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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MRXM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245436**
2.STATE VENDOR OR MEDICAID NO.
(L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER WELLS INC**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

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) **04/01/2009**

6. DATE OF SURVEY **06/10/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (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: * Code: **A5*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Kathryn Serie, Unit Supervisor 07/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(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
06/12/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 24-5436

Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on June 10 2014. Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 has been forwarded. Approval of the waiver request has been requested.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245436

July 2, 2014

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

Dear Mr. Johannsen:

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 May 25, 2014 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

Your request for waiver of K67 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Program.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 1, 2014

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

RE: Project Number S5591024

Dear Mr. Johannsen:

On May 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 25, 2014. 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 June 10, 2014, the Minnesota Department of Health and the Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 25, 2014 and May 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 25, 2014 and May 6, 2014, effective May 25, 2014 and therefore remedies outlined in our letter to you dated May 16, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K67 at the time of the April 25, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245436	A. Building B. Wing	6/10/2014

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0329** Reg. # **483.25(l)** LSC	**05/25/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**05/25/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**05/25/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GN/KFD	**Date:** 07/02/2014	**Signature of Surveyor:** 10160	**Date:** 06/10/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/25/2014	**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
245436	A. Building 01 - MAIN BUILDING 01 B. Wing	6/10/2014

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	05/25/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/kfd	07/02/2014	27200	06/10/2014
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
5/6/2014	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MRXM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245436**

2.STATE VENDOR OR MEDICAID NO.
(L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER WELLS INC**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

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) **04/01/2009**

6. DATE OF SURVEY **04/25/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B5** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Pamela Manzke, HFE NE II 06/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/11/2014 (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
03/01/1987
(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
AW K67 Emailed to CMS 06/12/2014 CO.

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 24-5436

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction. Documentation supporting the facility's request for a continuing waiver involving K67 will be forwarded. Approval of the waiver request will be recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4882

May 16, 2014

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, Minnesota 56097

RE: Project Number S5436023

Dear Mr. Johannsen:

On April 25, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 4, 2014, 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 June 4, 2014 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 July 25, 2014 (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 October 25, 2014 (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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 05/15/2014
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
	245436	A. BUILDING _____ B. WING _____	04/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER WELLS INC	55 TENTH STREET SOUTHEAST WELLS, MN 56097

(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	2014 SURVEY PLAN OF CORRECTION F-329, F-431, F-441	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F-329 It is our intent to comply with regulation** **Drug regimen is free from unnecessary drugs.** The facilities compliance for monitoring medication was reviewed by the Director of Nursing and Consulting pharmacist. A checklist for medications that require monitoring for dose reduction, target behaviors was implemented and a monthly summarization of dose reduction and target behaviors will be reviewed monthly by the DON, ADON and consulting pharmacist. The AIMS, Moses and Discus will be used quarterly and as needed to monitor for side effects and effectiveness. All monthly reports from the consulting pharmacist are currently reviewed by the DON and correspondence with the doctor will be tracked on a monthly basis.	

Approved
KMS
6/2/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert J. Rasmussen — TITLE: Administrator — (X6) DATE: 25 May 2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING _____ B. WING _____	04/25/2014

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F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor the effectiveness of non-pharmacological interventions and failed to analyze behavior data for 1 of 5 residents (R1) reviewed, who received psychotropic medications. Findings include: R1's annual Minimum Data Set (MDS) dated 2/24/14, indicated he had minimal depression symptoms and his cognition was intact. The care area assessment (CAA) dated 2/25/14, revealed R1 was not concerned about his mood. The CAA identified R1 received medication for anxiety and had no behavior issues. R1's Facility Behavior Management follow-up dated 2/25/14, identified target behaviors of anxiety and restlessness. Non-pharmacological measures included activities, rest periods, toileting and repositioning. R1's mood care plan dated 2/25/14, revealed interventions which included allowing R1 to verbalize, encouraging him to participate in activities, allowing him to make his own decisions, and provision of one-on-one attention. His psychotropic drug use care plan dated 3/11/14, revealed approaches including administration of Ativan at bedtime, monitoring for the effectiveness of his medications, attempting non-pharmacological interventions and attempting to taper his Ativan per the facility protocol.	F 329	To sustain compliance the facility will audit target behaviors, dosage change or reduction and these will be discussed quarterly at Quality Assurance meeting. Corrective action will be completed by May 25, 2014.	

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F 329	Continued From page 2 Review of the facility's nursing assistant (NA) documentation dated 3/28/14, through 4/26/14, revealed behaviors of short tempered occurred on three occasions, poor appetite/over-eating occurred twice, and rejection of care occurred once. The NA documentation identified non-pharmacological interventions of re-direction and one-to-ones. The NA documentation revealed that of the six incidents noted, R1's behavior was altered only one time with use of one-on-ones. R1's identified target behaviors of anxiety and restlessness were not the behaviors that were reflected on the NA documentation and the non-pharmacological interventions used by staff, were mostly unsuccessful. Review of the medication administration record (MAR) dated 4/1/14, to 4/24/14, revealed R1 received Ativan 0.5 milligrams (mg) daily at bedtime, for anxiety. Observations of R1 included the following: · On 4/21/14, at 7:30 p.m. no mood or behavior concerns were observed. · On 4/22/14, at 8:40 a.m. and 10:30 a.m., no mood or behavior concerns were observed. · On 4/23/14, at 2:00 p.m. no mood or behavior concerns were observed. · On 4/24/14, at 7:17 a.m., 8:30 a.m. and 10:30 a.m., no mood or behavior concerns were observed. During interview on 4/25/14, at 7:20 a.m. assistant director of nursing (ADON) stated R1 received Ativan for restlessness and anxiety at bedtime. ADON stated non-pharmacological interventions were used, such as one-to-one visits and repositioning. ADON stated the	F 329		

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F 329	Continued From page 3 non-pharmacological interventions were not documented and were not monitored for effectiveness. During interview on 4/25/14, at 9:10 a.m. director of nursing (DON) verified the facility lacked analysis of behavioral data to identify effectiveness of the scheduled anti-anxiety medication. DON stated the facility completed an assessment for the use of Ativan, monitored target behaviors, and implemented attempts to taper Ativan. DON stated the information was located in several areas, including NA, nurse, and social service documentation. DON verified the facility failed to pull all of the data together, to analyze the effectiveness of R1's use of Ativan to manage his anxiety. During interview on 4/25/14, at 9:40 a.m. R1 stated he did not know why he received Ativan.	F 329		
F 431 SS=D	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 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.	F 431	**F-431 It is our intent to comply with regulation** **Drug Records, Label/Store drugs and biologicals** The facilities compliance for Drug records, label/store drugs and biologicals was reviewed by the DON, Consulting Pharmacist. Medications that have a change in dosage will be labeled with a sticker see MAR until a new label will be sent. No writing on or altering the medication labels.	

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F 431	Continued From page 4 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility altered two pharmacy labels with order changes, for 1 of 1 resident (R36) observed for administration of insulin. Findings include: R36's physician orders dated 3/24/14, through 4/24/14, revealed a diagnosis of diabetes mellitus. Medication orders were as follows: · Humalog insulin, eight units, subcutaneous, before each meal, with a start date of 1/3/14. · Lantus insulin, 45 units, subcutaneous, once each morning, with a start date of 1/3/14. · Blood glucose checks, four times daily, with a start date of 2/17/13. Review of R36's medication administration record	F 431	Monitoring of labels and dose changes will be done weekly by the DON or ADON and monthly by the Consulting Pharmacist. This monitoring will be discussed quarterly at the Quality Assurance meeting. Corrective action will be completed by May 25, 2014	

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F 431	Continued From page 5 (MAR) dated 4/1/14, through 4/24/14, revealed they received humalog and lantus insulin as ordered, and the blood glucose was checked as ordered. During observation of the medication pass on 4/24/14, at 7:52 a.m. licensed practical nurse (LPN)-B was observed to draw humalog insulin, eight units, into a syringe for R36. Observation of the humalog insulin pharmacy label revealed directions for six units, but was written-over in ink, to indicate eight units. A notation of "8 U" (eight units), was also written in ink elsewhere on the pharmacy label. The pharmacy label dispense date was 3/21/14. The humalog insulin was dated as opened on 4/22/14. LPN-B was observed to write, "1/3/14," on the label, with an ink pen. LPN-B confirmed R36's Humalog order had changed on 1/3/14. LPN-B stated facility's process was to use a hi-liter to yellow-out the prior order when there was an order change, then to write the new order, with the new order date, in ink on the pharmacy label. LPN-B verified the pharmacy label had been altered with the order change. During observation of the medication pass on 4/24/14, at 7:59 a.m. LPN-B was observed to draw lantus insulin, 45 units, into a syringe for R36. Observation of the lantus insulin pharmacy label revealed directions for 55 units. The pharmacy label dispense date was 3/17/14. The lantus insulin was dated as opened on 4/9/14. LPN-B verified R36's lantus order had changed on 1/3/14. LPN-B confirmed the date of the order change was already written in ink on the pharmacy label, but the prior order had not been yellowed out. LPN-B proceeded to use a hi-liter to yellow-out the order of 55 units on the	F 431		

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F 431	Continued From page 6 pharmacy label. LPN-B then used an ink pen to write, "45," on the pharmacy label. LPN-B verified the pharmacy label had been altered with the order change. During interview on 4/24/14, at 8:08 a.m. assistant director of nursing (ADON) stated the facility's process for medication order changes was to notify nursing of the change, make the change in the computer, and pass the change on in report. ADON stated she expected staff to cross off the original order and write the new order on the pharmacy label. ADON stated she expected nursing to then call or fax the order change to the pharmacy for a new label. During interview on 4/24/14, at 8:30 a.m. director of nursing stated she expected the nurses to cross-off the original order, write the new order in ink on the pharmacy label, and then notify the pharmacy for a label change right away. She stated the pharmacist made one to two visits a day to the facility. She stated she expected the label change to be done right away. The facility's Pharmaceutical Services Policy & Procedure Manual revised 10/04, directed the following: "Medication change orders resulting in new directions on the container label shall necessitate a new label which will be affixed to the container at the time of the next refill. Nursing procedures are as follows: 1. Nurse receives change order and updates resident's personal care record. 2. Nurse calls the dispensing pharmacy with the change order. 3. Nurse removes the respective container of medication and crosses the existing label with a large black line or X, or places an auxiliary,	F 431		

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F 431	Continued From page 7 order-change, warning label over the existing label. 4. Nurse administers medications from the medication sheet. 5. Nurse receives the update medication label on a new container at date of next refill and assures the label is accurate." During telephone interview on 4/24/14, at 9:30 a.m. the facility's pharmacy consultant confirmed the facility was not to write on the pharmacy labels. He expected facility nurses to use a sticker on the medication container to alert staff of the order change and to update the dispensing pharmacist of order change so a new label could be provided at the time of the next refill.	F 431		
F 441 SS=F	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	F 441	**F-441 It is our intent to comply with the regulation. Infection control, prevent spread, linens.** The facilities compliance for Infection control was reviewed by the Administrator, Director of Nursing and Maintenance manager. Regular floor maintenance will include mopping with Virex II 256 or similar commercial disinfectant, in resident rooms, bathrooms, and common areas. Any resident with confirmed C-Diff or multidrug resistant organisms will be identified and a solution of 1:10 bleach will be used on the resident room and bathroom floors. This will be reflected in the Infection control policy and procedure.	

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F 441	Continued From page 8 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident room and bathroom floors were cleaned with a disinfecting solution as an infection control precaution. This had the potential to affect all 47 of 47 residents who resided in the facility. Findings include: On 4/24/14, at 7:20 a.m. housekeeper (HSKP)-B explained that a large container that was noted on the housekeeping cart, contained clear water for mopping resident room and bathroom floors. HSKP-B stated the facility had utilized virex (a disinfectant solution) in mop water to clean the floors in the past, but the solution was too hard on waxed floors. HSKP-B reported the facility had since utilized only clear water for cleaning the floors. At 7:26 a.m. HSKP-B had just completed	F 441	The facility will review each resident upon admission and readmission for any identified organisms and discuss with maintenance manager the cleaning procedure. A checklist will be made for the housekeeping team to keep track of the identified residents. This will be reviewed at monthly safety meeting and as needed. Corrective action will be completed by May 25, 2014	

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F 441	Continued From page 9 mopping a resident room and bathroom floor. The floors were observed to still be wet. HSKP-B verified the floors were mopped with clear water. HSKP-B stated one mop cloth was used for the bathroom floor and then the mop cloth was changed to a clean cloth for the resident room floor. At 7:38 a.m., HSKP-B mopped two additional resident bathroom floors, changing the mop cloth between each room. HSKP-B then demonstrated how they filled the mop handle with clear water by removing the end of the handle. During observation and interview on 4/24/14, at 9:50 a.m. the facility's maintenance director opened the locked utility room and demonstrated that the virex disinfectant lid had a squeeze handle that was connected to the water faucet. He turned on the water faucet and squeezed the virex handle. This process ran the water through the lid, mixing it with solution from the virex container, then out of the faucet, expelling a mixture of water and virex solution. The maintenance director stated that this mixture of water and virex solution was to be placed in the large container and used for mopping floors. During observation on 4/24/14, at 10:00 a.m. HSKP-A and HSKP-B unlocked the utility room on the facility's West wing. HSKP-B demonstrated how they filled the large container on the housekeeping cart for mopping floors. HSKP-B disconnected the lid from the virex container. HSKP-B then turned the water faucet on, and squeezed the lid handle. With this procedure, the water ran through the lid, but bypassed the virex solution, expelling only water through the lid and into the large container on the housekeeping cart. HSKP-A verified this was the process she used as well to fill the large container on the	F 441		

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F 441	Continued From page 10 housekeeping cart. HSKP-A and HSKP-B verified they used only clear water to mop bathroom and resident room floors. They confirmed that no virex solution was mixed into the water they used. During interview on 4/24/14, at 10:10 a.m. maintenance director confirmed the virex disinfectant bubbled the floor wax. During observations on 4/24/14, at 1:30 p.m. HSKP-B removed the top of the mop handle and filled the handle with clear water from the large container on the housekeeping cart. During interview at that time, HSKP-B verified the container was filled with clear water only. During interview on 4/25/14, at 7:35 a.m. maintenance director confirmed the facility did not have a policy for cleaning resident room floors and bathroom floors. Review of Guidelines for Environmental Infection Control in Health-Care Facilities, Recommendations of the Center for Disease Control (CDC) dated 6/6/03, revealed the following: "Use a one-step process and an EPA [Environmental Protection Agency]-registered hospital detergent/disinfectant designed for general housekeeping purposes in patient-care areas where ... uncertainty exists as to the nature of the soil on the surfaces... or... uncertainty exists regarding the presence of multidrug resistant organisms on such surfaces."	F 441		

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

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PRINTED: 05/15/2014
FORM APPROVED
OMB NO. 0938-0391

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	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/06/2014**

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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, Parkview Care Center Wells Inc. was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	POC OK 6/4/14 LAST DATE 5/25/14 WAIVER FOR K-067 RECEIVED JUN - 3 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 4-25-14 DC: 6-4-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Thompson	Administrator	25 May 2014

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW CARE CENTER WELLS INC	**55 TENTH STREET SOUTHEAST** **WELLS, MN 56097**

(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 St Paul, MN 55101-5145, or By email to: 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 Care Center Wells Inc. is a 1-story building. The original building was constructed in 1961 and was determined to be of Type II (222) construction. In 1967, an addition was constructed and determined to be of Type II(222) construction, with a partial basement. In 1999, an addition was constructed and was determined to be of Type II(000) construction. The building will be surveyed as one building Type II (000). The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/06/2014

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 45 residents. Findings include: On facility tour between 4:00 PM and 6:00 PM on 05/06/2014, the review of the fire drills reports for May 2013 to April 2014 and the following drills were missed: 1. 2013 3rd quarter night shift 2. 2013 4th quarter night shift These deficient practices were confirmed by the Facility Maintenance Director (SR) at the time of	K 050	**K050 NFPA 101 Life Safety Code Standard** The facilities compliance for Life Safety Code Standard and practice of fire drills was reviewed by the Administrator and Maintenance Supervisor. After further investigation, it was found that the overnight fire drills (9pm-6am) were done by the Administrator, however filed incorrectly. Copies are attached. The facility will be compliant with this standard in the future, maintaining the standards of one drill per shift per quarter. Administrator and Maintenance Supervisor will review after each completed drill and file in the appropriate log book for compliance. Corrective Action will be complete as of May 25 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/06/2014

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K 050	Continued From page 3 discovery.	K 050		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and documentation review, the facility's general ventilating and air conditioning system (HVAC) in the 1960's buildings is not installed in accordance with the 2000 NFPA 101 LSC, Section 19.5.2.1 and 1999 NFPA 90A, Sections 2-3.11 and 3-4.7. A noncompliant HVAC system could affect all 45 residents. Findings include: On facility tour between 4:00 PM and 6:00 PM on 05/06/2014, observation revealed, that the corridors in the 1961 and 1967 buildings are being utilized as the supply air plenum for the resident rooms. Annual waiver as been approved in previous year. This deficient practice was confirmed by the Facility Maintenance Director (SR) at the time of discovery. *TEAM COMPOSITION*	K 067	**K067 NFPA 101 Life Safety Code Standard** See attached waiver request.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245436	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/06/2014**

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K 067	Continued From page 4 Gary Schroeder, Life Safety Code Spc.	K 067		

FIRE DRILL REPORT

Fire Drill Report or Actual Fire Report (circle appropriate)

Date: 12/3/13 Time: 1035 AM or PM (circle appropriate)
Location: East Dorm
Describe Condition: (Simulated) or Actual (circle appropriate)

	YES	NO
Was the alarm sounding?		✓
Was a pull station used?		✓
Was alarm audible in all required areas?		✓
Was facility appropriate announcement made effectively?		✓
Were residents in hallway removed to area of safety?		✓
Were all corridor doors closed by staff?		✓
Was smoke compartment evacuated?		✓
Was escape path used?		✓
Was building evacuated?		✓
Were extinguishers brought to fire scene?	✓	
Did someone call the Fire Department?		✓
If yes, at what time.____		
Was the fire protection plan executed correctly?	✓	
Was employee pool formed as per policy?		✓

Evacuation time: _____
What is extent and type of fire? Simulation, staff knew what to do will sound alarm in AM
List of personnel present attached.

Fire alarm system tested on: 11/1/14
Performance: X Satisfactory _____ Unsatisfactory
Remarks:
Doors all shut, alarm sounded, stations good

_____
Signature

Facility Services Staff Only:
Was signal received at monitoring station? ✓ Yes _____ No

Called CA (Bruce)	8:56 AM
Pull Alarm	8:58
Silence Alarm	8:59
Reset Alarm	9:01
Called CA (Bruce)	9:05

SIGN IN FOR FIRE DRILL:

DATE: 10/31/13 TIME: 1035 SHIFT: NOC

NAME	DEPT	NAME	DEPT
Marlene Culleton	NSG		
Candace Clark, LPN	NSG		
Nicole Jardong	NSG		
Terri Mithun	CNA		
Monica Romano	CNA		

FIRE DRILL REPORT

Fire Drill Report or Actual Fire Report (circle appropriate)

Date: 9-13-13 Time: 0400 (AM) or PM (circle appropriate)
Location: East Hall Linen Closet
Describe Condition: (Simulated) or Actual (circle appropriate)

	YES	NO
Was the alarm sounding?		X
Was a pull station used?		X
Was alarm audible in all required areas?		X
Was facility appropriate announcement made effectively?	X	
Were residents in hallway removed to area of safety?		X
Were all corridor doors closed by staff?	X	
Was smoke compartment evacuated?		X
Was escape path used?		X
Was building evacuated?		X
Were extinguishers brought to fire scene?	X	
Did someone call the Fire Department?		X
If yes, at what time.		
Was the fire protection plan executed correctly?	X	
Was employee pool formed as per policy?		X

Evacuation time: No evac - late noc drill
What is extent and type of fire? _____

List of personnel present attached.

Fire alarm system tested on: _____
Performance: _____Satisfactory _____Unsatisfactory
Remarks:

_____
_____
_____

_____
Signature

Facility Services Staff Only:
Was signal received at monitoring station? _____Yes _____ No

SIGN IN FOR FIRE DRILL:

DATE: 9-13-13 TIME: 0400 SHIFT: NOC

NAME	DEPT	NAME	DEPT
Corine Simon	Nursing		
Monica Romero	NRSG		
Elida Duran	Nursing		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, June 09, 2014 1:16 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: gary.schroeder@state.mn.us; 'bob.johannsen@parkviewccwells.com'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Parkview Care Center Wells Inc (245436) 2014 K67 Annual Waiver Request

This is to inform you that Parkview CC Wells is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 4-25-14.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility
Parkview Care Center

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K67 HVAC Equipment shall comply with Sec 9.2 and NFPA 90A.	A waiver is requested for K 67 for the following reasons: A. There will be no adverse effect on the health and safety of the facilities residents and staff since: a. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13. b. The facility is smoke free and signs to that effect are prominently posted at all major entrances. c. Annual service and maintenance contracts exist to service all the facilities fire protection systems (i.e. fire alarm, sprinkler system, and portable fire extinguishers.) d. The building fire alarm system is monitored to provide automatic fire department notification. e. The HVAC system automatically shuts down when the fire alarm is activated. f. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. g. Fire drills are conducted monthly on all shifts. B. Compliance with this provision would impose an unreasonable hardship on the facility since: a. Bid obtained from the Schwickert Company to fabricate and install the new supply and return ductwork through corridors is quoted at $119,438.00. This bid does not include removal, moving or re-installation of ceiling grid, electrical wiring, control wiring, plumbing piping, control wiring with suppression system, permits, signed drawings, or state plan review costs. b. There is concern about whether the building electrical system is adequate to handle the additional HVAC equipment required. c. The building is in compliance with all other fire safety requirements. d. LSC(OO), Sec 9.2.1 gives the A.HJ authority to allow existing HVAC systems that do not comply it NFPA 90A to be continued in service.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 6-9-14