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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M85O

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 04/08/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Timothy Rhonemus, HFE NEII 04/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/12/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 5/3/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5475

Post certification revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B for both health and life safety code. Effective April 2, 2013, the facility is certified for 30 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5475 April 12, 2013

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

Dear Mr. Stordahl:

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

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

Effective April 2, 2013, the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

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

April 12, 2013

RE: Project Number S5475024

Dear Mr. Stordahl:

On March 11, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 21, 2013. 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 April 8, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 3, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 2, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 21, 2013, effective April 2, 2013 and therefore remedies outlined in our letter to you dated March 11, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900
Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245475	01 - MAIN BUILDING 01	4/3/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0048	Correction Completed 04/02/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/25/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245475	A. Building B. Wing	4/8/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/19/2013**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/19/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/19/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/cbl	04/12/2013	10562	04/08/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/21/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245475	01 - MAIN BUILDING 01	4/3/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0048	Correction Completed 04/02/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/cbl	Date: 04/12/2013	Signature of Surveyor: 22373	Date: 04/3/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/25/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M85O

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 **02/21/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the Standard survey, the facility was not in substantial compliance with Federal certification regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Timothy Rhonemus, HFE NEII 03/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/25/2013 CO.
M85O

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3873

March 11, 2013

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

RE: Project Number S5475024

Dear Mr. Stordahl:

On February 25, 2013, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7338

Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 2, 2013, 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 April 2, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 May 21, 2013 (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 August 21, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

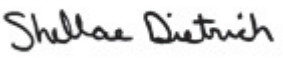
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5475s13.rtf

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 _____	02/21/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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.	F 000	RECEIVED MAR 2 1 2013 MN Dept of Health St.Cloud	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide rehabilitative services according to the written plan of care (POC) for 2 of 3 residents (R7, R22) in the sample reviewed for rehabilitative services. Findings include: R7 was not provided a rehabilitative program in accordance with his POC. R7 was observed on 2/19/13 from 2:00 p.m. to 8:00 p.m. and on 2/20/13 from 7:00 a.m. to 4:00 p.m. during this time R22 did not complete the exercises with restorative nursing as identified on	F 282	3/25/13 AT	

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

Michael Stoutner Administrator March 20, 2013

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

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F 282	Continued From page 1 his care plan. R7's POC dated 9/5/2012, indicated R7 was at risk for physical decline and was referred to a restorative nursing program. The POC indicated restorative nursing interventions to be provided included bilateral pulleys, bilateral hand gripper, five pound weight pulleys, two pound dumbbell to right arm and one pound dumbbell. R7 also was to use a bike and exercise machine. The monthly restorative nursing monitoring sheets indicated R7 participated in the nursing rehab program only 13 times in October 2012, three times in November 2012, once in December 2012 and January 2013 and only 10 times in February 2013. R7 was not receiving the rehabilitative services as directed by the plan of care. R22 was not provided rehabilitative program as directed by his POC. R22's POC dated 9/25/2012, indicated R22 was to receive restorative nursing services which consisted of 5 pound weight pulleys to the upper extremities bilaterally, and to utilize the NuStep (exercise machine) for as long as R22 could hold his attention. The monthly nursing rehab sheets indicated R22 participated in the exercise program seven times in September 2012, three times in October 2012, and only six times in November 2012. The facility was unable to locate the remaining months of the rehab nursing sheets. During interview on 2/20/13, at 1:51 p.m., the	F 282		

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F 282	Continued From page 2 director of nursing (DON) stated the restorative nursing services have not been consistently provided as identified in the care plan because of facility changes, "it just hasn't been done." On 2/21/13, at 9:15 a.m. registered nurse (RN)-A stated, they were unable to locate the remaining restorative nursing sheets. At 12:30 p.m., RN-A stated, as of 6/22/12, R22 should have received restorative nursing program three times per week but R22 exercise program was not implemented as directed by the POC.	F 282		03/19/2013
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure rehabilitative nursing was consistently implemented for 1 of 3 residents (R7) who received rehabilitative nursing services. Findings include: R7's diagnoses included cerebrovascular disease, and coronary artery disease. The quarterly MDS dated 11/14/2012, indicated R7 needed assistance of one staff for transferring and ambulation and had a history of falls. R7's plan of care (POC) dated 9/5/2012, indicated R7 was at risk for physical decline and	F 311		03/19/2013

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F 311	Continued From page 3 was referred to a restorative nursing program. The POC indicated restorative nursing interventions to be provided included bilateral pulleys, bilateral hand gripper, five pound weight pulleys, two pound dumbbell to right arm and one pound dumbbell. R7 also was to use a bike and the NuStep (exercise machine). Review of the monthly restorative nursing monitoring sheets indicated the upper extremity, bike and NuStep exercises were completed 13 times in October 2012, three times in November 2012, once in December 2012, once in January 2013 and ten times in February. The Restorative Care Plan Strengthening Template form dated 11/20/12, identified R7's goals were to increase strength for mobility function and to tolerate the exercise program. Treatment included exercises in sitting, standing and supine positions doing straight leg raises, side leg raises, back leg kicks, knee raises, ankle pumps, bridging, knee extension and knee flex hip adduction with ball squeezes three times a week for 8 weeks. These exercises were not identified on the care plan. The lower extremity exercises of leg raises, leg kicks and knee raises were not identified on the monthly restorative monitoring sheets until January 2013, even though they were to start in November 2012. The January 2013 sheet indicated these exercises were never completed and in February they were completed only once. R7 was observed on 2/19/13 from 2:00 p.m. to 8:00 p.m. and on 2/20/13 from 7:00 a.m. to 4:00	F 311		

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F 311	Continued From page 4 p.m. during this time R7 did not complete the upper and lower extremity exercises with restorative nursing as identified by the care plan or Restorative Care Plan Strengthening Template. During interview on 2/20/13, at 1:51 p.m., the director of nursing (DON) stated, the restorative nursing was reviewed monthly. She was not sure why R7's restorative program was dated for only 8 weeks. The DON stated due to staffing changes they do not have time to provide the restorative nursing services, "it just hasn't been done." In addition, the DON stated staff needed to work with therapy on the frequency of restorative services so everyone was consistent with the plan.	F 311		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that residents with limited range of motion (ROM) received the services needed to maintain and/or improve physical ability for 1 of 2 residents (R7, R22) with a limited range of motion.	F 318		03/19/2013

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F 318	Continued From page 5 Findings include: R22's was discharged from the facility in December 2012 his diagnoses included rhabdomyolysis (the breakdown of muscle fibers), Parkinson's disease, chronic obstructive pulmonary disease and a stroke. The quarterly Minimum Data Sets (MDS), dated 6/25/12, and 9/14/12, indicated R22 had no functional impairment but the quarterly MDS dated 12/12/12, indicated R22 had functional limitation in ROM on one side of the lower extremity. A physical therapy (PT) noted dated 6/25/12, indicated R22 had "Improved towards all goals and met strength goal. Improved gait technique." R22 was discharged from PT, and the Rehab To Restorative Referral sheet dated 6/25/2012, indicated R22 was to exercise with five pound weight pulleys and upper extremity bike 3-5 times per week. R22's POC, dated 9/25/2012, indicated R22 had difficulty in maintaining strength for mobility. The POC directed staff to provide restorative nursing services which consisted of five pound weight pulleys to the upper extremities bilaterally, and NuStep (exercise machine) for as long as R22 could hold his attention. The POC also recommended R22 try to exercise for 10 minutes but there was no frequency. Review of the monthly restorative nursing sheets indicated R22 participated only seven times in September 2012, three times in October 2012, and six times in November 2012. The instructions on the monitoring sheets directed staff to document if R22 refused services, was ill, or had an appointment. However, no such	F 318		

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F 318	Continued From page 6 notations were made on the sheets. The facility was unable to find the remaining monthly monitoring sheets. During interview on 2/21/13, at 9:15 a.m., registered nurse (RN)-B stated, R22 was not interested in participating in therapy. RN-B also stated, the restorative nursing sheets should be in his chart, but they were unable to locate them. During interview on 2/20/13, at 1:51 p.m., the director of nursing (DON) stated, due to staffing changes they do not have time to provide the restorative nursing services, "it just hasn't been done." During interview on 2/21/13 at 12:30 p.m., RN-A stated, as of 6/20/12, R22 should have been provided restorative nursing program services three times per week. RN-A also stated they were unable to locate R22's restorative nursing sheets for the other months.	F 318		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		03/19/2013

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F 425	Continued From page 7 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 10 resident (R33) were administered medications according to the manufacture's instructions. Findings include: R33 had a history of cerebral vascular accident (CVA) with impaired swallowing, and gastro-esphogeal reflux disease (GERD). During medication administration observations on 02/21/13, at 8:58 a.m., licensed practical nurse (LPN)-A was observed preparing morning medications for R33. LPN-A stated, R33's medications were crushed, due to difficulty swallowing as well as R33's family member (FM) -A's request. LPN-A continued to prepare R33's medications, which consisted of Metoprolol-XL (extended release tablet, blood pressure medication) 25 milligrams (mg) and Protonix (an enteric coated tablet, used for esophageal reflex) 40 mg in the medication cup. Once all the morning medications were placed in the medication cup, LPN-A removed the Vitamin D capsule (which was a gel cap), and crushed R33's medication including the Metoprolol-XL and	F 425		

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F 425	Continued From page 8 Protonix. Once crushed, LPN-A placed the Vitamin D gel cap and the crushed medications in a cup of applesauce and went to R33 room to administer the medications. Prior to the administration of the medications, this surveyor stopped LPN-A to verify which medication were crushed, specifically the Metoprolol - XL and the Protonix. LPN-A verified both of these medications had been crushed. Additionally, LPN-A stated the nurses had been crushing R33's medications because of FM-A's request. The manufacturer of Metoprolol-XL instructed the medication not be crushed, due to being an extended release medication. The manufacturer of Protonix instructed this medication was not be crushed. In review of the physician's orders (last signed 12/19/12,) there was no evidence that the physician had given any orders to crush R33's medications. During interview on 02/21/13, at 9:40 a.m., registered nurse (RN)-A stated both medications should not have been crushed. RN-A further stated, the facility did not have a list or procedures that identified which medications could be crushed.	F 425		
F 431 SS=C	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		03/19/2013

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F 431	Continued From page 9 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to reconcile narcotic medication count each shift as directed by the facility policy, which had the potential to affect all 22 residents currently residing in the facility.	F 431		

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F 431	Continued From page 10 Finding include: During review of narcotic medication reconciliation logs, it was noted that the staff were not reconciling narcotic medications each shift as directed by the facility policy. The Daily Narcotic Count record dated February 2013, indicated staff had not reconciled narcotic medications on 7 of 21 night shifts, 13 of 21 day shifts and 6 of 21 evening shifts. The Daily Narcotic Count record dated January 2013, indicated staff had not reconciled narcotic medications on 15 of 31 night shifts, 26 of 31 day shifts and 9 of 31 evening shifts. The Daily Narcotic Count record dated December 2012, indicated staff had not reconciled narcotic medications on 13 of 31 night shifts, 31 of 31 day shifts and 17 of 31 evening shifts. The Daily Narcotic Count record dated November 2012, indicated staff had not reconciled narcotic medications on 14 of 30 night shifts, 23 of 30 day shifts and 20 of 30 evening shifts. The facility Narcotic Count policy dated 7/22/11, directed licensed practical nurses (LPN), registered nurses (RN) and trained medication administrators (TMA) "To complete a physical inventory on each shift to identify discrepancies and need for reconciliation and accountability." During interview on 2/21/13, at 11:03 a.m., LPN-A, stated, on average, they only reconcile the narcotic count once a day. We should be reconciling this three times a day with shift	F 431		

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F 431	Continued From page 11 change, but this does not happen.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		03/19/2013

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F 441	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control practices were maintained during 1 of 10 resident (R28) medication administration observations. In addition, soiled linen was placed on the floor for during cares for 1 of 3 resident (R19) observed during morning cares. Findings include: R28 received medications by RN-B who did not wash her hands or use gloves during the administration of medications. During observation on 2/19/13, at 6:05 p.m., registered nurse (RN)-B, opened R28's medication cabinet and placed her medications into a med cup. RN-B then proceeded to place two drops into both of R28's eyes with her bare hands. RN-B did not wash her hands or use protective gloves prior to administering the eye drops. RN-B then proceeded to touch each of R28's medication tablets and one by one placed them into R28's mouth with her bare hands. RN-B then proceed to touch R28, and opened R28 door and left the room without first washing her hands. RN-B went to the utility room, touching the handle and then washed her soiled hands. On 2/19/13, at 6:06 p.m., RN-B stated, she usually touches R28's medications with bare hands and does not wear gloves when administering R28 eye drops.	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 The above observation was discussed with the infection control nurse RN-C on 02/21/13, at 10:20 a.m., stated that gloves should be worn during installation of eye drops and that either gloves or a spoon should be used when administering oral medications into the residents' mouth. RN-C stated, she was unable to locate a policy for proper oral medication administration. Review of the facility's policy last updated 1/22/00, Eye Medication, Installation Of, directed staff to "wash your hands before and after all procedures. Wear gloves when appropriate". R19 soiled clothing was placed on the floor in R19's room, and not in a bag as directed by the facility soiled linen policy. During observation of morning cares on 2/20/13, at 7:36 a.m., nursing assistant (NA)-A, was providing person cares to R19 in the bathroom. When NA-A completed cares, she dropped R19's soiled towel, washcloth T-shirt/night shirt and socks on the floor in R19 room. NA-A proceed to assist R19 with cares, and wheeled R19 to the dining room for breakfast. At 8:04 a.m., registered nurse (RN)-C was observed to pick up the soiled towels and dirty clothes from R19's floor and carried them out of R19's room. On 02/21/13, at 10:20 a.m., the infection control nurse RN-C stated the soiled linens should not have been placed on the floor, but rather in linen bags provided on the unit.	F 441		

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 _____	02/21/2013

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

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F 441	Continued From page 14 The facility's policy, entitled: Laundry and Linen Handling last revised 12/30/08, indicated "1. Soiled linen should be handled as little as possible and with minimum agitation to prevent gross microbial contamination or the air and the persons handling the linen. 2. All soiled linen should be bagged at the location where it is used."	F 441		

Parkview Home

Plan of Correction for Minnesota Department of Health QIS 2/19/13-2/21/13

F 282 It is the policy of Parkview Home to implement plans of care for rehab nursing.

Rehab nursing will be addressed in the plan of care for residents #19 and #7. #22 is no longer at Parkview.

To prevent future occurrences, plans of care will be implemented for current residents with a nursing rehab program and for future residents with nursing rehab programs. The RN case manager staff were updated on 3/6/13. All staff will be educated at a training session on 3/19/13. It will be the responsibility of the DON or designee to complete audits monthly for 6 months. If positive results, audits will be changed to quarterly. Concerns will be addressed at staff and QA meetings.

Completion date for plan of correction will be 3/19/13.

F 311 It is the goal of Parkview Home to provide nursing rehab services to improve and/or maintain ADL's.

For resident # 7, rehab services will be offered as recommended. Staff was made aware of the rehab concerns on 2/21/13.

To prevent future occurrences, rehab services will be offered to promote individual resident's highest level of functioning, as safely as possible. Staff will be educated at a training session on 3/19/13 on the policy and purpose of rehab nursing. We will also discuss the desire to develop a new style rehab nursing program that involves more input from the residents. It will be the responsibility of the DON or designee to complete audits weekly for 3 months and if positive results are seen the meetings will be changed to quarterly. Concerns will be addressed at staff, restorative, resident council, and QA meetings.

Completion date for plan of correction will be 3/19/13.

3/25/13

F 318 It is the goal of Parkview Home to ensure that residents receive rehab services to maintain or improve their limited ROM, strength, conditioning, and prevent decline.

For resident # 7, rehab services will be offered as recommended. Staff was made aware of the rehab concerns on 2/21/13. Resident # 22 is no longer at Parkview.

To prevent future occurrences, rehab services will be offered as recommended by professional therapy services to current and newly admitted residents, with respect to resident rights. Staff will be educated at a training session on 3/19/13. The QA team had addressed the desire to develop a new style of restorative nursing program (with more input from residents and their families). We will have an active task force committee. It will be the responsibility of the DON or designee to complete audits weekly for 3 months and if positive results, will change to quarterly. Concerns will be addressed at staff, restorative, QA, and resident council meetings as needed.

Completion date for plan of correction will be 3/19/13.

F 425 It is the policy of Parkview Home that medications are administered according to manufactures instructions.

For resident # 33, staff member involved was educated on 2/22/13.

To prevent future occurrences, all staff will be educated at an education session on on 3/19/13. We will review the importance of reading the labels of medications. It will be the responsibility of the DON or designee to complete random audits during medication administration weekly for 2 months. If positive results, will reduce audits to monthly. Concerns will be addressed at staff and QA meetings.

Completion date for plan of corrections will be 3/19/13.

F 431 It is the goal of Parkview Home to reconcile narcotic medications according to the facility policy.

Staff was made of aware of the non-compliance concern on, 2/21/13.

To prevent future occurrences, all appropriate staff will be re-educated at an education session on 3/19/13. The narcotic reconciliation policy was updated and reviewed. It will be the responsibility of the DON or designee to complete weekly audits for 2 months. If

positive results, audits will be reduced to monthly. Concerns will be addressed immediately when needed and at staff and QA meetings.

Completion date for plan of correction will be 3/19/13.

F 441 It is the goal of Parkview Home to follow proper infection control practices.

Staff was made aware of the infection control concerns for residents #28 and #19 on 2/21/13.

To prevent future occurrences, all staff will be re-educated at a training session on 3/19/13. Infection control practices for medication and linen handling will be discussed. Health Care Academy courses "Hand Hygiene" and "Laundry Measures to Control the Spread of Infection" will be assigned to staff. Staff will also be re-educated on medication administration for eye drops. It will be the responsibility of the DON or designee to complete random audits 3 times per week for one month. If positive results, audits will be reduced to weekly for 2 months. Concerns will be addressed with individual staff as needed, at staff meetings, QA and infection control meetings.

Completion date for plan of correction will be 3/19/13.

F 5475022

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

PRINTED: 03/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/25/2013

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 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 25, 2013. At the time of this survey, Parkview Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok PB 3-21-13 RECEIVED MAR 21 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	4/2/2013

DC: 04.02.2013

EXIT: 02.21.2013

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

Michael Stordahl | Administrator | 03-20-2013

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2013**

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 000	Continued From page 1 By eMail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@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. The facility has an automatic fire alarm system with smoke detection at all smoke barrier doors and in all 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 20 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	Parkview Home will ensure that there is a written plan for the protection of all patients and for their evacuation in the event of an emergency.	4/2/2013
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7 This STANDARD is not met as evidenced by: Based upon a review of available documentation, the facility's fire safety plan did not provide for all nine (9) of the required elements at NFPA 101 (00) Chapter 19, Section 19.7.2.2. In a fire emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors. FINDINGS INCLUDE: On 2/25/2013 at 11:30 AM, during a review of the facility's written Fire & Emergency Plan, it was confirmed that no provision existed for the preparation of floors and building for evacuation, in accordance with NFPA 101 (00) Chapter 19, Section 19.7.2.2 (7). This finding was confirmed with the facility's chief building engineer.	K 048	Staff were made aware of the deficiency at an all staff meeting on 3/19/13. A template for a fire and emergency plan was taken from the Minnesota Department of Health web site. This template will be used to create a new fire and evacuation plan for Parkview Home. The plan will include the required elements listed in NFPA 101 Chapter 19, section 19.7.2.2. The Maintenance Director, John Lewis will be responsible for the creation and implementation of the new fire and evacuation plan for Parkview Home. A staff meeting will be held on 4/2/2013 to educate the staff on the updated fire and evacuation plan. The Maintenance Director will also be responsible for holding yearly in-services on the fire and emergency plan for Parkview Home. The new plan will also be given to new employees and reviewed during new employee orientation from the completion date forward.	