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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NBHW

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 **12/12/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements

Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 12/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/04/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/29/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/13/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245475
January 4, 2017

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

Dear Mr. Goeritz:

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

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

Effective November 23, 2016 the above facility is certified for or recommended for:

30 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 4, 2017

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

RE: Project Number S5475028

Dear Mr. Goeritz:

On November 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 27, 2016. 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 December 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 5, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 27, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 27, 2016, effective November 23, 2016 and therefore remedies outlined in our letter to you dated November 15, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245475	A. Building B. Wing	12/12/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 11/22/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 11/22/2016	ID Prefix F0463 Reg. # 483.70(f) LSC	Correction Completed 11/23/2016
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 (INITIALS) BF/KJ	DATE 01/04/2017	SIGNATURE OF SURVEYOR 10562	DATE 12/12/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/27/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245475	A. Building 01 - MAIN BUILDING 01 B. Wing	12/5/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 11/23/2016	ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 11/23/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 11/23/2016
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 (INITIALS) TL/KJ	DATE 01/04/2017	SIGNATURE OF SURVEYOR 35482	DATE 12/5/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: NBHW

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 **10/27/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(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):
LSC was open and PoC was unapproved as of 12/12. Processed 12/12 kj.

17. SURVEYOR SIGNATURE — Date :
Bruce Melchert, HFE NE II 12/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 12/12/2016 (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 12/13/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 15, 2016

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

RE: Project Number S5475028

Dear Mr. Goeritz:

On October 27, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 6, 2016, 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 December 6, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 27, 2017 (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 April 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245475	A. BUILDING _____ B. WING _____	10/27/2016

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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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		
F 431 SS=E	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. 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,	F 431		11/22/16

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

Electronically Signed | 11/23/2016

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 _____	10/27/2016

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 431	Continued From page 1 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 failed to ensure Fentanyl patches (narcotic pain medication delivered via a skin patch) were appropriately disposed of according to the facility policy for 3 of 3 (R16, R20, R25) residents who received this medication. Findings include: During observation on 10/24/16, at 7:16 p.m. in the medication room, there was a harps container (a puncture resistant container designed to limit accidental or intentional access to sharps) which contained a single Fentanyl patch. A log titled, "Discontinued Medication Destruction Record", was observed on the counter. The log identified there were three residents (R16, R20, R25) who had used Fentanyl patches, and also indicated the destruction of 14 patches. During interview on 10/24/16, at 7:16 p.m. licensed practical nurse (LPN)-A stated Fentanyl patches were disposed of by throwing them away in the sharps container with two nurses present, and this was documented on the log.	F 431	It is the goal of Parkview Home to establish and maintain a Fentanyl Patch Destruction Policy to ensure the safety and proper destruction of used Fentanyl Patches. The facility has updated and implemented their Fentanyl Destruction Policy to now include clear instruction of the method of destruction. This method is that the nurse will don gloves to remove the patch from the resident's skin, fold the patch sticky sides together, and then will be placed in the approved Pharmaceutical Disposal System container (Rx Destroyer or similar)following the manufacturers directions. This will be witnessed by another Nurse/TMA, documented on the Destruction Record Sheet, and signed by the two nurses. All Nurses and TMA's were trained on this policy on November 9, 2016. Ongoing surveillance will be completed by the DON by reviewing the Fentanyl Destruction log sheets and Narcotic Sign-out Log Book for compliance of this policy. The consulting licensed Pharmacist will review	

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F 431	Continued From page 2 During interview on 10/25/16, at 2:09 p.m. LPN-B stated that once a Fentanyl patch was removed from a resident, the used Fentanyl patch was disposed in the presence of two nurses by placing it into the sharps container, and documented on the destruction log. LPN-C stated that once the sharps container is full, it was sealed and given to the maintenance department for destruction. During interview on 10/26/16, at 11:30 a.m. registered nurse (RN)-A stated that the policy for destruction of Fentanyl patches included two nurses signing off the destruction of a patch following placement of that patch into a sharps container with coffee grounds. RN-A stated that the sharps container in the medication room must have been replaced recently and the coffee grounds had not been added yet. During interview on 10/27/16, at 8:02 a.m. the director of nursing (DON) stated that previously the consultant pharmacist had recommended cutting up the Fentanyl patches and then placing them into a regular sharps container. The DON stated that staff are currently either cutting up the patches or leaving them whole, placing the patches in a separate sharps container, and logging destruction with two nurses signatures. The DON stated that the addition of coffee grounds, "Hasn't been a practice that has been used in the few months that I have been managing." During follow-up interview on 10/27/16, at 1:00 p.m. the DON stated it was unclear which way they are going to get rid of the used [Fentanyl] patches and verified they were not following their	F 431	all controlled drug destruction to ensure that the policy is followed and that the systems of records of receipt, distribution, and destruction are maintained and reconciled monthly.	

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F 431	Continued From page 3 current policy. A facility policy titled, Fentanyl Patch Destruction, dated 11/05/14, identified under the procedure that "The Nurse will have another staff witness, the following process: The nurse (with another staff member watching) will wear gloves and show the other nurse the used Fentanyl patch. The Nurse will cut the used Fentanyl patch in at least 2 pieces. While still wearing gloves the Nurse while being witnessed by another staff member will flush down the sewer system all parts/pieces of the used Fentanyl patch." The policy goes on to identify that the destruction is to be "recorded in the Narcotic book. The Nurse and second staff member will both need to sign a line in the narcotic book verifying destruction of the used Fentanyl patch."	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	F 441		11/22/16

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F 441	Continued From page 4 (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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facilty failed to implement an infection control program which included an analysis of the surveillance, and investigation of any identified infection patterns and trends. This had the potential to affect all 19 residents who currently resided in the facility. Findings include: Facility Infection Report forms between 2/1/16 through 10/27/16 were reviewed. The facility completed a report for every occurrence of infection, which listed resident's name, date symptoms noticed, room, and whether resident received influenza and pneumococcal vaccinations. The form documented other	F 441	It is the policy of Parkview Home to maintain an Infection Control Program that includes an analysis of the surveillance and data collection of any identified infection patterns and trends that may effect all residents of Parkview Home. At the time of survey, the DON was unable to provide such policy that related to the surveillance and trend analysis. There has since been identified a separate binder titled 'Infection Control Policy and Procedure Manual' from the other general "Nursing Policy and Procedure Manual' that does contain this policy. In review of the IC Policy titled 'Surveillance and Data Collection', there is a requirement for maintaining a monthly	

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F 441	Continued From page 5 information including: whether infection was acquired in or out of facility, the kind of infection, whether is was cultured, pertinent lab work, what organism was present, if an antibiotic was administered; and whether a resident was in a room with another infected resident. The Facility's monthly Infection Control Summary reports from February through October 2016 were also reviewed. The reports tallied the number of resident infections for the following categories: lower and upper respiratory, gastro-intestinal, skin, urinary tract, sepsis, and eyes. The report then summarized the same information of infection types in narrative form. The individual Infection Reports and monthly report summaries, however, lacked a review of trends and tracking. There was no analysis of microorganism pattern or trend with respect to frequency or location in facilty. During interview on 10/27/16, at 11:31 a.m. registered nurse (RN)-A stated she has just recently taken over responsibility of the infection control program for the facility. RN-A said the Infection Reports contained only basic information about resident infections. RN-A also stated that one could not tell from the reports if the infections had resolved. RN-A said the monthly summaries were "pretty basic," and acknowledged that those reports did not analyze or thoroughly investigate any trends within the month or between months, with regard to type of infection, location, specific microorganism, or if a prescribed antibiotic was fully effective. RN-A said even though she did consider and thought about an analysis of trends, this was not completed or documented.	F 441	log record for residents and staff, an Infection Report for each infection identified, and an Illness/Symptom Checker log record. The Infection Reports were in the past not completed to it's entirety to include the follow up surveillance for all infection that would track trends, locations, and possible sources of infections which would better enable the IC Nurse to monitor and maintain a healthy environment for our residents and facility. Parkview Home has now updated their tracking logs to report more data regarding each infection and the microorganism pattern by utilizing a map of the facility to record the location of each infection (using color-coding to identify each origin of the infection). Another update implemented is a more detailed Data Collection log that includes a prevention section to ensure follow up of all infections and to identify organisms more easily to monitor any potential trends developing. A monthly review will continue to be held with the IC Nurse, Quality Assurance members, and the Medical Director to review and discuss all findings, treatments, and prevention measures to also ensure a healthy environment of the facility and care of the residents. There will be enhanced discussions held regarding identifying trends, treatment courses, results of infection interventions, and preventative measures required.	

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F 441	Continued From page 6 During interview on 10/27/16 at 12:00 p.m., the director of nursing (DON) stated she could not say the infection control investigations were totally adequate, and "we definitely could do better." The DON stated infection control information was shared at the facility's QA (quality assurance meetings) and with the medical director. A facility policy regarding an infection control program was requested, but none was provided.	F 441	In addition, the DON will work closely with the IC Nurse to monitor the completion of each phase to ensure compliance with policies, surveillance, data collection, ongoing analysis, and medical reviews.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident call lights were functional for 1 of 17 residents (R4) in the sample, whose room and bathroom call lights were checked for functionality. Findings include: During observation on 10/24/16, at 5:53 p.m. the bathroom call light in (R4's) room 18 would not activate when the string cord was pulled. However, the call light did activate when the blue button on the wall call light box was pushed. During interview on 10/24/16, at 6 p.m., the maintenance director (MD), in the presence of the	F 463	It is the policy of Parkview Home to ensure that all call lights will be in proper working order to provide the residents with the ability to seek assistance when needed. Parkview home has included in this policy to monitor all call lights monthly to ensure they are in proper working order. This will include all call lights positioned in the resident rooms and bathrooms, bathing/showering rooms, activity rooms, dining rooms, chapel, and beauty salon room. The call light system is electrically connected to hand held radios and a marque signage located throughout the	11/23/16

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F 463	Continued From page 7 surveyor, was also unable to activate the bathroom call light by pulling the string. When asked if the battery was low, the MD stated that maintenence staff would be signaled via pager if that occured. During interview on 10/26/16, at 2:13 pm the MD was asked if there was a system of checking to ensure call lights were working. The MD stated, "None that I'm aware of" and said he would find out. Later, the MD stated staff reported nurses were checking call lights two times daily, and documented this on back side of nurses daily communication log. During interview 10/26/16, at 2:38 p.m. licensed practical nurse (LPN)-D stated resident rooms were checked to make sure the residents were safe. LPN-D stated that they check the pull cord and push the buttons, and for the most part, it was done two times a day, and got checked off on the communication sheet. Nurses Communication Logs from 10/15/16 to 10/27/16 were reviewed. The only reference about call lights was noted on the log dated 10/25/16, and included a note written by MD-A: "call light in room 18 not working, switched out with room 17 call light." A facility policy titled , "Call Light, Use Of" dated, 7/22/11, was reviewed. The policy indicated as its purpose, "to assure call system is in proper working orde." Policy directed under item 11, Log defective call lights, with exact location, in maintenance, if the facilty has such a log.	F 463	building to allow audible and visual alerts when a resident has requested assistance by pushing the activation button on the call light system. The maintenance department will inspect, test, and report monthly every call light box and cord, the marque signage, and the hand held radios to assure proper functionality. Any damage or improper functioning units will be repaired or replaced promptly as to not put any residents at risk due to the inability to communicate through these devices. The monthly log record will be reviewed for completeness by the Administrator.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey the Parkview Home was found not in 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 TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/23/2016

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Parkview Home was constructed as follows:

The original building was built in 1965, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The first addition was built in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The second addition was built in 1990, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The most recent addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction.

The facility has an automatic fire alarm system with smoke detection at all smoke barrier doors

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K 000	Continued From page 2 and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 19 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain one hour fire rated construction in accordance with 8.4.1 and/or 19.3.5.4 the protection of hazardous areas. This deficient practice could affect all patients, staff and visitors. One hour fire rated construction (with one hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029	Laundry Room door latch was removed. Kitchen storage room doors #63 and #64 will be connected to the fire alarm system by the sprinkler company within 60 days. The Kitchen mechanical room door latch will be replaced with a positive locking latch within 30 days.	11/23/16

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K 029	Continued From page 3 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 FINDINGS INCLUDE: On the facility tour between 9:30 am to 12:30 pm on 10/25/2016 observations and staff interview revealed the following discrepancies in the following Hazardous Areas: 1.) The Laundry Room door was observed being held open with a magnetic hold open device that is not connected to the Facility Fire Alarm System. 2.) The Kitchen Storage Room door #63 was observed being held open with a magnetic hold open device that is not connected to the Facility Fire Alarm System. 3.) The Kitchen Storage Room door #64 was observed being held open with a magnetic hold open device that is not connected to the Facility Fire Alarm System. 4.) The Kitchen Mechanical Room door does not positively latch into the door frame when closed. These deficient practices were verified by the Facility Maintenance Director.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1.This deficient practice could affect all of the residents, visitors and staff.	K 038	The kitchen exit door that had a thumb turned deadbolt lock is now disabled and a key pad lock will be installed within 30 days. The door from the Kitchen to the Dining room had a thumb turn deadbolt lock and now the deadbolt has been	11/23/16

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PARKVIEW HOME	**102 COUNTY STATE AID HIGHWAY 9 BELVIEW, MN 56214**

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K 038	Continued From page 4 FINDINGS INCLUDE: On the facility tour between 9:30 am to 12:30 pm on 10/25/2016 observations and staff interview revealed the following discrepancies on doors within the path of egress: 1.) The Kitchen Exit Door was observed to have a thumb turn deadbolt lock installed. 2.) The door from the Kitchen to the Dining Room was observed to have a thumb turn deadbolt lock installed. 3.) The door from the Activities Room/Dining Room was observed to have a thumb turn deadbolt lock installed. These deficient practices were verified by the Facility Maintenance Director.	K 038	disabled. The door from the Activities room/Dining room had a thumb turn deadbolt installed that has now been disabled.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain a facility protected throughout by an approved , supervised automatic sprinkler system. Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with	K 056	Parkview maintenance has contacted the Sprinkler Co and confirmed that sprinklers will be added to the Mechanical room in the Kitchen within 60 days.	11/23/16

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 _____	**10/25/2016**

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 056	Continued From page 5 section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13.This deficient practice could affect all of the residents, visitors and staff. FINDINGS INCLUDE: On the facility tour between 9:30 am to 12:30 pm on 10/25/2016 observations and staff interview revealed that an approved, supervised automatic fire sprinkler system was not observed within the Kitchen Mechanical Room. This deficient practice was verified by the Facility Maintenance Director.	K 056		