DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 18, 2025

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: CCN: 245474
Cycle Start Date: January 23, 2025

Dear Administrator:

On March 10, 2025, we notified you a remedy was imposed.

On March 14, 2025, the Minnesota Department Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 14, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 23, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of March 10, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 23, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 14, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Correction of the Life Safety Code deficiency cited under K0226 at the time of the January 23, 2025, standard recertification survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of June 30, 2025, has been forwarded to the the Centers for Medicare and Medicaid Services (CMS) Location for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 21, 2025

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: CCN: 245474
Cycle Start Date: January 9, 2025

Dear Administrator:

PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.

On February 20, 2025, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2025

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: CCN: 245474
Cycle Start Date: January 9, 2025

Dear Administrator:

PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.

On January 9, 2025, a survey was completed at your facility by the Minnesota Department of Health, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 April 9, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by July 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 24, 2025

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

Re: Event ID: SJHY11

Dear Administrator:

The above facility survey was completed on January 9, 2025, 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 - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 24, 2025

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: CCN: 245474
Cycle Start Date: January 23, 2025

Dear Administrator:

PLEASE NOTE THAT HEALTH AND LIFE SAFETY CODE SURVEYS ARE BEING PROCESSED IN SEPERATE ENFORCEMENT CYCLES.

On January 23, 2025, a survey was completed at your facility by the Minnesota Department of 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 April 23, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by July 23, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 _____	C 01/09/2025

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 On 1/6/25 through 1/9/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/6/25 through 1/9/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with NO deficiencies cited: H54743960C (MN100832). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 880	Infection Prevention & Control	F 880		2/17/25

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

Electronically Signed | 01/31/2025

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 _____	C 01/09/2025

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 880 SS=D	Continued From page 1 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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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	F 880		

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 _____	C 01/09/2025

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 880	Continued From page 2 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. §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 proper infection control practices were followed for 1 of 1 residents (R82) when exiting the residents room with a COVID-19 positive diagnosis during medication observation. This deficient practice had the potential to affect all 84 residents who were currently residing in the facility, staff and visitors.	F 880	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.	

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 _____	C 01/09/2025

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

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F 880	Continued From page 3 Per the Center for Disease Control (CDC), Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. This would include Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. The CDC further identified contact precaution use for a COVID-19 infection included use of designated or disposable patient care equipment. Findings include: R82's admission Minimum Data Set (MDS) identified R82 had intact cognition with diagnoses of bladder mass, weakness, rheumatoid arthritis, urinary tract infection and receiving palliative care. The MDS further identified R82 required extensive to total dependence of staff for activities of daily living (ADL's) which included bathing, toileting, dressing and wheelchair mobility. On 12/30/24, R82 tested positive for COVID-19. R82's care plan revised 1/7/25, lacked documentation of R82's COVID-19 diagnosis and contact precautions.	F 880	It is the policy of Cassia to comply with the Centers for Medicare & Medicaid Services (CMS) regulations regarding infection control practices, specifically ensuring adherence to Transmission-Based Precautions as outlined by the Centers for Disease Control and Prevention (CDC). To assure continued compliance, the following plan has been put into place: Corrective Action for Affected Resident (R82): Immediate re-education of all staff involved in the care of Resident R82 on proper medication administration. Conduct a thorough review of the incident to identify any lapses in protocol and address them with targeted training sessions. Identification of Other Potentially Affected Residents " Conduct a facility-wide audit to identify any other residents with similar occurrences of improper infection control practices, no other residents identified in isolation. Measures to Prevent Recurrence " Re-educate TMA and Nurses regarding proper medication pass in regards to infection prevention for residents in isolation. Monitoring and Auditing " The Infection Control Nurse or designee will audit medication	

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 _____	C 01/09/2025

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 880	Continued From page 4 R82's physician order report signed 1/8/25, identified R82 was to receive the following medications. Calcium 600 mg with Vitamin D3 by mouth twice daily, Nicotine patch 14 mg/24 hours once daily and remove old patch before applying new patch, Senna-S 8.6 mg by mouth daily, Tylenol 325mg two tablets by mouth four times a day, Nitrofurantoin 100 mg by mouth twice daily, Oxycodone 2.5 mg/0.125 ml by mouth every twelve hours. During an observation on 1/8/25 at 7:02 a.m., licensed practical nurse (LPN)-A prepared the following medications for R82 at the medication cart stationed in the hallway near the dining room. Calcium 600 milligrams (mg) with Vitamin D, Nicotine patch 14 mg, Senna-S 1 tablet, Tylenol 325mg two tablets, Nitrofurantoin 100 mg, Oxycodone 100 mg/5 milliliters (ml). LPN-A opened the locked drawer in the medication cart and removed a box with an oral syringe inside the box. LPN-A drew up 0.125 ml equal to 2.5 mg and set the syringe in a plastic cup. LPN-A put the box and medication back into the locked drawer, locked medication cart and brought prepared medications towards R82's room. LPN-A put on (PPE)in the hallway outside of R82's room; gown, gloves, N95 mask and goggles and entered R82's room. LPN-A put the syringe of Oxycodone into R82's mouth and handed R82 a plastic glass of water. LPN-A gave R82 the other medications on a spoon into R82's mouth, R82 drank the water and handed the glass back to LPN-A who set the syringe into the empty glass. LPN-A proceeded to remove an old nicotine patch off R82's back and placed a new nicotine patch to R82's left back/shoulder area. LPN-A left R82's room and placed the empty plastic glass with the syringe in it on the (PPE) bin outside of R82's	F 880	administration infection prevention practices for 4 resident medication passes per week for 4 weeks for any residents in isolation. " Results of these audits will be reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) committee. The committee will determine if further monitoring or audits are necessary based on the findings. Responsible Person " The Director of Nursing or designee is responsible for maintaining compliance with infection control practices and ensuring the implementation of this plan of correction. Completion Date " The completion date for the implementation of this plan of correction is February 17th, 2025. _____ By adhering to this plan, Cassia aims to ensure the safety and well-being of all residents, staff, and visitors, and to prevent any future occurrences of similar deficiencies.	

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 _____	C 01/09/2025

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

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F 880	Continued From page 5 room in the hallway. LPN-A removed his gown and gloves and discarded them, sanitized his hands, removed goggles and N95 mask and discarded them, sanitized hands, put a surgical mask on and used sanitizing wipes to clean goggles and placed back in the (PPE) bin. LPN-A picked up the plastic glass and brought back to the medication cart and placed on top of the cart. LPN-A opened the medication cart and the locked drawer, placed the syringe back into the box of Oxycodone, locked the drawer and the medication cart, threw the cup away and sanitized his hands. During an interview on 1/8/25 at 11:30 a.m., LPN-A stated the facility policy was to sanitize any item that was put back into the medication cart if it was in a residents room. LPN-A further stated if a resident had COVID-19 that nothing would be returned to the cart but should be left in the residents room. LPN-A confirmed R82 was positive for COVID-19 and supplies brought into the room that R82 touched were returned to the medication cart and not sanitized. LPN-A verified it was important to clean any items returning to the cart to get rid of germs and prevent the spread of germs to other residents or staff. During an interview on 1/8/25 at 11:37 a.m., registered nurse (RN)-A confirmed R82 was positive with COVID-19 and that supplies should not be leaving the residents room when in isolation. RN-A stated the (PPE) cart in the hallway was a clean area and supplies from a residents room should not be placed on the cart to prevent contamination. RN-A verified the plastic glass and syringe used for R82 should have been thrown away in the residents room to prevent the spread of germs or COVID-19 to	F 880		

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F 880	Continued From page 6 others. During an interview on 1/8/25 at 11:52 a.m., clinical support interim director of nursing (DON) confirmed any disposable items should be discarded in a positive COVID-19 resident room. DON stated items used in a residents room would not be placed on the (PPE) bin in the hallway as that was considered a clean space. DON verified this was important to reduce the risk of Covid-19 exposure and cross contamination from clean to dirty items. A facility policy titled Infection Prevention and Control Program revised 8/12/22, identified transmission based precautions and enhanced barrier precautions would be provided for residents requiring additional precautions if the facility was able to meet the resident's needs and infection control recommendations. Multiple use equipment would be sanitized per manufacturer's instructions and per procedure. A policy for use of transmission based precautions was requested from the facility and not received.	F 880		

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	00719	A. BUILDING: _____ B. WING _____	C 01/09/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 1/6/25 through 1/9/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed during the survey: H54743960C (MN100832). NO licensing orders were issued. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 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.	2 000		

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	245474	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/23/2025**

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PARK VIEW CARE CENTER	**200 PARK LANE** **BUFFALO, MN 55313**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/23/2025. 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/31/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Park View Care Center is a 1-story building with a partial basement. The building was constructed at four 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	K 000		

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K 000	Continued From page 2 determined to be of Type II(111) construction. All buildings have been surveyed as one. The facility has a capacity of 92 beds and had a census of 88 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress corridors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. This deficient finding could have an impact on the residents within the facility. Findings include: On 01/23/2025 at 11:14 AM, it was revealed by observation that two chairs were in the egress corridor near the north woods and mechanical room 232 dining room narrowing the corridor to 34".	K 211	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. Detailed Description of Corrective Action or Planned Corrective Action: 1. Immediate Inspection and Clearance:	2/28/25

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K 211	Continued From page 3 An interview with the Administrator and the Maintenance Technician verified this deficient finding at the time of discovery.	K 211	Conduct a comprehensive inspection of all egress corridors to identify and remove any obstructions or non-compliant items. This will ensure that all corridors are clear and accessible at all times. 2. Staff Training: Implement a mandatory training program for all staff members on the importance of maintaining clear egress corridors and the specific requirements of NFPA 101. This training will include practical demonstrations and assessments to ensure understanding and compliance. 3. Measures Put in Place to Ensure the Deficiency Does Not Reoccur: • Regular audits: Schedule regular inspections of egress corridors by the maintenance team weekly x 4 weeks to ensure ongoing compliance. • Staff Accountability: Assign specific staff members to be responsible for monitoring egress corridors during each shift. _____ _____ Person Responsible for Compliance: • Name: Director of Maintenance • _____ _____ Date of Completion: 2/28/25 • The facility is committed to ensuring the safety and well-being of all residents and staff by maintaining compliance with all relevant safety codes and standards.	
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101	K 225		2/28/25

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K 225	Continued From page 4 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell emergency egress doors and paths per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.2.2.1, 7.1.6.4, 7.1.10.1, and 7.2.1.4.5.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/23/2025 at 10:47 AM, it was revealed by observation that snow and ice were covering the stairs outside of the exit door from the northwest stairwell. 2. On 01/23/2025 at 10:52 AM, it was revealed by observation that the door leading outside from the southwest stairwell was difficult to open. An interview with the Administrator and the Maintenance Technician verified these deficient findings at the time of discovery.	K 225	Immediate corrective actions include: • Inspection and Repair: The facility immediately removed the remaining snow on the steps. The facility adjusted the sticking stairwell door. The facility conducted a comprehensive inspection of all stairwell emergency egress doors and paths to identify specific areas of non-compliance. • Staff Training: Conduct mandatory training sessions for all staff on the importance of maintaining clear egress paths and the proper operation of emergency egress doors. Measures put in place to ensure the deficiency does not reoccur: • Routine Audits: Implement a monthly inspection schedule for all emergency egress doors and paths to ensure ongoing compliance with NFPA 101 standards. • Compliance Officer: Director of Maintenance, will be responsible for overseeing the implementation of corrective actions and ongoing compliance with NFPA 101 standards. Date of completion: 2/28/25 _____ _____	

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K 225	Continued From page 5	K 225	This plan of correction is designed to address the identified deficiency comprehensively and ensure the safety and well-being of all residents and staff within the facility.	
K 226 SS=E	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire doors in fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, 7.2.4.4.2, and 8.3.1.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 01/23/2025 at 11:05 AM, it was revealed by observation that the fire rating tag on the fire door separating the assisted living from the care center in the basement had been removed, so the fire rating for the door could not be verified. An interview with the Administrator and the Maintenance Technician verified this deficient finding at the time of discovery.	K 226	Immediate corrective actions include: • Inspection and Repair: The facility is working with a vendor to recertify or replace the the identified fire door. The facility conducted a comprehensive inspection of all fire doors within the facility to identify any non-compliance issues. Any identified issues will be promptly repaired or replaced to meet the required standards. • How the facility plans to monitor future performance to ensure solutions are sustained: • Audit System: The facility will do an annual audit to ensure the fire rating tags are in place. • Director of Maintenance will be responsible for overseeing the implementation of corrective actions,	2/28/25

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K 226	Continued From page 6	K 226	ongoing compliance, and reporting to the facility administration. Date of completion: 2/28/25	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		2/28/25

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PARK VIEW CARE CENTER	**200 PARK LANE** **BUFFALO, MN 55313**

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K 363	Continued From page 7 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5 and 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/23/2025 at 10:58 AM, it was revealed by observation that the door to office 622CL was held open with a wooden wedge. An interview with the Administrator and the Maintenance Technician verified this deficient finding at the time of discovery.	K 363	1. Immediate Inspection and Repair: o The wooden wedge was removed from the identified fire door. o Other doors will be audited to ensure they are fully compliant. How the Facility Plans to Monitor Future Performance to Ensure Solutions are Sustained: • Audits: o The facility will conduct weekly audits x 4 weeks of corridor doors to verify compliance with NFPA 101 standards. o Use the review findings to update policies and training programs. _____ Person Responsible for Compliance: • Name: Jason Rislund • Title: Facility Maintenance Director • _____ • Expected Completion Date: 2/28/2025	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K 372		2/28/25

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 _____	**01/23/2025**

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K 372	Continued From page 8 Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 01/23/2025 at 10:36 AM, it was revealed by observation that a section of the concrete block near the ductwork and been broken out of the smoke barrier wall above the smoke barrier doors near the North Woods nurses station. An interview with the Administrator and the Maintenance Technician verified this deficient finding at the time of discovery.	K 372	1. Immediate Inspection and Repair: o The facility repaired the identified penetration. o The facility also conducted a comprehensive inspection of all other smoke barriers within the facility to identify any other breaches or areas of non-compliance. 2. Staff Training: o Provide training sessions for maintenance and safety staff on the requirements of NFPA 101 related to smoke barriers. Measures put in place to ensure the deficiency does not reoccur: • Scheduled Inspections: o Establish annual inspection/smoke barrier maintenance schedule for all smoke barriers, conducted by the facility's maintenance team to identify other possible new penetrations.	

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K 372	Continued From page 9	K 372	Person responsible for compliance: • Maintenance Supervisor: Jason Rislund _____ _____ • Target Completion Date: 2/28/25 The facility is committed to ensuring the safety and well-being of all residents by maintaining compliance with all applicable fire safety standards.	
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 a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 712	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.	2/28/25

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K 712	Continued From page 10 1. On 01/23/2025 between 09:15 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been completed during the third shift during the second quarter of 2024. 2. On 01/23/2025 between 09:15 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been completed during the first shift during the fourth quarter of 2024. An interview with the Administrator and the Maintenance Technician verified these deficient findings at the time of discovery.	K 712	It is the policy of Cassia to comply with the Centers for Medicare & Medicaid Services (CMS) regulations regarding infection control practices, specifically ensuring adherence to Transmission-Based Precautions as outlined by the Centers for Disease Control and Prevention (CDC). To assure continued compliance, the following plan has been put into place: _____ _____ The following corrective actions have been implemented: 1. Immediate Review and Update of Fire Drill Procedures: The facility has conducted a comprehensive review of the current fire drill procedures to ensure compliance with NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. 2. Staff Training and Education: All staff members responsible for conducting fire drills have undergone re-education related to the 1 per shift per quarter. 3. Scheduled Fire Drills: A schedule for fire drills has been established, ensuring that drills are conducted at varying times and 1 per shift per quarter, as required by the Life Safety Code. _____ _____ Measures put in place to ensure the deficiency does not reoccur: • Regular Audits: The facility will conduct monthly audits of fire drill records	

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K 712	Continued From page 11	K 712	to ensure compliance and identify any areas for improvement. • _____ _____ Person responsible for compliance: • The Administrator is responsible for overseeing fire safety protocols and ensuring compliance with all relevant standards. _____ _____ Date of completion: 2/28/25 • The facility is committed to maintaining a safe environment for all residents and staff by ensuring full compliance with fire safety regulations.	