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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P52C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00406

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245553**
2.STATE VENDOR OR MEDICAID NO.
(L2) **104740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW MANOR NURSING HOME**
(L4) **308 SHERMAN AVENUE**
(L5) **ELLSWORTH, MN** (L6) **56129**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/08/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(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 :
Maria King, Unit Supervisor 04/08/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 06/21/2013 (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
03/01/1991
(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 6/21/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/01/2013
(L33)

DETERMINATION APPROVAL

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

On April 8, 2013 a Post Certification Revisit (PCR) by review of the plan of correction was completed by the Department of Health and on April 3, 2013 a PCR was completed by the Department of Public Safety. Based on the plan of correction the deficiencies issued pursuant to the February 14, 2013 standard survey were corrected as of April 8, 2013. Refer to the CMS 2567b forms for both health and life safety code.

Effective April 8 2013, the facility is certified for, 42 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5553

May 22, 2013

Mr. Michael Werner, Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, Minnesota 56129

Dear Mr. Werner:

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

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

Effective April 8, 2013 the above facility is certified for or recommended for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 8, 2013

Mr. Michael Werner, Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, Minnesota 56129

RE: Project Number S5553023

Dear Mr. Werner:

On March 1, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 14, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 8, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 3, 2013 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 February 14, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 26, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 14, 2013, effective April 8, 2013 and therefore remedies outlined in our letter to you dated March 1, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5553r13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245553	A. Building B. Wing	4/8/2013

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **04/08/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/08/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/08/2013**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/08/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/08/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/MK	04/08/2013	08769	04/08/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/14/2013			

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
245553	A. Building B. Wing 01 - MAIN BUILDING 01	4/3/2013

Name of Facility	Street Address, City, State, Zip Code
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0045	Correction Completed 03/26/2013	ID Prefix Reg. # NFPA 101 LSC K0048	Correction Completed 03/26/2013	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 03/26/2013
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/PS	Date: 04/08/2013	Signature of Surveyor: 22373	Date: 04/03/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/19/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P52C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00406

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245553**

2.STATE VENDOR OR MEDICAID NO.
(L2) **104740000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW MANOR NURSING HOME**
(L4) **308 SHERMAN AVENUE**
(L5) **ELLSWORTH, MN** (L6) **56129**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/14/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

At the time of the February 14, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

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

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/30/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/01/2013 CO. P52C

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9424

March 1, 2013

Mr. Michael Werner, Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, Minnesota 56129

RE: Project Number S5553023

Dear Mr. Werner:

On February 14, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Maria King
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite 2105
Mankato, Minnesota 56001-7789

Telephone: (507) 344-2716

Fax: (507) 344-2723

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 March 26, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 26, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 14, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 14, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Maria King, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (507) 344-2716 Fax: (507) 344-2723

Enclosure

cc: Licensing and Certification File

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

PRINTED: 03/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING ______ B. WING ______	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW MANOR NURSING HOME	308 SHERMAN AVENUE ELLSWORTH, MN 56129

(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		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain resident care equipment in good working condition for 4 of 15 residents (R6, R7, R26, R32) in the facility who utilized wheelchairs for mobility. Findings include: During observation of resident equipment throughout the survey, R6, R7, R26 and R32 were noted to have wheelchairs that were not maintained in a good working condition. Each of the resident's wheelchairs were noted to have vinyl covered armrests that were torn and the material underneath the vinyl was exposed.	F 253	F253 Housekeeping and Maintenance Services. 1. The listed wheel chairs arm rest have been replaced. 2. All wheel chairs are on a cleaning schedule in which time they shall be inspected for condition. 3. Housekeeping staff that clean wheel chairs will be directed to notify maintenance when replacement or repairs need to be done. Maintenance will keep replacement parts on hand. 4.Maintenance supervisor will conduct audit/inspections to assure compliance. Administrator will monitor to assure plan is sustained. RECEIVED MAR 15 2013 Minnesota Dept of Health Mankato	3-26-13

accepted w/ completion dates per Daniel DW via phone 3/20/13 mg

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Admin (X6) DATE: 3-14-13

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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	245553	A. BUILDING _____ B. WING _____	02/14/2013

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F 253	Continued From page 1 During interview with the facility maintenance director on 2/14/13 during the environment tour at 9:30 a.m., he looked at these resident wheelchairs, verified the findings, and stated the nursing staff would be responsible to let him know about maintenance issues with wheelchairs and verified he had not received any requests for maintenance on these identified wheelchairs.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to maintain the highest practicable well-being for 1 of 3 residents (R1) reviewed for non-pressure related skin issues. Findings include: R1 did not receive the necessary care and services to assess and monitor squamous cell carcinoma areas on her forehead. R1 was admitted to the facility on 12/10/08, and had diagnoses that included: chronic anxiety, hypertension, hypothyroidism, glaucoma, hyperlipidemia, and squamous cell carcinoma of	F 309	F309 Provider Care/ Services 1. The squamous cell carcinoma on R1's forehead is being monitored on a weekly basis by charge nurse. Monitoring includes measurements of area, observation for drainage, noticeable change or signs of infection. Resident's forehead addressed by physician during hospitalization January 23 and again on physician visit February 7 at clinic. 2. Any resident having a non-pressure related skin issue will have area monitored on a weekly basis by the charge nurse. Areas will be monitored for; size, drainage, changes, and infection. Once monitoring by charge nurse begins, it is not necessary to record on weekly shower audit. 3. Director of Nursing will educate licensed staff on need for monitoring of non-pressure related skin issues. 4. Director of Nurses will audit charts and records to assure proper monitoring is being documented and plan is sustained.	

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F 309	Continued From page 2 the skin (forehead). During observation of R1 on 2/11/12 at 3:57 p.m., R1 was noted to have two areas of squamous cell carcinoma on her right forehead. The areas were approximately the size of a nickel and were crusted, flaky and reddened. The resident's scalp was noted to have heavy flaking which was also observed in her hair. R1's record was reviewed. A physician's progress note dated 2/7/13, indicated the resident currently had squamous cell carcinoma on her forehead. According to the progress note, the physician had discussed cancer treatments with R1 on 2/7/13, and R1 had stated she wanted to wait and see how the cancer progressed. During interview with licensed practical nurse (LPN)-B on 2/12/13 at 3:36 p.m., she stated R1 had experienced ongoing issues with her skin cancer. LPN-B stated R1 had a history of surgical removal of the lesions in the past which had improved the site, however it had recently started to deteriorate again. LPN-B acknowledged R1's scalp was very flaky as a result and stated she was not sure what staff do for it. Although the facility had conducted weekly skin audits at the time of R1's bath, the audits did not identify the changes to the resident's cancerous areas on her forehead. The skin audits titled, Shower Day Worksheet/Body Audit, were reviewed from 11/15/12 to 2/7/13. Documentation from on the audits indicated R1's skin was free of any issues. Additional review of R1's medical record revealed there was no documentation of monitoring of the cancerous	F 309		

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F 309	Continued From page 3 sites in order to identify whether the areas were increasing in size, shape or flakiness, or if other sites had developed. The director of nursing confirmed during interview on 2/13/13 at 11:00 a.m., that they had not initiated any specific monitoring of the resident's cancerous areas on her forehead.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329	F329 Drug Regimen 1. Parameters have been set for these residents pain and psychoactive medications by Physician and Director of Nurses. Parameters are clear and descriptive as to when to administer medications. 2. All residents with pain medications and psychoactive medications have been reviewed by director of nurses and parameters are in place. 3. Licensing Nursing Staff will receive inservice education to address need for parameters with pain and psychoactive medication. 4. Director of Nurses will monitor MAR's and PRN records to assure pain and psychoactive medications have clear parameters for use and to assure plan is sustained in the future.	3-26-13

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F 329	Continued From page 4 by: Based on interview and document review, the facility failed to ensure 2 of 10 residents (R24 and R25) in the sample, who were reviewed for unnecessary medication usage, had clear indications and parameters for use of pain and/or psychoactive medications. Findings include: R24 failed to have clear indications and parameters for use for the use of as needed (PRN) risperdal (antipsychotic) and ativan (anti-anxiety) medications. In addition, there was no specific diagnosis or clinical indication documented for R24's continued use of the antipsychotic medication, respirdal. R24 was admitted to the facility on 6/5/12 with diagnoses that included: Dementia, osteoarthritis, chronic lumbar pain and anxiety. R24's record was reviewed. The resident had current physician orders for the use of ativan 0.5 mg (milligrams) po (orally) every 4 hours PRN and risperidone (risperdal) 0.25 mg po every 12 hours as needed. However, there had been no clear parameters established for when to use which medication. The medication administration records (MAR) for R24 were reviewed. The MARs indicated R24 had utilized both the prn ativan and the prn risperdal. According to the documentation, in January 2013, R24 had received the prn Ativan twice and the prn risperdal once. Documentation from December 2012, indicated R24 had received 16 doses of the prn ativan, and 16 doses of the prn risperdal. Documentation from November 2012, indicated	F 329		

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F 329	Continued From page 5 the resident had received the ativan 8 times and the risperdal 8 times. The staff administering the medications had recorded the reasons for the use of the medications as including but not limited to: agitation, anxious, restlessness, yelling out. There was no differentiation noted by the nurse's for why they chose one medication over the other. During interview with the director of nursing (DON) on 2/13/13 at 9:30 a.m., she stated staff were to give R24 ativan when she was exhibiting restlessness and anxiety, and were to use the risperdal for agitation such as striking out at staff. The DON verified the MAR lacked parameters to direct staff when to use which medication, but stated it had been identified in the medical record. The Monthly Behavior Monitoring Flowsheets were reviewed. Target behaviors were identified as: 1) verbal abuse- curses and screams 2) resistive with cares 3) picks skin until open, tears out toenails 4) restlessness increased and many times can't sit still 5) insomnia/up at night 6) anxious 7) unable to locate room 8) exposes self in public 9) removes sandals/boots. During interview registered nurse (RN)-A at 9:47 a.m. on 2/13/13, she stated she would give the ativan first and if that did not work she would give the risperdal. RN-A stated if R24 was restless she would start with ativan. She also stated that if R24 was exhibiting behaviors she would use the risperdal. RN-A verified the physician's orders and MAR offered no parameters to identify which medication should be used for which symptoms. R25 had physician orders for three PRN pain medications with no parameters established to	F 329		

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F 329	Continued From page 6 determine when to use which of the pain medications. R25's record was reviewed. The resident was admitted to the facility 2/7/12, with diagnoses including restless leg syndrome and osteoarthritis. Current physician orders for pain medications included: acetaminophen 650 mg every 6 hrs PRN, hydrocodone/APAP 5-500 mg one tab every 4 hours PRN, and naproxen 500 mg one tablet twice daily PRN. In addition, R25 had physician orders to receive hydrocodone/APAP 5-500 mg one tablet three times daily and for the use of aspercreme to affected area/s PRN. Review of the medication administration record (MAR) indicated R25 had utilized the PRN dose of hydrocodone/APAP 12 times in November 2012, 7 times in December 2012, 10 times in January 2013 and 6 times through the time of surveyor review on February 11, 2013. The naproxen had been utilized 9 times in November, 3 times in December, 6 times in January and 1 time thus far in February 2013. The acetaminophen had not been used in November or thus far in February 2013, but had been used 4 times in December and 6 times in January. The MAR reviews indicated there had been no consistent pain rating utilized to determine which pain medication to use. For example, the acetaminophen had been used for pain rated at a 6 (scale of 1-10 - 1 least pain, 10 most severe), for "leg pain" with no pain rating and as a "sleep aide." The Naproxen was documented as having been used for pain rated 7, 8 and 10 and also for "leg pain" and "foot pain" when there had been no pain rating identified. The hydrocodone/APAP	F 329		

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F 329	Continued From page 7 had been used for pain rated at 6, 8, 9 and 10 and for "leg pain" with no pain rating identified. During interview with registered nurse (RN)-A on 12/13/13 at 10:21 a.m., she stated that she would offer the tylenol (acetaminophen) first, then the naproxen, then hydrocodone/APAP depending on whether the resident's level of pain. RN-A confirmed there were no parameters for use of the PRN medications unless they physician specified it in an order. During interview with licensed practical nurse (LPN)- Lori Johnson) on 2/14/13 at 8 a.m. she verified that there were no parameters as to when to give which PRN pain medication. Interview with the director of nursing at 10:21 a.m. on 2/13/13 she stated she would expect them to try the Naproxen first then the Hydrocodone/APAP if the Naproxen doesn't work. She verified they had not developed specific parameters for the use of the pain medications and likely would not have developed them unless the physician had ordered it.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		

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F 356	Continued From page 8 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the required nurse staffing data on a daily basis at the beginning of each shift. This deficient practice had the potential to affect each of the 33 current residents and/or their families, and any other members of the public who wished to view the data. Findings include: During observations of the posted nurse staffing data, the information posted did not include all the specified components. During observation on 2/14/13 at 7:00 a.m., the posted staffing form did not include actual nursing	F 356	F356 Posting Nursing Staff 1. The daily posting of nursing staff does meet all the listed requirements of the regulation. It included: a. facility name, b. current date, c. total number and actual hours worked by shift of licensed and unlicensed staff per shift, and d. resident census. The current posting had shifts classified as day, evening , and night. The new interpretation of the requirement states that the shifts must be defined by time. The administrator verified that on the day shift two registered nurses may be working but one may start employment at 6:30 am and the other at 8am. The new posting requirement will be met as the times of each shift will be listed. 2. The posting signage sheet has been revised once again to specify components required according to new interpretation. Hours of each shift worked will be listed. Director of Nurses completes posting signage on a daily basis. The charge nurse completes the census portion of the signage before posting. 3. Charge nurses will be educated on the changes of the signage. Once a format is approved, the plan will be sustained into the future or until interpretation changes. 4. Director of Nurses will monitor the posting and Administrator will interpretation of requirement to assure plan is sustained.	3-26-13

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F 356	Continued From page 9 hours worked by shift. Licensed practical nurse (LPN-A) was interviewed at 7:50 a.m. on 2/14/13. She stated that the specific shifts that registered nurses, licensed practical nurses and certified nursing assistants worked were not identified on the facility's posted form, Report of Nursing Staff Directly Responsible for Resident Care. LPN-A stated the staff worked a variety of shifts. The administrator was interviewed at 9:45 a.m. on 2/14/13. The administrator stated the nursing staff shifts varied and verified the staff posting failed to include the hours that comprised the shifts for the actual nursing hours worked. The administrator stated he had been unaware the actual shifts needed to be included on the posted nurse staffing form.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to assure that drug regimen	F 428	F428 Drug regimen Review 1. Consulting Pharmacist has reviewed these residents pain and psychoactive medications to assure clear parameters are in place. 2. Consulting pharmacist has reviewed all residents medications to assure appropriate and clear parameters for use 3. Director of Nurses has met with consulting pharmacist to address need for clear parameters with pain and psychoactive medications 4. Director of Nurses will audit charts to assure pharmacy reviews parameters for psychoactive and pain medications and assure plan is sustained into the future.	3-26-13

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F 428	Continued From page 10 irregularities are reported by the pharmacist to the attending physician and the director of nursing for 2 of 10 residents in the sample (R24, R25) who were reviewed for unnecessary medication usage. Findings include: R24 failed to have clear indications and parameters for use for the use of as needed (PRN) risperdal (antipsychotic) and ativan (anti-anxiety) medications. In addition, there was no specific diagnosis or clinical indication documented for R24's continued use of the antipsychotic medication, respirdal. R24 was admitted to the facility on 6/5/12 with diagnoses that included: Dementia, osteoarthritis, chronic lumbar pain and anxiety. R24's record was reviewed. The resident had current physician orders for the use of ativan 0.5 mg (milligrams) po (orally) every 4 hours PRN and risperidone (risperdal) 0.25 mg po every 12 hours as needed. However, there had been no clear parameters established for when to use which medication. The medication administration records (MAR) for R24 were reviewed. The MARs indicated R24 had utilized both the PRN ativan and the PRN risperdal. According to the documentation, in January 2013, R24 had received the PRN Ativan twice and the PRN risperdal once. Documentation from December 2012, indicated R24 had received 16 doses of the PRN ativan, and 16 doses of the PRN risperdal. Documentation from November 2012, indicated the resident had received the ativan 8 times and the risperdal 8 times. The staff administering the	F 428		

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F 428	Continued From page 11 medications had recorded the reasons for the use of the medications as including but not limited to: agitation, anxious, restlessness, yelling out. There was no differentiation noted by the nurse's for why they chose one medication over the other. During review of the pharmacy consultant's notes since admission there was no documented concern about the lack of identified parameters for the use of the ativan and risperdal. During interview with the consultant pharmacist on 2/14/13 at 9:10 a.m., she verified that R24's medical record should indicate a specific diagnosis for the use of risperdal and verified there should have been more clear parameters established to indicate when to use the risperdal in place of the ativan. R25 had physician orders for three PRN pain medications with no parameters established to determine when to use which of the pain medications. The consultant pharmacist had not identified this as a potential irregularity. R25's record was reviewed. The resident was admitted to the facility 2/7/12, with diagnoses including restless leg syndrome and osteoarthritis. Current physician orders for pain medications included: acetaminophen 650 mg every 6 hrs PRN, hydrocodone/APAP 5-500 mg one tab every 4 hours PRN, and naproxen 500 mg one tablet twice daily PRN. In addition, R25 had physician orders to receive hydrocodone/APAP 5-500 mg one tablet three times daily and for the use of aspercreme to affected area/s PRN. Review of the medication administration record	F 428		

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F 428	Continued From page 12 (MAR) indicated R25 had utilized the PRN dose of hydrocodone/APAP 12 times in November 2012, 7 times in December 2012, 10 times in January 2013 and 6 times through the time of surveyor review on February 11, 2013. The naproxen had been utilized 9 times in November, 3 times in December, 6 times in January and 1 time thus far in February 2013. The acetaminophen had not been used in November or thus far in February 2013, but had been used 4 times in December and 6 times in January. The MAR reviews indicated there had been no consistent pain rating utilized to determine which pain medication to use. For example, the acetaminophen had been used for pain rated at a 6 (scale of 1-10 - 1 least pain, 10 most severe), for "leg pain" with no pain rating and as a "sleep aide." The Naproxen was documented as having been used for pain rated 7, 8 and 10 and also for "leg pain" and "foot pain" when there had been no pain rating identified. The hydrocodone/APAP had been used for pain rated at 6, 8, 9 and 10 and for "leg pain" with no pain rating identified. Review of the consultant pharmacist's monthly reports indicated the pharmacist had not not identified the missing parameters as a potential irregularity. During interview with the pharmacist on 2/14/13 at 9:10 a.m., she stated she had not identified that there were no parameters in place for the use of the different pain medications. She verified that parameters should be in place so staff are aware of which pain medication to utilize first.	F 428		

651-215-0525

F 5553021

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	245553	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/19/2013

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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, on February 19, 2013. At the time of this survey, Parkview Manor Nursing Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok PB 3-27-13 RECEIVED MAR 20 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION RECEIVED MAR 15 2013 Minnesota Dept of Health Mankato	

EXIT: 02.14.2013 DC: 03.26.2013

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

Admin — 3-14-13

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 By eMail to: Barbara.Lundberg@state.mn.us, and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Parkview Manor Nursing Home was constructed as follows: The original building was constructed in 1970, is one-story, has no basement, is partially sprinklered, and was determined to be of Type I(332) construction; The 1st Addition was constructed in 1980, is one-story, has no basement, is not sprinklered, and was determined to be of Type I(332) construction; The 2nd Addition was constructed in 1993, is one-story, has no basement, is fully sprinklered, and was determined to be of Type II(111) construction. The 1980 Addition consists solely of an attached Generator Room, which is separated from the Nursing Home by a 2-hour fire wall, with no communicating openings. This room is accessible only from the building exterior. Also, the original nursing home of Type I(332)	K 000		

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K 000	Continued From page 2 construction is separated from the 1993 Addition of Type II(111) construction by a 2-hour fire wall, with a labeled 90-minute fire rated door assembly. The facility has a fire alarm system with smoke detection located at smoke barrier doors and in spaces open to the corridors, which are monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with automatic smoke detection. The facility has a capacity of 42 beds and had a census of 33 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: NFPA 101 (2000 edition) LIFE SAFETY CODE SURVEY REGULATION - Illumination of means of egress, including exit discharge, is arranged so that a failure of any single lighting fixture or bulb will not leave the area in darkness, and shall be in accordance with NFPA 101 (00), Chapter 7, Section 7.8.1.4. This STANDARD is not met as evidenced by: Based on observation, the facility had exit	K 045	RECEIVED MAR 15 2013 Minnesota Dept of Health Mankato	

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K 045	Continued From page 3 discharge locations which were not illuminated in accordance with NFPA 101 (2000), Chapter 19, Section 19.2.8. and Chapter 7, Section 7.8. In an emergency evacuation situation, this deficient practice could adversely affect 21 of 42 residents, staff and visitors. FINDINGS INCLUDE: On 2/19/2013 between 1:00 PM and 4:30 PM, observation revealed sections of the exterior exit discharge paths located directly outside of the East and West corridor exit discharge doors, which were equipped with single light fixtures of the single-bulb type. These findings were verified with the facility administrator.	K 045	K045 Life Safety 101 1. An additional light fixture or two bulb system will be added above east and west exit doors. 2. March 26,2013 3. Mike Werner, Administrator will monitor installation.	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7 This STANDARD is not met as evidenced by: Based upon a review of available documentation, the facility's fire safety plan did not provide for all nine (9) of the required elements at NFPA 101 (00) Chapter 19, Section 19.7.2.2. This deficient practice could adversely affect 42 of 42 residents,	K 048	RECEIVED MAR 15 2013 Minnesota Dept of Health Mankato	

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K 048	Continued From page 4 staff and visitors. FINDINGS INCLUDE: On 2/19/2013 at 1:25 PM, during a review of the facility's Fire & Disaster Plan, it was confirmed that no written provision existed for the preparation of floors and building for evacuation, in accordance with NFPA 101 (00) Chapter 19, Section 19.7.2.2 (7). This finding was confirmed with the facility administrator.	K 048	K048 Life Safety 101 1. The existing Fire Plan will be updated to include all elements of the requirements. It will include provision for preparation of floors and building for evacuation. The plan will be reviewed by all staff. 2. March 26,2013 3. Mike Werner, Administrator will write the plan and be responsible that staff understand the new plan.	
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: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - 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	K 050		

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K 050	Continued From page 5 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 upon a review of available records, it was determined the facility had failed to conduct one or more quarterly fire drills during the previous year, in accordance with NFPA 101 (2000) Chapter 19, Section 19.7.1.2. In a fire emergency, this deficient practice could adversely affect 42 of 42 residents, staff and visitors throughout the facility. FINDINGS INCLUDE: On 2/19/2013 at 1:55 PM, during a review of fire drill reports provided by facility staff, it was confirmed that fire drills were not conducted on the PM-Shift during the First and Fourth Quarters of 2012. This finding was verified with the facility administrator.	K 050	K050 Life Safety 101 1. Maintenance Supervisor will be educated as requirements for a minimum of monthly drills. Drills are required on each shift at a minimum of each quarter. 2. March 26,2013 3. Mike Werner, Administrator will responsible to monitor compliance. RECEIVED MAR 15 2013 Minnesota Dept of Health Mankato	