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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: QMPV
Facility ID: 00719

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245474**

2. STATE VENDOR OR MEDICAID NO.
(L2) **163843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK VIEW CARE CENTER**
(L4) **200 PARK LANE**
(L5) **BUFFALO, MN** (L6) **55313**

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 **06/08/2018** (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 **123** (L18)

13. Total Certified Beds **123** (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
	123			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathleen Lucas, Unit Supervisor 06/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/13/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00803
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/17/2018
(L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 245474

June 13, 2018

Ms. Annette Greely, Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

Dear Ms. Greely:

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

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

Effective May 11, 2018 the above facility is recommended for:

123 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 123 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
June 13, 2018

Ms. Annette Greely, Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: Project Number S5474028

Dear Ms. Greely:

On May 3, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 19, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 8, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 29, 2018 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 April 19, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 11, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 19, 2018, effective May 11, 2018 and therefore remedies outlined in our letter to you dated May 3, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: QMPV
Facility ID: 00719

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2. STATE VENDOR OR MEDICAID NO. (L2) **163843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARK VIEW CARE CENTER**
(L4) **200 PARK LANE**
(L5) **BUFFALO, MN** (L6) **55313**

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 **04/19/2018** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Approved Waivers:

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

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

12. Total Facility Beds **123** (L18)

13. Total Certified Beds **123** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	123			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE: LoAnn DeGagne, HFE - NE II — Date: 05/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Alison Helm, Enforcement Specialist — Date: 05/17/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00803** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
May 3, 2018

Ms. Annette Greely, Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: Project Number S5474028

Dear Ms. Greely:

On April 19, 2018, 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 electronically attached CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 29, 2018, 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 May 29, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 19, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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
	245474	A. BUILDING ______ B. WING ______	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW CARE CENTER	**200 PARK LANE BUFFALO, MN 55313**

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/16/18 through 4/19/18 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 4/16/18 through 4/19/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		5/11/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/10/2018

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
	245474	A. BUILDING ______ B. WING ______	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW CARE CENTER	**200 PARK LANE BUFFALO, MN 55313**

(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 755	Continued From page 1 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure keys used to access controlled medication awaiting destruction were secure and failed to implement a system for prompt reconciliation of controlled medication awaiting destruction. This practice had the potential to affect all residents in the facility receiving controlled medication. Findings include: During observation and interview on 4/17/18, at	F 755	F755 Pharmacy Services/Procedures/Pharmacist Records (#2) It has been and remains the policy of Park View Care Center to assure that the facility 1.Has in place policy & procedures for routine and emergency drugs and biologicals for its residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING ______ B. WING ______	04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW CARE CENTER	**200 PARK LANE BUFFALO, MN 55313**

(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 755	Continued From page 2 9:20 a.m. registered nurse (RN)-A used a key to unlock a medication cart, then used a key to unlock a drawer within the cart. The drawer contained controlled medication. RN-A stated the controlled medication were logged and tracked in a ledger. RN-A stated 2 nurses count and reconcile each controlled medication at the change of each shift. RN-A stated when a resident's controlled medication were discontinued, the discontinued medication was reconciled by 2 nurses, signed out on the ledger, and brought to the unit manager. RN-A stated the unit manager brings the controlled medication to the director of nursing (DON)'s office for storage until destroyed. During observation and interview on 4/17/18, at 9:46 a.m. the DON stated the unit manager brings the controlled medication to the DON's office for storage. The DON stated she gives the keys to the locked controlled medication drawer to the unit manager. The unit manager opens the drawer and documents the medication/strength, quantity, patient name, prescription number, and pharmacy on a form in the drawer. The DON stated after the unit manager placed the medication in the drawer, she counts and reconciles the medication with the unit manager. The DON stated the medication is not counted and reconciled again until the medication is destroyed. The DON stated she and the pharmacist count and reconcile the medication when the pharmacist comes to the facility monthly. The DON stated both she and the pharmacist then destroy the medication together and document the destruction on the form. The DON stated she has never had a medication discrepancy.	F 755	2.Only allows unlicensed personnel to administer drugs under the general supervision of a licensed nurse 3.Provides pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident 4.Employs the services of a licensed pharmacist who- a.Provides consultation on all aspects of the provision of pharmacy services in the facility b.Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and c.Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled Regarding Corrective Action Taken: 1.The facility's Director of Nursing in consultation with the facility's consultant pharmacist & medical director have made & approved the following revisions to the facility's revised "Disposition of Controlled Medications Schedule II-V" Policy & Procedure (effective 5-7-18): a.Discontinued scheduled drugs II-V will no longer be turned in to the director of nursing for storage, reconciliation or destruction with the consulting pharmacist I. The disposition/destruction of	

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	245474	A. BUILDING ______ B. WING ______	04/19/2018

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F 755 Continued From page 3

When asked to observe the discontinued controlled medication in the drawer, the DON obtained keys from an unlocked drawer in her desk. The DON walked across the room to a drawer, located behind the DON's office entry door. The DON used the keys to unlock 2 locks on the drawer. Inside the drawer was a loose paper titled Certificate of Inventory and Destruction of Controlled Substances. The form included documentation of medication/strength, quantity, patient, prescription number, and pharmacy name. The following medication were documented on the form:
-morphine Sulfate 100 mg/5 ml with a quantity of 12.5 ml.
-lorazepam 2 mg/ml with a quantity of 30 ml.
-hydrocodone-Acetaminophen with a quantity of 30 tablets
-oxycodone 5 mg with a quantity of 19 half tablets
-tramadol 50 mg with a quantity of 3 tablets
-diazepam 5 mg with a quantity of 12 tablets
-hydrocodone-Acetaminophen 5-325 mg with a quantity of 57 tablets
-oxycodone 5 mg with a quantity of 30 half tablets
-hydrocodone-Acetaminophen with a quantity of 23 tablets
-oxycodone 5 mg with a quantity of 29 tablets

All 10 medications were prescribed to 10 different residents.

When asked about access to keys, the DON stated she and the administrator had keys to the DON's office. The unit manager would get the keys to my office from the administrator when she was not in the facility. The drawer that contains the keys to the controlled medication was kept in an unlocked drawer in the DON's desk.

F 755

controlled medications will be done on the nursing unit as soon as practical when the medication has been discontinued & upon a resident' s death by 2 licensed staff, one of which must be a registered nurse

ii.All discontinued controlled medications (II-V) will continue to be counted/reconciled per regulatory requirements until they are destroyed by the 2 licensed nurses

iii.Both nurses must observe the entire destruction & documentation process together

iv. For each resident that has a controlled medication discontinued, a “Certificate of Disposition Form” will be completed by 2 licensed staff with both signatures & titles provided on the form

1.The form includes the following:

a. Resident’s name, Date of disposition, Drug Name, Drug strength, RX #, Quantity destroyed, RN & other nurse signature

2. A copy of the completed “Certificate of Disposition Form” is given to the director of nursing following destruction

a.This form is retained in the facility for two (2) years following the disposition of a schedule II V medication

3.The original of the completed “Certificate of Disposition Form” becomes a part of the resident’s medical record following disposition.

2.Licensed staff has been provided education regarding the procedural

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F 755 Continued From page 4

During observation and interview on 4/17/18, at 10:05 a.m. unit manager, registered nurse (RN)-B stated when a resident's controlled medication was discontinued or a resident with controlled medication was discharged, the controlled medication was removed from the medication carts and brought to the DON's office to await disposal. RN-B stated she obtains the keys to open a double locked drawer in the DON's office from the DON. RN-B stated she opens the drawer and logs the controlled medication on a sheet of paper in the drawer. RN-B stated the DON then reconciles the medication. RN-B went on to say when the DON was not in the facility, she goes into gets the keys to the DON's office from office manager (OM)-A's office. When asked to observe the key, RN-B walked into OM-A's office. Behind the office door stood a metal cabinet. RN-B opened the metal cabinet and took out a plastic index card container. Inside the container was a key. RN-B stated the key was to the DON's office. RN-B stated she uses the key to unlock the DON's door. RN-B stated she uses the keys in the DON's office drawer to unlock the controlled medication drawer in the DON's office, and logs the controlled medication onto the form. RN-B stated when the DON is not at facility, the medication was not counted or reconciled with another nurse when placing the medication in the drawer.

During an interview on 4/17/18, at 10:15 a.m. OM-A stated the nurses have a key to her office as nursing supply's they need access to are kept in her office.

During an interview on 4/17/18, at 10:21 a.m. housekeeper-A stated she had a key to OM-A's

F 755

changes made to the facility's policy & procedure for Schedule II-V disposition/destruction

3. Measures put into place to ensure deficient practice does not reoccur:

a.Schedule II – V medications will remain locked in the medication cart narcotic drawer on the unit & continue to be counted/reconciled until they are destroyed by 2 licensed staff, one of which must be a registered nurse.

b.The RN Unit manager is responsible to review (audit) order changes for their unit's residents

I. Weekly medication cart audits will be conducted by the RN Unit Manager to assure discontinued schedule II-V medications have been timely & properly disposed of

c.The RN Unit Manager for the next 90 days will provide the Director of Nursing with audit findings

d.The Director of Nursing will submit a written report to the facility's next QAPI committee regarding the audit findings

4.Those responsible to maintain compliance:

a.Licensed staff on the unit with order transcription

b.RN Unit Manager with review of order changes & weekly medication cart

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F 755	Continued From page 5 office. During a follow up interview on 4/18/18, at 10:43 a.m. the DON stated it was not common knowledge there was a key in OM-A's office. The DON stated the key in OM-A's office was unmarked. The DON stated she was having a locked box with a code installed in her office today. The facility's policy Controlled Substance Disposal & or Destruction, revised 12/27/16 indicated "Controlled substance medications remaining in the facility after a resident has been discharged, becomes deceased, or the order is permanently changed/discontinued, are disposed of using a method in accordance with state and federal regulation."	F 755	audits c.Facility Consultant Pharmacist with monthly reviews d.Director of Nursing with written report to QAPI committee e.QAPI committee through review of reports submitted by the Director of Nursing	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		5/1/18

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staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 7 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nebulizer equipment was rinsed and dried after each use to reduce the risk of infection for 2 of 2 residents (R87, R96) observed during nebulizer (drug inhalation delivery device) medication administration. Findings include: R87's Annual Minimum Data Set (MDS), dated 3/20/18 identified R87 had a diagnoses of chronic obstructive pulmonary disease and received oxygen therapy. R87 was cognitively intact. R87's physician orders identified a 10/30/17 order for Ipratropium-albuterol solution for nebulization 0.5 mg-3 mg (milligrams)/3 ml (milliliters). Administer 4 times daily. May self administer after set up. The order directed to rinse and dry equipment after each treatment. During observations of a medication pass on 4/18/18, at 7:29 a.m. with registered nurse (RN)-C. RN-C listened to R87's lungs using a stethoscope. RN-C donned (put on gloves), opened a Rubbermaid container located on a table in R87's room, and took out the nebulizer equipment. RN-C stated the nebulizer equipment	F 880	Tag 880 It has been & remains the policy of Park View Care Center to establish & maintain an infection prevention & control program. This program is designed to provide a safe, sanitary and comfortable environment to help prevent the development & transmission of communicable diseases & infections. Regarding cited incidents involving residents R87 & R96; action was taken to retrain all licensed staff and TMA's on the revised policy for the cleaning of nebulizer cup and attachments after each use; Rinse each piece with warm water, let air dry by tilting them on a clean paper towel to ensure the moisture drains out of the cup sections. Cover with another paper towel to keep the dust off. When pieces are dry, reassemble nebulizer for the next use. Wipe out the face mask with a clean cloth. 1) A treatment sheet audit was done of every resident in the facility currently with nebulizer orders. The audit ensured all treatment sheets contained the correct cleaning instructions for each resident with nebulizer orders.	

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was cleaned by the night nurse. RN-C emptied the vial of ipratropium/albuterol 0.5 mg/3 mg 3 ml vial into the nebulizer equipment. RN-C placed the mask over the R87's nose and mouth and instructed R87 to look at her watch and keep the mask of for 10 minutes. RN-C doffed (removed) her gloves, washed her hands and left the room. RN-C stated she was going to administer R96's nebulizer.

R96's 5 day MDS, dated 3/28/17, identified R96 had a diagnoses of chronic obstructive pulmonary disease and received oxygen therapy. R96 was cognitively intact.

R96's physician orders identified a 4/16/18 physician order for albuteral sulfate solution for nebulization 2.5 mg/3 ml, administer 1 nebulizer three times daily. The order directed to rinse and dry equipment after each treatment.

During observations and interview of a medication pass on 4/18/18, at 7:38 a.m. RN-C entered R96's room. RN-C donned gloves. RN-C listed to R96's lungs and check an oxygen level using an oximeter. RN-C removed the nebulizer equipment from a canister located on shelf in R96's room. RN-C emptied the vial of albuterol sulfate 2.5 mg 3 ml vial in the nebulizer equipment and placed the mask over R96's nose and mouth. RN-C stayed with R96 during the administration of the Albuterol. RN-C stated the night nurses wash all the nebulizer equipment with soapy water at the beginning of their shift and lay it out to dry. At the end of the night nurses shift, the nurses put the nebulizer equipment together and place it back in the container.

At 7:51 a.m., RN-C turned off R96's nebulizer,

F 880

2) Education was done with the HUCs and Unit Managers on the proper transcription of orders regarding nebulizer equipment cleaning.

3) Licensed staff & TMAs received education on the nebulizer treatment and the cleaning of the equipment. A Competency Checklist was used for the re-training.

4) Audits will be conducted to ensure compliance;
a. The first audit was done on 5/1/18 by RN/Director of Staff Development/Infection Prevention. The audit reviews areas of proper treatment procedure, Infection Control Measures-including the daily, weekly, & monthly cleaning of the nebulizer equipment.
b. Audits will continue to be done x2monthly by RN/Staff Development/ Infection Prevention as well as by the Unit Managers. The Competency Checklist will be the tool used to complete the audit.
c. An Audit summary will be submitted by RN/Staff Development/Infection Prevention to the quarterly QAPI committee for review and monitoring.
d. RN/Staff Development/Infection Prevention will be the person responsible for correction & monitoring to prevent a re-occurrence of the deficiency.

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and removed the nebulizer equipment. RN-C put the nebulizer device back into the canister. RN-C did not rinse out the nebulizer equipment. RN-C doffed her gloves, washed her hands and left the room. RN-C walked back to the medication cart.

During observations on 4/18/18 at 7:54 a.m., after walking out of R96's room, back to the medication cart, R87's nebulizer equipment was observed to be laying on top of the nebulizer machine in her room. R87 was not in the room.

During an interview on 04/18/18 at 07:58 AM RN-C was standing next to the medication cart and stated she was done with R87's and R96's nebulizer treatments. When asked if there was anything to do with the nebulizer equipment RN-C stated "not on my shift." RN-C went on to say "We found when you rinse it [nebulizer equipment] in between there is a higher risk for infection."

During an interview on 4/18/18, at 10:43 a.m., the DON stated the nurses are to rinse out the nebulizer equipment after each use, then set out the equipment to dry on a paper towel. The DON went on to say this was the facility's policy.

Manufacturers instructions for the Pulmonate nebulizer directed Clean after every use:
1. With power switch in the "off" position, unplug power cord from wall outlet.
2. Disconnect tubing from the air-inlet connector and set aside.
3. Disassemble mouthpiece or mask from cap. Open nebulizer by turning cap counterclockwise and removing baffle.
4. Wash all items, except tubing, in warm water/dishwashing detergent solution. Rinse

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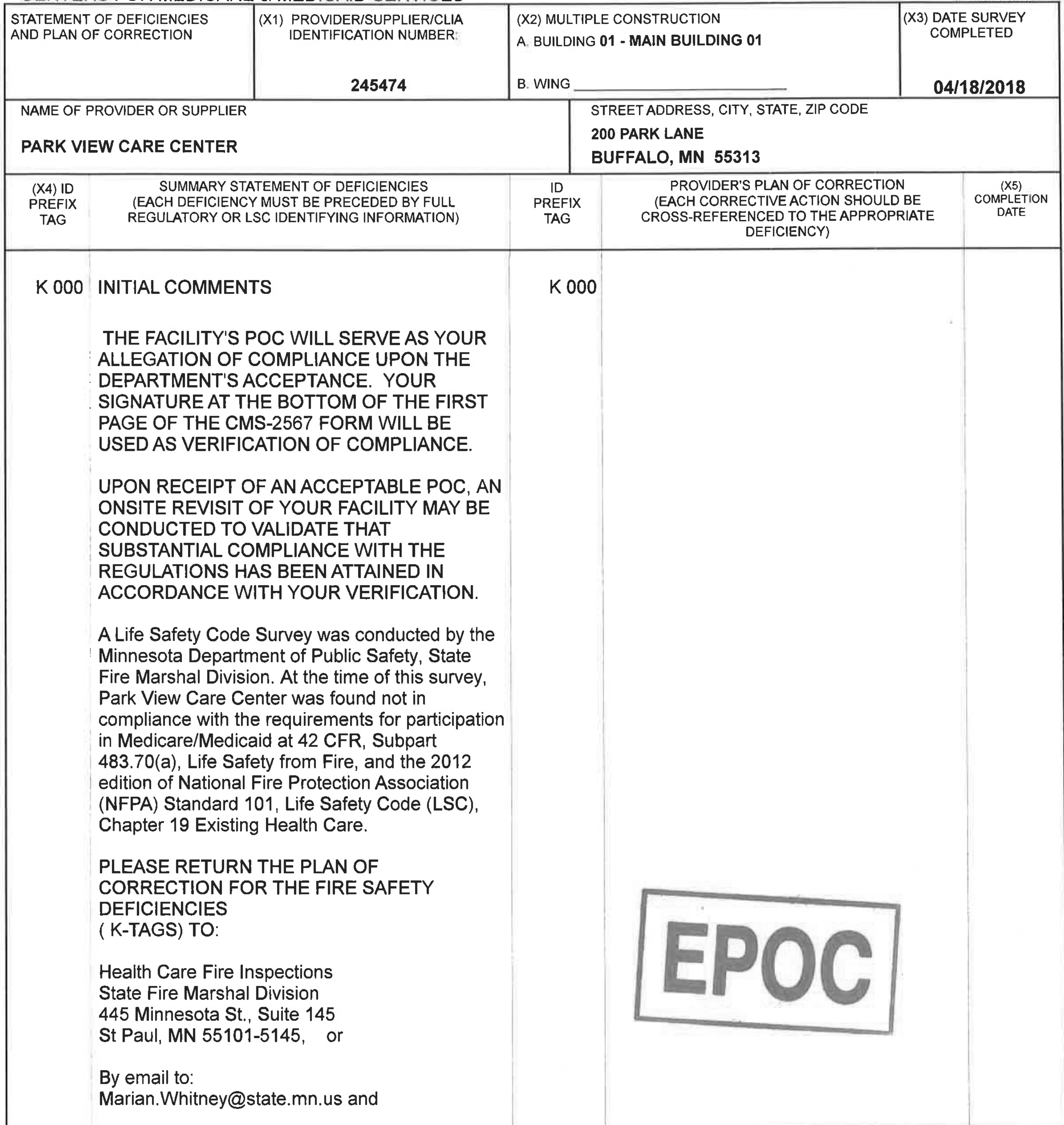
F 880	Continued From page 10 under warm tap water for 30 seconds to remove detergent residue. Allow to air dry. The facility's policy Nebulizer Care & Cleaning, revised "2-08" directed to: 1. Disconnect the oxygen tubing and set aside 2. Take apart the neb cup and attachments 3. Rinse each piece with warm water. 4. Let them air dry by tilting them on a clean paper towel so that moisture drains out of the cup sections. Cover with another paper towel to keep dust off. 5. When pieces are dry, reassemble nebulizer for next use. 6. Wipe out face mask with clean cloth.	F 880		



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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Park View Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2018

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

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Angela.Kappenman@state.mn.us

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

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

2. The actual, or proposed, completion date.

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

Park View Care Center is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1961 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the northeast and was determined to be of Type II(111) construction. In 1979, an addition was constructed to the northwest and was determined to be of Type II(111) construction. In 2007 an addition was added to the southeast of the facility and was determined to by of type II (111) construction. All buildings have been surveyed as one.

The building has a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors that is monitored for fire department notification. The facility has a capacity of 123 and had a census of 107 at the time of the survey.

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

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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
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of residents, staff and visitors. Findings include:	K 353	K353 Sprinkler head was replaced with a new one per fire safety code on 5/2/2018 by vendor Viking Sprinkler. Sprinkler head will be monitored and tested routinely as part of overall sprinkler maintenance.	5/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**04/18/2018**

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K 353	Continued From page 3 On facility tour and between the hours of 8:30 AM and 12:30 PM on 04/18/2018, observations and staff interview revealed 1 painted sprinkler head located in the lactation room. This deficient practice was confirmed by the Facility Enviromental Services Director at the time of discovery.	K 353		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all residents and an undetermined amount of staff and visitors. Findings include:	K 712	K712 Fire drills will be conducted per policy and will have staff sign per participation. A list of staff will be printed and staff in attendance for the drill will sign by their name to verify participation. Records will be kept by Environmental services manager and documentation will be saved for 2 years.	5/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/18/2018**

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K 712	Continued From page 4 On facility tour and between the hours of 8:30 AM and 12:30 PM on 04/18/2018, record review and staff interview revealed the fire drill sheets were not filled out with all of the required information for the last 12 months. This deficient practice was confirmed by the Facility Enviromental Services Director at the time of discovery.	K 712		