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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Q1XV

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 **02/06/2014** **03/07/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (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
	37			
(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 :
George Shellum, DSFM — 03/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 03/27/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(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 04/11/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/16/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

CCN 24-5553

The facility submitted documentation to attain an, Immediate Extraordinary and Sustained Mitigation during Sprinkler Installation.

On February 6, 2014, determination was made re: the 10 extraordinary measures, during sprinkler installation.CMS reviewed the documentation and determined the deficiency would be reduced to a scopy and severity level of "C", which puts the facility in substantial compliance and remedies previously recommended to the CMS Region V office would not be imposed. Refer to the CMS 2567 and related documentation for the 10 extraordinary measures.

On March 7, 2014, the Department of Public Safety complete a Post Certification Revisit to verify full compliance was acheived by installing sprinklers in non sprinklered areas as required under Federal requrements. The PCR verified all areas of the nursing home are sprinklered and the facility is in full compliance with Federal requirements.

Refer to the CMS 2567b

Effective March 7, 2014 the facility is certified for 37 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5553

March 27, 2014

Mr. Michael Werner, Administrator
Parkview Manor Nursing Home
308 Sherman Avenue
Ellsworth, MN 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 March 7, 2014 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 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, Enforcement 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

Protecting, Maintaining and Improving the Health of Minnesotans

March 27, 2014

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

RE: Project Number F5553022

Dear Mr. Werner:

On December 2, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 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 December 31, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the facility's plan of correction and on January 12, 2014, 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 November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 17, 2013. Based on our visit, we had determined that your facility had not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 7, 2013. The deficiency not corrected is as follows:

- **K0056 -- S/S: F -- NFPA 101 -- Life Safety Code Standard Bld: 01**

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

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 7, 2014. (42 CFR 488.417 (b))

On February 6, 2014, the Minnesota Department of Public Safety and the CMS Region V Office completed review of the ten (10) Extraordinary and Sustained Risk Mitigation Measures submitted by the facility demonstrated the deficiency cited at K56 pursuant to the standard survey, could be reduced to a scope and severity level of "C", determined the facility met the measures and has achieved substantial compliance.

Based on the determination your facility has obtained substantial compliance with, but has not totally corrected, the deficiencies issued pursuant to our standard survey, completed on November 7, 2013, effective February 6, 2014. The deficiency not fully corrected, but considered to be in substantial compliance is as follows:

- **K0056 -- S/S: C -- NFPA 101 -- Life Safety Code Standard Bld: 01**

Since these deficiencies are considered to be in substantial compliance, remedies outlined in our letter to you dated January 17, 2014 will not be imposed. As a result of obtaining substantial compliance, we recommended the following to the CMS Region V Office. CMS concurs with our recommendation and has authorized this Department to notify you of this action:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 7, 2014, be rescinded. (42 CFR 488.417 (b))

In addition, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 29, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

On March 7, 2014, the Department of Public Safety completed PCR to verify deficiency cited a K56 related to the sprinkler system had been corrected. The PCR verified the installation of the sprinkler system in the formerly unsprinklered areas of the building had been acheived. As of March 7, 2014, the facility is considered to be a fully sprinklered nursing home.

A copy of the Statement of Deficiencies (CMS-2567) and CMS 2567b from the February 6, 2014 and March 7, 2014 visits are enclosed for you records.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **02/06/2014**

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
{K 000}	INITIAL COMMENTS Provider submitted documentation and CMS RO reviewed and determined the Immediate Extraordinary, and Sustained Risk Mitigation during Sprinkler Installation was met and the S/S level was reduced to "C", Substantial Compliance.	{K 000}		
{K 056} SS=C	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Provider submitted documentation and CMS RO reviewed and determined the Immediate Extraordinary, and Sustained Risk Mitigation during Sprinkler Installation was met and the S/S level was reduced to "C", Substantial Compliance.	{K 056}	10 extra ordinary Measures for LSC until the installation is completed for the last of the area previously not sprinklered. The documents submitted met the 10 measures to reduce the scope and severity to a "C"	

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245553	A. Building B. Wing 01 - MAIN BUILDING 01	3/7/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0056	03/07/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/PS	Date: 03/07/2014	Signature of Surveyor: 22373	Date: 03/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/8/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **03/07/2014**

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
{K 000}	INITIAL COMMENTS Provider submitted documentation and CMS RO reviewed and determined the Immediate Extraordinary, and Sustained Risk Mitigation during Sprinkler Installation was met and the S/S level was reduced to "C", Substantial Compliance. The Department of Public Safety conducted a revisit to verify the deficiency cited at K56 pursuant to the standard survey had been corrected. The deficiency was in substantial compliance as of February 6, 2014 with approval of the Immediate Extraordinary and Sustained Risk Mitigation during sprinkler installation, which than reducedd the scope andseverity to a "C", which avoided the Mandatory Denial of Payment for new Medicare and Medicaid Admisissions. The March 7, 2014 revisit verified full correction of K56, with the installation of a sprinkler system in the areas previouly not sprinklered.	{K 000}		

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

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.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Q1XV

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 **01/12/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (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,1** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kathryn Serie, Unit Supervisor — 02/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 03/27/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(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 04/11/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/16/2014
(L33)

DETERMINATION APPROVAL

CCN 24-5553

On December 31, 2013 the Department of Health a Post Certification Revisit (PCR) by review of the facility's plan of correction and on January 12, 2014 a PCR was completed at the facility by the Department of Public Safety. The facility was not in substantial compliance with Federal requirements. One life safety code deficiency (K56) was not corrected as a result of the new Federal requirment that all nursing homes be fully sprinklered. As a result of not being in substantial compliance, this Department recommended to the CMS Region V Office, they concurred with our recommendations and authoized this department to notify the facility of the following actions:

- Mandatory Denial of Payment for new Medicare and Medicaid Admissions

If Mandatory Denial of Payment for New Medicare and Medicaid Admissions goes into effect, the facility would be subject to a loss of NATCEP beginning February 7, 2014.

Refer to the CMS 2567 for the results of this visit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6923

January 17, 2014

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

RE: Project Number S5553024

Dear Mr. Werner:

On December 2, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 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 December 31, 2013, the Minnesota Department of Health completed a revisit by review of the facility's plan of correction and on January 12, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 17, 2013. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 7, 2013. The deficiency not corrected is as follows:

K0056 -- S/S: F -- NFPA 101 -- Life Safety Code Standard Bld: 01

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

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 7, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 7, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 7, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Parkview Manor Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 7, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing

request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258-2529

Office: (507) 537-7158
Fax: (507) 537-7194

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 May 7, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Ben Zwart, Engineering Services

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	12/31/2013

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**12/12/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	**12/12/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** KS/cbl	**Date:** 01/17/2014	**Signature of Surveyor:** 03048	**Date:** 12/31/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 11/7/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245553	01 - MAIN BUILDING 01	1/12/2014

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 K0074	Correction Completed 12/17/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/cbl	Date: 01/17/2014	Signature of Surveyor: 22373	Date: 01/12/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/8/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **02/06/2014**

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
{K 000}	INITIAL COMMENTS Provider submitted documentation and CMS RO reviewed and determined the Immediate Extraordinary, and Sustained Risk Mitigation during Sprinkler Installation was met and the S/S level was reduced to "C", Substantial Compliance.	{K 000}		
{K 056} SS=C	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Provider submitted documentation and CMS RO reviewed and determined the Immediate Extraordinary, and Sustained Risk Mitigation during Sprinkler Installation was met and the S/S level was reduced to "C", Substantial Compliance.	{K 056}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **01/12/2014**

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
{K 000}	INITIAL COMMENTS	{K 000}		
{K 056} SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by:	{K 056}		

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

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.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3964

February 24, 2014

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

RE: Project Number F5553022

Dear Mr. Werner:

On December 2, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 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 December 31, 2013, the Minnesota Department of Health completed a revisit by review of the facility's plan of correction and on January 12, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 17, 2013. Based on our visit, we had determined that your facility had not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 7, 2013. The deficiency not corrected is as follows:

- **K0056 -- S/S: F -- NFPA 101 -- Life Safety Code Standard Bld: 01**

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

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 7, 2014. (42 CFR 488.417 (b))

On February 6, 2014, the Minnesota Department of Public Safety and the CMS Region V Office completed review of the ten (10) Extraordinary and Sustained Risk Mitigation Measures provided by the facility and determined the deficiency cited at K56 pursuant to the standard survey, could be reduced to a scope and severity level of "C" (be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm).

Based on the determination your facility has obtained substantial compliance with, but has not totally corrected, the deficiencies issued pursuant to our standard survey, completed on November 7, 2013, effective December 17, 2013. The deficiency not corrected is as follows:

- **K0056 -- S/S: C -- NFPA 101 -- Life Safety Code Standard Bld: 01**

The most serious deficiencies in your facility were found to be (Level C), as evidenced by the attached CMS-2567, whereby corrections are required.

Since these deficiencies are considered to be in substantial compliance, remedies outlined in our letter to you dated January 17, 2014 will not be imposed. As a result of obtaining substantial compliance, we recommended the following remedy, CMS Region V Office has concurs, is imposing the following rememdy and has authorized this Department to notify you of this imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 7, 2014, be rescinded. (42 CFR 488.417 (b))

In addition, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 29, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 1, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

A copy of the Statement of Deficiencies (CMS-2567) for this visit is enclosed.

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 o compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
	Parkview Manor Nursing Home	2/6/14

Administrator: Mike Werner Phone Number: 507.967.2482

Email address: parkviewmanor@frontiernet.net

State Fire Inspector: Shellum, George

~~These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by mail.~~

☐ At the time of this inspection, this facility was ~~found to comply with~~ the requirements of the 2000 Life Safety Code applicable to Skilled Nursing Facilities/~~Nursing~~ Facilities participating in the Medicare/Medicaid programs.

☐ The ~~following fire/life~~ safety deficiencies were found during this inspection:

K TAG S& S	☐ Draft Summary of Deficiency(ies) ☐ Revisit ☐ Clearance
	Verification of Compliance w/ CMS S&C 13-55-LSC, Attachment FOUR, Part I: Immediate, Extra-ordinary & Sustained Risk Mitigation during Sprinkler Installation:
ITEM	
#1	Yes
#2	Yes
#3	Yes
#4	Yes
#5	Yes
#6	Yes
#7	Yes
#8	Yes
#9	Not yet determined / not yet required by CMS - YES
#10	A) Verified on-site: fire sprinkler installation is underway. - YES B) Completion date not later than 04/30/2014 - YES

Meath, Mark (MDH)

From: Suzuki, Jan M. (CMS/CQISCO) <Jan.Suzuki@cms.hhs.gov>
Sent: February 18, 2014 1:27 PM
To: Meath, Mark (MDH)
Subject: RE: Parkview Manor N.H. - 10 Extraordinary Measures Fulfilled

Mark,

Can you please, or have someone, create a revisit survey shell for the 2/6/14 visit and make the K56 a C?

Let me know if you have questions.

Thanks,

Jan Suzuki
Principal Program Representative
Centers for Medicare & Medicaid Services
RO V, Chicago
Midwest Division of Survey and Certification
LTC Certification and Enforcement Branch
(P) 312-886-5209
(F) 443-380-6602
jan.suzuki@cms.hhs.gov

From: Meath, Mark (MDH) [mailto:mark.meath@state.mn.us]
Sent: Tuesday, February 11, 2014 2:49 PM
To: Suzuki, Jan M. (CMS/CQISCO)
Subject: FW: Parkview Manor N.H. - 10 Extraordinary Measures Fulfilled
Importance: High

Hi Jan,

Attached is the information from Pat Sheehan of the SFM.

Let me know if you have additional questions.

THANK YOU.

Mark Meath

MARK MEATH, ENFORCEMENT SPECIALIST
PROGRAM ASSURANCE UNIT
LICENSING AND CERTIFICATION PROGRAM
DIVISION OF COMPLIANCE MONITORING
85 EAST SEVENTH PLACE, SUITE 220
P.O. BOX 64900
ST. PAUL, MN 55164-0900
TELEPHONE: (651) 201-4118 FAX: (651) 215-9697
EMAIL: MARK.MEATH@STATE.MN.US

From: Sheehan, Pat (DPS)
Sent: February 07, 2014 4:43 PM
To: Meath, Mark (MDH)
Subject: FW: Parkview Manor N.H. - 10 Extraordinary Measures Fulfilled
Importance: High

The email and attachment from George are self-explanatory as this all relates to Parkview Manor NH in Ellsworth.

We will be doing at least one more, or a final, inspection in about another 30 days or so, depending on George's schedule and/or proximity to Ellsworth.

Let me know if you need anything further.

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

From: Shellum, George (DPS)
Sent: Friday, February 07, 2014 8:44 AM
To: Sheehan, Pat (DPS)
Cc: Whitney, Marian (DPS)
Subject: Parkview Manor N.H. - 10 Extraordinary Measures Fulfilled
Importance: High

Mr. Sheehan:

On February 06, 2014 I conducted a site visit at Parkview Manor N.H. [245553], in Ellsworth, MN. The purpose of this visit was to verify the facility's compliance with CMS Ref: S&C 13-55-LSC (revised), Attachment Four, Part I – Immediate,

Extraordinary & Sustained Risk Mitigation during Sprinkler Installation, Items 1 through 10. I am referring to these requirements as "the 10 Extraordinary Measures."

Based upon a review of documentation provided by Michael Werner, Administrator, coupled with an inspection of the premises, I have verified the facility meets these 10 Extraordinary Measures. Additionally, Mr. Werner advises that installation of a complete, automatic fire sprinkler system will occur not later than March 31, 2014, and that implementation of the 10 extraordinary measures will continue until project completion.

Last, I provided Mr. Werner with a hand-written report, verifying my findings. A .pdf of same is attached above.

If there are questions, please let me know. Thank you.

Respectfully,

George Shellum,
Deputy State Fire Marshal - Inspector
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Office: 320-327-8465
Cellular: 651-769-7774
eMail: George.Shellum@state.mn.us
Web: www.fire.state.mn.us

Meath, Mark (MDH)

From: Sheehan, Pat (DPS)
Sent: March 10, 2014 1:49 PM
To: parkviewmanor@frontiernet.net; Meath, Mark (MDH); Zwart, Benjamin (MDH); Stephen.Pelinski@cms.hhs.gov; Jan.Suzuki@cms.hhs.gov
Cc: Shellum, George (DPS); Whitney, Marian (DPS)
Subject: Parkview Manor Fire Sprinkler Completion

To All – on Thursday, March 7, 2014, DSFM George Shellum and I conducted a site-visit at Parkview Manor to review the fire sprinkler system that had been installed in the formerly unsprinklered areas of the building.

This is to inform you all that as of March 7, 2014, Parkview Manor in Ellsworth, Mn., can now be considered to be a fully fire sprinklered nursing home.

Do not hesitate to call me if any on you have questions.

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

From: parkviewmanor@frontiernet.net [mailto:parkviewmanor@frontiernet.net]
Sent: Monday, February 24, 2014 9:23 AM
To: Sheehan, Pat (DPS); Meath, Mark (MDH); Zwart, Benjamin (MDH); Stephen.Pelinski@cms.hhs.gov; Jan.Suzuki@cms.hhs.gov
Subject: Parkview Manor sprinkler completion

Pat Sheehan, Mark Meath, Ben Zwart, Stephen Pelinski, and Jan Suzuki

Parkview Manor of Ellsworth MN Provider #24-5553 NPI # 1306840368 has competed the sprinkler installation and system has been operational since 2/21/14. The entire facility is protected.

Mike Werner
507 967 2482

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Q1XV

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 **11/07/2013** (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 **37** (L18)

13.Total Certified Beds 37 (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
	37			
(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 :
Joseph Garvey, HFE NE II 01/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 01/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(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 01/16/2014 CO. Q1XV

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5553

At the time of the standard survey completed 11/07/2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7463

December 2, 2013

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

RE: Project Number S5553024

Dear Mr. Werner:

On November 7, 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;

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:

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 17, 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 December 17, 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 February 7, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 7, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
	245553	A. BUILDING _____ B. WING _____	11/07/2013

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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	approved 12/18/13 KMS RECEIVED DEC 16 2013 Minnesota Department of Health Marshall	

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

Admin | 12-12-13

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.

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 _____	11/07/2013

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F 279	Continued From page 1 by: Based on observation, interview, and document review the facility failed to develop interventions related to bruising on the plan of care for 1 of 3 residents (R5) reviewed for non-pressure related skin conditions. Findings include: During observation and interview with R5 on 11/05/13 at 11:42 a.m., it was observed that bruising was evident on the dorsal aspect of both hands. The bruising was dark purple in color and encompassed the entire back of both hands. R5 was also noted to have an Opsite dressing (clear see through dressing) over the bruising on the left dorsal hand with a skin tear noted under the dressing. Further, R5 was noted to have a Band-Aid across the proximal knuckle area on the right pointer and middle fingers. R5's record was reviewed. R5 had been readmitted from the hospital on 10/30/13, with diagnoses that included pneumonia, diabetes and congestive heart failure. The record included documentation of body audits conducted weekly on shower day. During review of the audits, neither the skin tear, bruising, nor other skin issues were identified. During interview with nursing assistant (NA)-B on 11/6/13 at 6:40 p.m., NA-B stated R5 frequently had bruising on the hands but was unsure the reason the bruising had occurred. NA-B further stated that R5 sometimes bumps his hands on the mechanical stand lift when being transferred by staff. During interview with NA-C on 11/7/13 at 7:37	F 279	F279 1. Resident 5's care plan updated to reflect his fragile skin which bruises and tears easily. 2. All residents will have care plans updated to reflect problems of their fragile skin that may bruise or tear easily if pertinent. 3. Charge nurses were in-service educated on 12/4/13 on need to identify those residents who have thin, fragile skin that bruises and tears easily. The process will then be care planned. 4. QA nurse will monitor care plans to assure problem is reflected on each residents care plan. 5. Director of Nurses will assure plan is sustained.	12-12-13

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 _____	11/07/2013

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F 279	Continued From page 2 a.m., NA-C stated R5 frequently had bruising on his hands but was unaware what caused the bruising. R5's care plan dated 9/13/13, identified a problem of altered skin integrity related to degenerative joint disease and immobility as manifested by rashy, dark reddened area to buttocks. There was no problem identified, nor approaches developed, on the care plan that addressed R5's fragile skin and/or bruising history. During interview with the director of nursing (DON) on 11/7/13 at 9:00 a.m., she verified R5's care plan lacked any evidence of risk factors related to bruising or skin tears. The DON stated it would be her expectation that staff would at least document bruising and skin tears so a care plan could be developed.	F 279		
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 skin integrity, including assessment and adequate monitoring, for 2 of 3 residents (R5 and R1) reviewed for non	F 309		

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 _____	11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 3 pressure related skin conditions Findings include: During observation and interview with R5 on 11/05/13 at 11:42 a.m., it was observed that bruising was evident on the dorsal aspect of both hands. The bruising was dark purple in color and encompassed the entire back of both hands. R5 was also noted to have an Opsite dressing (clear see through dressing) over the bruising on the left dorsal hand with a skin tear noted under the dressing. Further, R5 was noted to have a Band-Aid across the proximal knuckle area on the right pointer and middle fingers. R5's record was reviewed. R5 had been readmitted from the hospital on 10/30/13, with diagnoses that included pneumonia, diabetes and congestive heart failure. The record included documentation of body audits conducted weekly on shower day. During review of the audits, neither the skin tear, bruising, nor other skin issues were identified. During interview with nursing assistant (NA)-B on 11/6/13 at 6:40 p.m., NA-B stated R5 frequently had bruising on the hands but was unsure the reason the bruising had occurred. NA-B further stated that R5 sometimes bumps his hands on the mechanical stand lift when being transferred by staff. During interview with NA-C on 11/7/13 at 7:37 a.m., NA-C stated R5 frequently had bruising on his hands but was unaware what caused the bruising.	F 309		

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 _____	11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 4 During interview with licensed practical nurse (LPN)-A on 11/7/13 at 7:41 a.m., LPN-A stated she was aware of R5's left hand skin tear and right hand abrasion but was unsure of the cause. LPN-A stated she believed R5 had returned from the hospital with the bruising and skin tear. LPN-A verified the record lacked any documented assessment identifying the skin concerns following R5's return from the hospital, and stated the bruising should have been addressed upon readmission and during subsequent weekly skin audits. R5's care plan dated 9/13/13, identified a problem of altered skin integrity related to degenerative joint disease and immobility as manifested by rashy, dark reddened area to buttocks. There was no problem identified, nor approaches developed, on the care plan that addressed R5's fragile skin and/or bruising history. During interview with the director of nursing (DON) on 11/7/13 at 9:00 a.m., she verified R5's care plan lacked any evidence of risk factors related to bruising or skin tears. The DON stated it would be her expectation that staff would at least document bruising and skin tears so a care plan could be developed. The DON further verified R5's medical record lacked documentation related to the bruising, skin tear and abrasion evident on R5's hands. R1's record was reviewed. According to the resident's admission history and physical documents, R1 was admitted with a diagnosis including legal blindness. During observation and interview with R1 on 11/6/13 at 10:13 a.m., R1 was noted to have a large dark purple bruise to	F 309		

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 _____	11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5 the top of her right hand. On 11/7/13 at 9:29 a.m., another bruise was noted above R1's right wrist which was also dark purple in color. R1 stated she did not know how she had sustained the bruises. Additional record review revealed no documentation about the bruising in the nursing or progress notes, or on flowsheets. R1's care plan updated on 9/27/13, identified a risk for impaired skin integrity related to overall Braden (assessment which indicates risk of skin breakdown) risk score of 19. Interventions included: (1) inspect the skin daily, (2) weekly skin assessment by licensed staff, (3) moisturize dry skin and (4) bathe with mild soap. Documentation was lacking to indicate a skin assessment had been conducted to determine risk factors for bruising in order to determine and implement preventative measures. During interview with licensed practical nurse (LPN)-A on 11/7/13 at 9:28 a.m., she stated that she was not aware of the bruises on R1's hand and wrist. After observation of the bruises, LPN-A indicated that R1 has very fragile skin and bruises easily, stating, "I think sometimes she bumps it on the lift." On 11/7/13 at 9:55 a.m., LPN-B was interviewed and confirmed she was unaware of R1's bruises to the hand and wrist. LPN-B stated she thought staff had reported "the other day" that R1 had bumped her arm on the lift. LPN-B reiterated that R1 bruises easily. She indicated that upon discovery of a bruise, it was supposed to be measured, documented in the chart and monitored until resolved.	F 309	F309 1. Resident 5 and Resident 1 bruises and skin tears were assessed and documented in nursing notes. A care plan was established addressing these issues. 2. All residents with bruises and skin tears, etc. will have areas of impaired skin integrity assessed and documented. A care plan will be established. 3. Nursing Staff was in-service educated on 12/4/13 on need and process for improved documentation of non-pressure related skin issues. CNA's will document on shower sheets and communicate to charge nurse any areas of concern. Areas will be addressed and documented. A care plan will be established. 4. QA nurse will monitor skin to assure areas are being assessed, documented, and care planned. 5. Director of Nurses will monitor to assure plan is sustained.	12-12-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/08/2013

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
K 000	INITIAL COMMENTS	K 000		

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 November 8, 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

POC ok
JB 1-3-14

RECEIVED
JAN - 2 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Admin	1-2-14 12-12-13

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/08/2013

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K 000	Continued From page 2 of Type II (111) construction by a 2-hour fire wall assembly, with opening protectives consisting of a factory labeled, self-closing, positive latching, 90 minute fire rated double door assembly. 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. 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 alarms. The facility has a capacity of 37 beds and had a census of 34 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K056 1. The building is a single story with no basement non-combustible (Type 1) built. It is partially sprinklered. It has 4 separate smoke corridors that are separated by 2 hour fire walls and protected by self closing positive latching 90 minute rated doors. The entire building has fire alarm system with smoke and/or heat detection that is monitored by automatic fire department notification system. All staff are trained on fire procedures. Fire drills are conducted. The facility has staff in the building 24 hours per day. The nurses station no more than 94 feet from any resident room with out sprinkler. Resident rooms are in one straight hallway so line of sight can be achieved from anywhere. The building meets all building codes. The building meets all life safety codes. The	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	building meets all National Fire Protection Association Codes except for the one that will be corrected NFPA 701. The facility owner, the city of Ellsworth has contracted with two consultants to try to do long range planning to try to decide what the building is going to be used for in the future. This process started in April of 2012. The facility has downsized from 70 beds to 37 in the small community of 510 people. We are fighting to remain open and currently have 29 residents. A letter has been sent to HCFA contact, James Merrill on 12-20-13 to decide options. Copies of all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245553	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/08/2013

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K 056	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, the facility failed to install a complete automatic fire sprinkler system, in accordance with CMS Ref: S&C-13-55-LSC, dated August 16, 2013. In a fire emergency, this deficient practice could adversely affect 37 of 37 residents, staff and visitors. FINDINGS INCLUDE: On 11/08/2013 between 11:00 AM and 1:30 PM, observation revealed the absence of a complete fire sprinkler system in this facility. Only the commercial kitchen area and the 1993 Resident Room Addition are protected with a fire sprinkler system. As such, the facility can only be considered to be partially fire sprinkler protected, and is not in compliance with the requirements at CMS Ref: S&C-13-55-LSC, dated 08/16/2013. This deficient practice was verified with the facility administrator (MW).	K 056	correspondence has been sent to Minnesota State Fire Marshall, Pat Sheehan. 2. The facility had a bid to put in a fire sprinkler system. The Board of Directors/ City of Ellsworth has decided to try to keep the facility open at 12-18-13 meeting. The facility will be fully sprinklered. A letter of engagement to install a sprinkler system was signed on 12-20-13. Flow testing will take place week of 1-10-14 Plan drawings will be completed 1-17-14. Permits and authorization will be completed week of 1-31-14. Complete installation will be done by 4-30-14. While the facility is not fully sprinklered, the "Immediate, Extraordinary and Sustained Risk Midigation" Criteria 1-10 will be in place as listed in CMS S and C-13-55-LSC Attachment four. Training for will be completed for staff by 1-10-13. Have verbal commitment for monthly fire inspections to satisfy criteria #8. Building meets criteria#3 and#4. The 29 residents of Parkview Manor are safe.	
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701 Newly introduced upholstered furniture within	K 074	3. Mike Werner, Administrator will monitor situation and assure that a solution is achieved.	

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	245553	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11 08 2013

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K 074	Continued From page 4 health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide documentation that newly introduced upholstered furniture met the requirements at NFPA 101 (2000), Chapter 19, Section 19.7.5.2 and Chapter 10, Section 10.3. In a fire emergency, this deficient practice could adversely affect 15 of 37 residents, staff and visitors. FINDINGS INCLUDE: On 11/08/2013 between 11:00 AM and 1:30 PM, observation revealed approximately ten (10) upholstered reclining chairs located in the Main Day area, and this area was not protected by an approved automatic fire sprinkler system. In an interview with the facility administrator (MW), it was confirmed that some of the upholstered chairs had been newly introduced into the facility, and no documentation could be provided verifying that each piece of newly introduced upholstered furniture was tested in accordance with NFPA 261 (1998) and NFPA 266 (1998), and did not meet the standard at NFPA 101 (00) Sections 10.3.2	K 074	K074 1. All furniture in common areas will checked to see that meets NFPA 101 standard. If no tags are present on furniture, then an approved fire suppression application will be done and documented. If an application can not be applied, then removal of furniture will be done. Vendors have been contacted for documentation of fire retardant qualities. An inventory system has been established to document each furnishing. 2. December 17th, 2013 the documentation will be available. 3. Mike Werner, Administrator will be responsible to monitor that compliance continues.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7463

December 2, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5553024

Dear Mr. Werner:

The above facility was surveyed on November 5, 2013 through November 7, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 1400 E Lyon St Marshall, Mn 56258-2529. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathy Serie at (507) 537-7158.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File