencing frequent moderate pain, with interventions of acetaminophen, warm packs and physical therapy. In a more recent pain assessment, dated 11/05/17, indicated that in addition to acetaminophen and warm packs, OxyCODONE had been added for pain management. In this assessment, R19 indicated pain of 5 out of 10 (10 being excruciating pain). In review of R19's care plan, undated, the care plan did not address any of R19's pain issues or have interventions for this identified concern. In review of R19's labs it was noted that this	2 570		

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2 570	Continued From page 4 resident's thyroid stimulating hormone (TSH - used to determine medication management of thyroid dysfunction) were the following: > On 6/5/17 R19's TSH results = 6.056 High - reference range of 0.358-3.740 milli-international units per milliliter (uIU/ml) A physician order dated 6/5/17, ordered R19's levothyroxine (medication used to manage thyroid dysfunction) dose change to 88 micrograms (mcg), and to recheck TSH in 2 months. > On 8/2/17 R19's TSH results = 9.414 High - reference range of 0.358-3.740 uIU/ml A physician order dated 8/2/17, ordered R19's levothyroxine dose changed to 125 mcg, and to recheck TSH in 8 weeks. > On 9/27/17 R19's TSH results = 1.122 Normal - reference range of 0.358-3.740 uIU/ml A physician order dated 9/27/17, ordered R19's levothyroxine dose to remain at 125 mcg. In review of R19's care plan, undated, the care plan did not address R19's fluctuating TSH and his identified thyroid concerns. On 12/07/17 at 12:07 p.m., registered nurse (RN)-A stated that during the time of the last comprehensive assessment, a part-time RN was filling in for the MDS/Care Plan RN. RN-A stated she was uncertain why R19's pain and thyroid issues had not been addressed in resident's care plan. In an interview on 12/07/17 12:34 p.m., the director of nursing (DON) stated that any health issue that a resident being treated for "should be addressed" in their care plan.	2 570		

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2 570	Continued From page 5 R15's diagnoses, as identified on the Admission Record dated 12/7/17, included cardiovascular disease (a disease affecting the blood vessels of the brain) and spastic hemiplegia affecting the dominant side. R15's quarterly Minimum Data Set (MDS), dated 10/19/17, indicated impaired cognition, with modified independence with decision making process. The MDS also indicated R15 required extensive assistance with activities of daily living (ADLs). During observation on 12/6/17 at 6:45 p.m., nursing assistant (NA)-B and NA-C provided evening cares for R15. R15 had yellow/purple bruising covering his right shoulder, which extended down his right arm and chest. During cares, R15 indicated a week ago he fainted in the bathroom and fractured his right arm and wore a sling to support his right arm. NA-B and NA-C transferred R15 into bed, lifting R15 using a mechanical lift and a sling. Staff completed the transfer without bumping or jarring R15's right arm. Once in bed, NA-B and NA-C completed cares, which included removing a foam boot and a compression stocking from R15's right foot. R15's right foot and leg had no signs of redness, skin breakdown, irritation or infection. NA-B and NA-C positioned R15 in bed in a side-lying position, with pillows placed for additional support. When interviewed on 12/6/17 at 6:55 p.m., NA-B stated the foam boot was used to protect R15's foot from skin breakdown. During the same interview, NA-C stated the compression sleeve on the leg worked well for R15's swelling. R15's care plan, dated 10/30/15, did not identify use of foam boot or compression hose to right	2 570		

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2 570	Continued From page 6 foot/leg. Further, R15's care plan did not identify any injuries related to recent fracture and interventions for pain and transfers. A physician order, initiated on 1/5/17, identified R15 was to have edema wear to right leg on in the morning and off in the evening. During interview on 12/6/17, at 12:40 p.m., registered nurse (RN)-B stated she was unable to find the information regarding implementation of interventions of compression hose and foam boot. RN-B stated R15's right foot was padded with foam boot to protect form potential injuries, related to contracture. RN-B stated the care plan did not address skin care, but that it should. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review and/or revise policies and procedures to assure care plans reflect the current, assessed needs of the residents. The Director of Nursing or designee could develop a monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		12/29/17

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2 830	Continued From page 7 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to comprehensively assess and provide interventions for skin irritations for 1 of 1 residents (R11) reviewed for non-pressure related skin concerns. Findings include: R11's diagnoses, as listed on the admission record face sheet dated 12/7/17, including bronchiectasis (a condition which affects the respiratory system which causes cough and mucous secretions), cerebral infarction (stroke), and diabetes. A significant change MDS dated 10/3/17, identified R11 had noted cognitive impairment and required extensive assistance of one to two staff with ADL's. During observation on 12/5/17, at 11:02 a.m. R11 was noted to have an abrasion on left side of the chin, approximately 0.75 centimeter (cm) in diameter, with no surrounding redness, with scab in center. R11 was unable to state what happened to her chin when asked. During interview on 12/6/17, at 6:40 p.m. registered nurse (RN)-A stated she had first noted the area on R11's chin during the evening meal tonight. RN-A stated she would initiate a treatment to this area, which would include gentle cleansing followed by an application of bacitracin	2 830	CORRECTED	

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2 830	Continued From page 8 (an antibiotic ointment) per standing orders. RN-A stated this should be identified in the narrative progress notes. During a follow up interview on 12/6/17, at 7:00 p.m., NA-A and NA-B stated they were unaware of R11's skin irritation prior to this evening. During observation at 12/0/17, at 12:37 p.m. R11 was in the dining room following the evening meal and drinking coffee. The area below R11's chin was scabbed over, and the outer edge of the scab appeared slightly pink. R11 was noted to have some food debris present around lips and chin. During interview on 12/7/17, at 1:15 p.m., NA-A stated R11 required assistance to complete basic cares. NA-A stated she did not recall seeing an area on R11's chin. NA-A stated when any areas of skin breakdown were noted, a nurse should be informed to assess the area. During interview on 12/7/17, at 2:09 p.m. RN-B stated R11 recently had a change in silverware on 12/4/17 as was noted to have problems with smearing food on her face. RN-B stated R11 has had excessive drooling related to her history of cerebral infarction (onset date of diagnosis 10/1/15 per Admission Record), with increased problems noted with her health decline over the past two months. R11 had a historic irritation noted on her chin with a prescription in place for cortisone cream as needed. RN-B stated the area of irritation had been relayed by evening nurse in the communication book on 12/6/17, however, had not documented this information in the medical record. RN-B stated the treatment should be placed on the treatment sheet or the medication administration record. During a	2 830		

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2 830	Continued From page 9 subsequent interview on 12/7/17 at 2:23 p.m., RN-B reviewed R11's care plan, initiated on 10/5/17, and identified although the resident had the potential for impairment in skin integrity related to declining condition, it did not address history of skin irritation related to increased oral secretion and difficulty in self feeding, resulting in presence of food debris on lips and chin. The care plan did not identify the need for prompt facial cleansing after meals to decrease the potential for irritation or the availability of cortisone cream as needed (PRN) to treat these areas of irritation. RN-B stated it would be appropriate to address both the recurrent irritation of the chin, use of alternate silverware, cleansing of face promptly after meals, and PRN cortisone cream on the care plan. Review of R11's 5-day Medicare coverage Minimum Data Set (MDS) assessments dated, 9/18/17, and significant change MDS of 10/3/17 did not identify any area of skin breakdown. R11 was identified as having used applications of ointment/medications noted as noted under skin and ulcer treatment. A review of narrative notes from the past 30 days did not identify any problems with irritation or skin breakdown even though R11 had a history of skin irritation on her chin from oral secretions. Even though R11 had a history of skin irritations, these were not assessed or a plan provided to help reduce the risk of these skin irritations. A policy regarding assessment of skin condition and care plan development was requested, but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for skin irritation to assure	2 830		

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 _____	12/07/2017

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
2 830	Continued From page 10 they are receiving the necessary treatment/services to prevent these area from developing and to promote healing. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce of the development of skin irritations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by:	21426		12/29/17