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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** ID: T8HB

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245436**

2. STATE VENDOR OR MEDICAID NO. (L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER WELLS INC**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

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) **04/01/2009**

6. DATE OF SURVEY **4/11/2016** (L34)

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

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

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

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

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (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)
__X__ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | **50** | | | |
| (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):
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on April 11, 2016. Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 has been forwarded. Approval of the waiver request has been approved.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 04/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

*Protecting, maintaining and improving the health of all Minnesotans*

CMS Certification Number (CCN): 245436

April 12, 2016

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, MN 56097

Dear Mr. Johannsen:

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

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

Effective April 1, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirement:K67.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112

cc: Licensing and Certification File

MDH
Minnesota
Department
*of* Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

April 12, 2016

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, MN 56097

RE: Project Number S5436025

Dear Mr. Johannsen:

On March 3, 2016, we informed you that we would recommend enforcement remedies based. 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 April 11, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 19, 2016, effective April 1, 2016 and therefore remedies outlined in our letter to you dated March 3, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the February 19, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Enclosure
cc: Licensing and Certification File

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 245436 Y1 | A. Building<br>B. Wing Y2 | 4/11/2016 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST<br>WELLS, MN 56097 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix F0278 | Correction | ID Prefix F0282 | Correction | ID Prefix F0309 | Correction |
| Reg. # 483.20(g) - (j) | Completed | Reg. # 483.20(k)(3)(ii) | Completed | Reg. # 483.25 | Completed |
| LSC | 04/01/2016 | LSC | 04/01/2016 | LSC | 04/01/2016 |
| ID Prefix F0312 | Correction | ID Prefix F0329 | Correction | ID Prefix F0356 | Correction |
| Reg. # 483.25(a)(3) | Completed | Reg. # 483.25(l) | Completed | Reg. # 483.30(e) | Completed |
| LSC | 04/01/2016 | LSC | 04/01/2016 | LSC | 04/01/2016 |
| ID Prefix F0428 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 483.60(c) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 04/01/2016 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| | KS/kfd | 4/12/2016 | 03048 | 4/11/2016 |
| **REVIEWED BY CMS RO** ☐ | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |

**FOLLOWUP TO SURVEY COMPLETED ON**
2/19/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 245436 Y1 | A. Building 01 - MAIN BUILDING 01<br>B. Wing Y2 | 4/4/2016 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST<br>WELLS, MN 56097 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0046 | 03/16/2016 | LSC K0050 | 03/16/2016 | LSC K0144 | 03/16/2016 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # | Completed |
| LSC K0154 | 04/01/2016 | LSC K0155 | 04/01/2016 | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| | TL/kfd | 4/12/2016 | 35482 | 4/4/2016 |
| **REVIEWED BY CMS RO** ☐ | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |

**FOLLOWUP TO SURVEY COMPLETED ON**
2/18/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: T8HB

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00784

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245436**

2. STATE VENDOR OR MEDICAID NO. (L2) **803692000**

3. NAME AND ADDRESS OF FACILITY
(L3) **PARKVIEW CARE CENTER WELLS INC**
(L4) **55 TENTH STREET SOUTHEAST**
(L5) **WELLS, MN** (L6) **56097**

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) **04/01/2009**

6. DATE OF SURVEY **02/19/2016** (L34)

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

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

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

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

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | **50** | | | |
| (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):
Documentation supporting the facility's request for a continuing waiver involving K67 will be forwarded.
Approval of the waiver request will be recommended. Refer to the CMS 2786R Provision Number K84 Justification Page.

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 03/31/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/01/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1987** (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) **00**
VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
*of* Health

*Protecting, maintaining and improving the health of all Minnesotans*

Certified Mail # 7013 3020 0001 8869 1128

March 3, 2016

Mr. Robert Johannsen, Administrator
Parkview Care Center Wells Inc
55 Tenth Street Southeast
Wells, MN 56097

RE: Project Number S5436025

Dear Mr. Johannsen:

On February 19, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

**DEPARTMENT CONTACT**

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 30, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**PLAN OF CORRECTION (PoC)**

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action

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

- Include signature of provider and date.

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

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

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

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

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

**Original deficiencies not corrected**

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will

recommend to the CMS Region V Office that those other remedies be imposed.

**Original deficiencies not corrected and new deficiencies found during the revisit**

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

**Original deficiencies corrected but new deficiencies found during the revisit**

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

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

If substantial compliance with the regulations is not verified by May 19, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

**Tom Linhoff, Fire Safety Supervisor**
**Health Care Fire Inspections**
**State Fire Marshal Division**
**Email: tom.linhoff@state.mn.us**
**Phone: (651) 430-3012 Fax: (651) 215-0525**

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245436 | A. BUILDING _____ B. WING _____ | 02/19/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST WELLS, MN 56097 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | **It is the intent of this facility to comply with the regulations.** | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each | F 278 | **F278-Assessment Accuracy/Coordination Certified**<br><br>The facilities compliance for assessments, accuracy and coordination of these Assessments were reviewed by The Director of Nursing. Resident R2's Care plan was updated<br><br>DON and MDS nurse will review all Assessments to maintain accuracy. Director of Nursing and MDS Coordinator Will review care plans.<br><br>To sustain compliance the facility will audit care plans And assessments that will be discussed quarterly at QA meeting.<br><br>Corrective action will be completed by April 1, 2016 | |

approved kmt 3/18/16

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

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

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| F 278 | Continued From page 1<br>assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to accurately assess 1 of 3 residents (R2) reviewed for dental.<br><br>Findings include:<br><br>On 2/16/16, at 3:32 p.m. R2 was observed to be missing most of his teeth. R2 was observed to have at least 2 discolored teeth on top and approximately 4 teeth on the lower palate.<br><br>Review of R2's annual Minimum Data Set (MDS) dated 2/3/15 indicated: No natural teeth or tooth fragments (edentulous). Review of the facility Oral/Dental Status Evaluation dated 10/7/15 indicated: No natural teeth present.<br><br>Review of the Dental Evaluation & Care Notes dated 12/17/15 by the in-house dentist indicated: "Exam at Parkview. Remaining teeth #4, 5, 11, 13, 14, 21,22,27,28,29. But are non restorable. Pt. (patient) didn't seem interested in dentures or any treatment. No tx (treatment) needed unless pt. has discomfort or if pt. or family interested in treatment."<br><br>When interviewed on 2/18/16, at 12:42 p.m. the MDS coordinator/registered nurse (RN)-B confirmed R2's last annual MDS was dated 2/3/15. RN-B further confirmed the MDS was inaccurate as indicated R2 was edentulous and to | F 278 | | |

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| F 278 | Continued From page 2<br>her knowledge he still had a few teeth. RN-B reviewed the dental note dated 12/17/15 and confirmed the documentation indicated R2 had teeth #4, 5, 11, 13, 14, 21, 22, 27, 28, 29 remaining.<br><br>When interviewed on 2/18/16, at 1:16 p.m. the director of nursing (DON) stated not realizing the resident had any remaining teeth and confirmed the facility oral/dental assessment and MDS was inaccurate. | F 278 | **F282- SERVICES BY QUALIFIED PERSONS/PER CARE PLAN**<br><br>The facilities compliance for skin monitoring And potential breakdown were reviewed by The Director of Nursing. Resident R53's plan of care was updated. | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to follow the plan of care for 1 of 3 residents (R53) reviewed for non-pressure related skin conditions.<br><br>Findings include:<br><br>On 2/16/16, at 2:00 p.m. and on 2/17/16, R53 was observed to have a 50 cent size bruise on the top of her left and a 10 cent size bruise next to the larger bruise. The bruises were dark purplish in color. Interview with R53 on 2/17/16 at 1:30 p.m. indicated she had not been aware of the bruises on her left hand and did not know how she obtained them. | F 282 | Director of Nursing will review all skin communication Sheets daily and compare them to plan of care. DON will Educate staff on importance of reporting change in skin Condition to charge nurse and follow up from nursing will Be reviewed.<br><br>Changes in skin condition will be reported and monitoring Put into place. Charge nurse will chart weekly on skin and As needed. Care plans will be reviewed weekly and as needed by Nursing.<br><br>To sustain compliance the facility will audit care plans, skin monitoring And this will be discussed quarterly at QA meeting<br><br>Corrective action will be completed by April 1, 2016 | |

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| F 282 | Continued From page 3<br>Review of R53's current plan of care identified the resident as having a potential for skin breakdown due to vision impairment and fragile skin integrity. Interventions included to report signs of skin breakdown.<br><br>Interview with NA-A on 2/17/16 at 11:00 a.m., indicated she identified the bruises on R53's left hand that morning when assisting the resident with cares, but had not reported the bruises to the nurse.<br><br>Interview with nursing assistant (NA)-B on 2/17/16 at 2:47 p.m., who assisted R53 with bathing on 2/16/16, indicated she identified the bruises on the residents left hand but thought it might be age spots. NA-B stated she did not report the bruises to the nurse.<br><br>Interview with the director of nursing (DON) on 2/17/16, at 3:04 p.m. confirmed R53 had 2 areas of bruising on top of her left hand. The DON further included the bruising should have been reported when identified as the plan of care indicated. | F 282 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced | F 309 | | |

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| F 309 | Continued From page 4<br>by:<br>Based on observation, interview and document review the facility failed to identify and monitor bruising for 2 of 4 residents (R50 & R53) reviewed for non-pressure related skin conditions.<br><br>Findings include:<br><br>On 2/16/16 at 2:00 p.m. and on 2/17/16, R53 was observed to have a 50 cent size bruise on the top of her left and a 10 cent size bruise next to the larger bruise. The bruises were dark purplish in color. Interview with R53 on 2/17/16 at 1:30 p.m. indicated she had not been aware of the bruises on her left hand and did not know how she obtained them.<br><br>Review of R53's current plan of care identified the resident as having a potential for skin breakdown due to vision impairment and fragile skin integrity. Interventions included to report signs of skin breakdown.<br><br>Review of R53's weekly bath/shower skin audit form dated 2/16/16, did not identify any bruising of the skin. No skin concerns.<br><br>Interview with NA-A on 2/17/16 at 11:00 a.m., indicated she identified the bruises on R53's left hand that morning when assisting the resident with cares, but had not reported the bruises to the nurse.<br><br>Interview with licensed practical nurse (LPN)-A on 2/17/16 at 1:40 p.m., indicated she was not aware of R53's bruises on the top of her left hand. LPN-A further indicated R53 will often bump her hands while wheeling up to the dining room table, but confirmed there were no interventions to | F 309 | **F309- PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**<br><br>The facilities compliance for skin monitoring And potential breakdown were reviewed by The Director of Nursing. Resident R53's plan of care Was updated.<br><br>Director of Nursing will review all skin communication Sheets daily and compare them to plan of care. DON will Educate staff on importance of reporting change in skin Condition to charge nurse and follow up from nursing will Be reviewed.<br><br>Changes in skin condition will be reported and monitoring Put into place. Charge nurse will chart weekly on skin and As needed. Care plans will be reviewed weekly and as needed by Nursing.<br><br>To sustain compliance the facility will audit care plans, skin monitoring And this will be discussed quarterly at QA meeting<br><br>Corrective action will be completed by April 1, 2016 | |

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| F 309 | Continued From page 5<br>prevent bruising.<br><br>Interview with nursing assistant (NA)-B on 2/17/16 at 2:47 p.m., who assisted R53 with bathing on 2/16/16, indicated she identified the bruises on the residents left hand but thought it might be age spots. NA-B stated she did not report the bruises to the nurse.<br><br>Interview with the director of nursing (DON) on 2/17/16 at 3:04 p.m., confirmed R53 had 2 areas of bruising on top of her left hand. The DON further included the bruising should have been reported when identified R53's bath day.<br><br>Review of the facility skin monitoring policy for bruises dated 1/15/15, indicates bruising will be monitored weekly with the residents bathing and as needed by the licensed nurse and NA. If a bruise is identified there will be an investigation into its origin and the physician notified. | F 309 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to offer/provide oral care for 1 of 3 residents (R2) reviewed for dental.<br><br>Findings include: | F 312 | | |

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| F 312 | Continued From page 6<br><br>On 2/16/16, at 3:32 p.m. R2 was observed to be missing most of his teeth. R2 was observed to have at least 2 discolored teeth on top and approximately 4 teeth on the lower palate.<br><br>Review of R2's annual Minimum Data Set (MDS) dated 2/3/15, indicated: No natural teeth or tooth fragments (edentulous). Review of the facility Oral/Dental Status Evaluation dated 10/7/15 indicated: No natural teeth present. The quarterly assessment dated 10/13/15, indicated R2 required extensive assistance (score=3) with personal hygiene, including brushing teeth. Review of the care plan last updated 1/11/16, indicated: Resident has no natural teeth or dentures (edentulous). Approaches included: Oral care given AM/HS (morning and bedtime) and prn (as needed). No reference to assisting with brushing teeth was documented.<br><br>Review of the Dental Evaluation & Care Notes dated 12/17/15, by the in-house dentist indicated: "Exam at Parkview. Remaining teeth #4, 5, 11, 13, 14, 21, 22, 27, 28, 29. But are non restorable. Pt. (patient) didn't seem interested in dentures or any treatment. No tx (treatment) needed unless pt. has discomfort or if pt. or family interested in treatment."<br><br>When interviewed on 2/18/16, at 10:30 a.m. nursing assistant (NA)-B stated being unsure whether R2 had any teeth. NA-B indicated being retired and working on a casual basis but would offer oral care for resident's in the morning and at bedtime.<br><br>When interviewed on 2/18/16, at 10:35 a.m. NA-C confirmed she had assisted R2 that | F 312 | **F312- ADL CARE PROVIDED FOR DEPENDENT RESIDENTS**<br><br>The facilities policies for Plan of Care, Assessment procedures were reviewed by DON. R2's plan of care was updated.<br><br>DON and MDS nurse will review all Assessments to maintain accuracy. Director of Nursing and MDS Coordinator Will review care plans to make sure care Is being provided according to assessment and Plan of care.<br><br>Assessments and care plans will be reviewed weekly And as needed by DON/MDS a nursing.<br><br>To sustain compliance the facility will audit ADL's, assessments, And this will be discussed quarterly at QA meeting<br><br>Corrective action will be completed by April 1, 2016 | |

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| F 312 | Continued From page 7<br>morning with his morning cares. NA-C denied ever providing R2 assistance with oral cares as the resident didn't have any teeth.<br><br>When interviewed on 2/18/16, at 1:16 p.m. the director of nursing (DON) stated she was unaware R2 had any remaining teeth and confirmed the oral/dental assessment was inaccurate. In addition, the DON verified staff must provide oral care which included tooth brushing, if the resident had teeth. When the surveyor reported that interviewed staff did not realize R2 had teeth and therefore had not been providing any oral care. The DON replied, "Not good". DON confirmed this would need to be addressed and further stated she would ask R2 whether he would allow staff assistance with oral care. | F 312 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic | F 329 | | |

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| F 329 | Continued From page 8<br>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to identify the need for laboratory monitoring of a cholesterol lowering medication (simvastatin) for 1 of 5 residents (R31) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R31 was admitted on 4/2/14, with diagnoses including: heart failure, hyperlipidemia (high cholesterol level) and atrial fibrillation per the resident admission record face sheet.<br><br>Review of the Physician Order Report dated 2/8/16, directed Simvastatin 40 mg (milligrams) be given at bedtime (used to lower cholesterol levels).<br><br>Review of most current laboratory values for lipids (cholesterol/fats) was dated 11/12/14 (more than 15 months). Review of the consultant pharmacist's monthly drug review documentation form did not indicate a recommendation for annual laboratory lipid tests related to cholesterol and the ongoing use of simvastatin although monthly reviews were completed.<br><br>During interview on 2/19/16, at 12:42 p.m. the | F 329 | **F329- DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS**<br><br>Policy and procedure for drug monitoring/lab With consulting pharmacist were reviewed by DON and consulting pharmacist. A lab test was Ordered and results obtained for resident R31.<br><br>An audit was completed by DON and consulting Pharmacist for those residents and lab compliance.<br><br>Director of Nursing will audit monthly lab compliance For residents with medications that require annual testing Or scheduled follow up and obtain orders from the doctor As necessary.<br><br>To sustain compliance the DON, Consulting Pham will have Monthly audits and this will be discussed quarterly at the QA Meeting<br><br>Corrective action will be completed by April 1, 2016 | |

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| F 329 | Continued From page 9<br>director of nursing (DON) confirmed with the local clinic the last lipid panel was completed 11/12/14.<br><br>During interview on 2/19/16, at 1:36 p.m. the consulting pharmacist confirmed the last documented lipid panel was drawn on 11/12/14. The pharmacist indicated his practice was to make recommendations to the physician annually related to laboratory monitoring with use of a cholesterol lowering medication or rationale why not to be completed. The pharmacist confirmed there was no documented evidence of communication with the physician. | F 329 | | |
| F 356 SS=C | 483.30(e) POSTED NURSE STAFFING INFORMATION<br><br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format.<br>o In a prominent place readily accessible to residents and visitors.<br><br>The facility must, upon oral or written request, | F 356 | **F356- POSTED NURSE STAFFING INFORMATION**<br><br>Policies and procedures in regards to posted Staffing information were reviewed by DON and Administer. A new form was completed for easier Understanding of hours and census.<br><br>The census/posting sheet will be updated every shift by the charge nurse for accuracy.<br><br>The director of nursing and administrator will monitor these on a daily basis.<br><br>Audits will be performed weekly by the DON and scheduler And will be discussed quarterly at QA.<br><br>Corrective action will be completed by April 1, 2016 | |

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| F 356 | Continued From page 10<br>make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to consistently include current census information and accurate nursing hours worked on the daily nursing hour posting. This had the potential to affect all 44 residents residing at the facility.<br><br>Findings include:<br><br>During observations on 2/16/16, 2/17/16, 2/18/16 and 2/19/16 the facility nursing hour posting did not have the correct daily census for each of these days. The posting also was incorrect on the actual hours worked for licensed practical nurses (LPN) and nursing assistance (NA). Inaccurate posting of the census and nursing hours worked are listed below:<br><br>Census posted/actual census<br>-2/16/16- 45/44<br>-2/17/16-45/43<br>-2/18/16-45/43<br>-1/19/16-45/43<br><br>Nursing hours posted/actual hours worked<br>-2/16/16-LPN:16 hrs posted/8 actual hours worked<br>NA: 31 hrs/27 hrs | F 356 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245436 | A. BUILDING _____ B. WING _____ | 02/19/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PARKVIEW CARE CENTER WELLS INC | 55 TENTH STREET SOUTHEAST WELLS, MN 56097 |

| (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 |
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| F 356 | Continued From page 11<br>-2/17/16-LPN:16 hrs/8 hrs<br>NA: 30.5 hrs/24 hrs<br>-2/18/16- LPN: 16 hrs/8 hrs<br>-2/19/16-LPN: 16 hrs/8 hrs<br>NA: 31 hrs/30.5 hrs<br><br>Interview with the director of nursing (DON) on 2/19/16, at 12:45 p.m. confirmed the facility daily nursing hour posting had inaccurate resident census and inaccurate actual nursing hours worked each day of the survey as listed above. | F 356 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the consulting pharmacist failed to identify the need for laboratory monitoring of a cholesterol lowering medication (simvastatin) for 1 of 5 residents (R31) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R31 was admitted to the facility on 4/2/14 with diagnoses including: heart failure, hyperlipidemia | F 428 | **F428- DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON**<br><br>Policy and procedure for drug monitoring/lab With consulting pharmacist were reviewed by DON and consulting pharmacist. A lab test was ordered and results obtained for resident R31.<br><br>An audit was completed by DON and consulting pharmacist for those residents and lab compliance.<br><br>Director of Nursing will audit monthly lab compliance for residents with medications that require annual testing or scheduled follow up and obtain orders from the doctor as necessary.<br><br>To sustain compliance the DON, Consulting Pham will have Monthly audits and this will be discussed quarterly at the QA Meeting<br><br>Corrective action will be completed by April 1, 2016 | |

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| F 428 | Continued From page 12<br>(high cholesterol level) and atrial fibrillation per the resident admission record face sheet.<br><br>Review of the Physician Order Report dated 2/8/16, directed Simvastatin 40 mg (milligrams) be given at bedtime (used to lower cholesterol levels).<br><br>Review of most current laboratory values for lipids (cholesterol/fats) was dated 11/12/14,(more than 15 months). Review of the consultant pharmacist's monthly drug review documentation form did not indicate a recommendation for annual laboratory lipid testing related to cholesterol and the ongoing use of simvastatin although monthly reviews were completed.<br><br>During interview on 2/19/16, at 12:42 p.m. the director of nursing (DON) confirmed with the local clinic the last lipid panel was completed 11/12/14.<br><br>During interview on 2/19/16, at 1:36 p.m. the consulting pharmacist confirmed the last documented lipid panel was drawn on 11/12/14. The pharmacist indicated his practice was to make recommendations to the physician annually related to laboratory monitoring (lipid panel) with use of a cholesterol lowering medication or rationale why not to be completed. The pharmacist confirmed there was no documented evidence of communication with the physician. | F 428 | | |

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

FY436025

PRINTED: 03/02/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245436 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 02/18/2016 |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division on February 18, 2016. At the time of this survey, Parkview Care Center Wells Inc. was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES<br>( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division | K 000 | APPROVED Tom Linhoff<br>By Tom Linhoff at 11:58 am, Mar 17, 2016<br><br>RECEIVED<br>MAR 17 2016<br>MN DEPT. OF PUBLIC SAFETY<br>STATE FIRE MARSHAL DIVISION | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Thomson | TITLE: Administrator | (X6) DATE: 16 Mar 2016

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

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| K 000 | Continued From page 1<br>445 Minnesota St., Suite 145<br>St Paul, MN 55101-5145, or<br><br>By email to:<br>Marian.Whitney@state.mn.us<br><mailto:Marian.Whitney@state.mn.us> and<br>Angela.Kappenman@state.mn.us<br><mailto:Angela.Kappenman@state.mn.us><br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Parkview Care Center Wells Inc. is a 1-story building. The original building was constructed in 1961 and was determined to be of Type II (222) construction. In 1967, an addition was constructed and determined to be of Type II(222) construction, with a partial basement. In 1999, an addition was constructed and was determined to be of Type II(000) construction. The building will be surveyed as one building Type II (000).<br><br>The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. | K 000 | | |

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| K 000 | Continued From page 2<br>The facility has a capacity of 50 beds and had a census of 44 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | It is the intent of this facility to comply with the regulations under NFPA.<br><br>K046 | |
| K 046 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.<br>This STANDARD is not met as evidenced by:<br>Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.<br><br>Finding include:<br><br>On facility tour between 2:30 PM and 4:00 PM on 2/18/2016, review of the Battery Emergency Light Testing documentation indicated that the 30 second test on the Battery Wall Mount Emergency Light was not conducted from July thru November, 2015.<br><br>This deficient practice was confirmed with the Building Maintenance Supervisor at the time of discovery. | K 046 | The facility has implemented the use of a preventive maintenance checklist as part of the Life Safety Code manual to be checked regularly by the Maintenance Supervisor or other designated individual.<br><br>On this Checklist the review of the Battery Emergency Light Testing documentation will be reviewed monthly for 3 months and quarterly thereafter for a period of one year by the facility Administrator and Maintenance Supervisor.<br><br>A quarterly report to the QA committee will be made for the remainder of the year to ensure follow through. This practice will begin not later than March 16, 2016. | |
| K 050 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent | K 050 | | |

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

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| K 050 | Continued From page 3<br>persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms.<br>18.7.1.2, 19.7.1.2<br>This STANDARD is not met as evidenced by:<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms.<br>18.7.1.2, 19.7.1.2<br><br>Findings include:<br><br>During documentatation review between 2:30 PM and 4:00 PM on 2/18/2016, the review of Fire Drill documentation showed that fire drills were not conducted during the 3rd quarter (Jul-Sep) on the day shift/night shift during the 4th quarter 2014 (Oct-Dec) on the day/night shift.<br><br>This deficient practice was confirmed with the Building Maintenance Supervisor at the time of discovery. | K 050 | K050<br><br>The facility has properly trained the new Maintenance Supervisor and Administrator to conduct and document mandatory fire drills.<br><br>Facility Administrator and Maintenance Supervisor will plan monthly fire drills to be completed for the next 6 months to ensure compliance.<br><br>Administrator and Maintenance Supervisor will review fire drills and documentation monthly for 3 months and quarterly thereafter for one year to ensure compliance. Reporting to the QA Committee quarterly.<br><br>The facility will implement these actions as of March 16, 2016. | |
| K 067<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, | K 067 | K067<br><br>Waiver Application | |

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| K 067 | Continued From page 4<br>19.5.2.2<br>This STANDARD is not met as evidenced by:<br>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2<br><br>Findings include:<br><br>During facility inspection between 2:30 PM and 4:00 PM on 2/18/2016, it was observed that the corridors in the 1961 and 1967 buildings are being utilized as the supply air plenum for the resident rooms.<br><br>This deficient practice was confirmed with the Building Maintenance Supervisor at the time of discovery. | K 067 | K144<br><br>The facility has implemented the use of a preventive maintenance checklist as part of the Life Safety Code manual to be checked regularly by the Maintenance Supervisor or other designated individual. Each individual will be trained to conduct weekly inspections and monthly load tests and properly document within the PM checklist.<br><br>Facility Administrator and Maintenance Supervisor will review on a monthly basis for 3 months and quarterly thereafter for a period of one year. Reporting quarterly to the QA committee.<br><br>The facility will implement these actions as of March 16, 2016. | |
| K 144<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)<br>This STANDARD is not met as evidenced by:<br>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)<br><br>Findings include:<br><br>During documentatation review between 2:30 PM | K 144 | | |

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| K 144 | Continued From page 5<br>and 4:00 PM on 2/18/2016, the review of Generator Testing documentation indicated:<br><br>1.)Weekly inspections were not conducted from 09/23/2015 to 11/9/2015.<br><br>2.) Monthly Load Tests were not conducted during September and October 2015.<br><br>This deficient practice was confirmed with the Building Maintenance Supervisor at the time of discovery. | K 144 | | |
| K 154 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1<br>This STANDARD is not met as evidenced by:<br>Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1<br><br>Findings include:<br><br>During documentatation review between 2:30 PM and 4:00 PM on 2/18/2016, observation and documentation reviewed revealed that there was | K 154 | K154<br><br>The facility has written a single plan for the out of service plan for the fire sprinkler system to maintain compliance with NFPA.<br><br>Facility will train the Maintenance Supervisor and another designated individual to maintain and carryout this plan in the event it is needed.<br><br>Facility administrator and Maintenance Supervisor will review the plan quarterly for one year and report findings to the QA committee.<br><br>The facility will create and implement this plan no later than April 1, 2016. | |

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| K 154 | Continued From page 6<br>not a single plan for the out of service plan for the fire sprinkler system.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 154 | | |
| K 155 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8<br>This STANDARD is not met as evidenced by:<br>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8<br><br>Findings include:<br><br>During documentatation review between 2:30 PM and 4:00 PM on 2/18/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 155 | K155<br><br>The facility has written a single plan for the out of service plan for the fire alarm system to maintain compliance with NFPA.<br><br>Facility will train the Maintenance Supervisor and another designated individual to maintain and carryout this plan in the event it is needed.<br><br>Facility administrator and Maintenance Supervisor will review the plan quarterly for one year and report findings to the QA committee.<br><br>The facility will create and implement this plan no later than April 1, 2016. | |

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**Name of Facility**
Parkview Care Center

**2000 CODE**

**PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS**

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

| PROVISION NUMBER(S) | JUSTIFICATION |
|---|---|
| K67<br><br>HVAC Equipment shall comply with Sec 9.2 and NFPA 90A. | A waiver is requested for K 67 for the following reasons:<br>A. There will be no adverse effect on the health and safety of the facilities residents and staff since:<br>a. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFPA 13.<br>b. The facility is smoke free and signs to that effect are prominently posted at all major entrances.<br>c. Annual service and maintenance contracts exist to service all the facilities fire protection systems (i.e. fire alarm, sprinkler system, and portable fire extinguishers.)<br>d. The building fire alarm system is monitored to provide automatic fire department notification.<br>e. The HVAC system automatically shuts down when the fire alarm is activated.<br>f. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires.<br>g. Fire drills are conducted monthly on all shifts.<br>B. Compliance with this provision would impose an unreasonable hardship on the facility since:<br>a. Bid obtained from the Schwickert Company to fabricate and install the new supply and return ductwork through corridors is quoted at $119,438.00. This bid does not include removal, moving or re-installation of ceiling grid, electrical wiring, control wiring, plumbing piping, control wiring with suppression system, permits, signed drawings, or state plan review costs.<br>b. There is concern about whether the building electrical system is adequate to handle the additional HVAC equipment required.<br>c. The building is in compliance with all other fire safety requirements.<br>d. LSC(OO), Sec 9.2.1 gives the A.HJ authority to allow existing HVAC systems that do not comply it NFPA 90A to be continued in service. |

| Surveyor *(Signature)* | Title | Office | Date |
|---|---|---|---|
| | | | |
| Fire Authority Official *(Signature)* | Title | Office | Date |
| Thomas Linhoff 12424 | Fire Safety Supervisor | State Fire Marshal Division | 03-31-2016 |