



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 4, 2021

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

RE: CCN: 245474
Cycle Start Date: May 27, 2021

Dear Administrator:

On August 3, 2021, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2021

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

RE: CCN: 245474
Cycle Start Date: May 27, 2021

Dear Administrator:

On May 27, 2021, a 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 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" tag), i.e., the plan of correction should be directed to:

**Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334**

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 August 27, 2021 (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 November 27, 2021 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.
Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

PRINTED: 07/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/27/2021
NAME OF PROVIDER OR SUPPLIER PARK VIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS On 5/27/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5474048C (MN00073218), with a deficiency cited at F609. H5474049C (MN00073220), with a deficiency cited at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609			7/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/23/2021

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 609	Continued From page 1 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of abuse to the State Agency (SA) within two hours of the allegation for 2 or 2 residents, (R1, R2) reviewed for employee to resident abuse. Findings include: R1's quarterly Minimum Data Set (MDS), dated 4/7/21, identified R1 had moderately impaired cognition and required extensive physical assist of two staff for bed mobility, transfers, and toileting activities of daily living (ADLs). In addition, the MDS identified R1 had bowel control and diagnosis of dementia, anxiety, and a delusional disorder (a mental illness where a person cannot tell what is real from what is imagined).	F 609	F609 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. It is the policy of Cassia -Park View Care Center to comply with F609. To assure continued compliance, the following plan has been put into place. Regarding the cited situation: The facility submitted alleged incidents for		

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F 609	Continued From page 2 R2's quarterly MDS, dated 3/5/21, identified R2 had severely impaired cognition and required extensive physical assist for ADLs. In addition, the MDS identified R2 had delusions (fixed, false belief that conflicts with reality) with diagnosis of psychotic disorder (a mental disorder where a person is disconnected from reality) with hallucinations (sensations that appear to be real but are not actually there), dementia with behaviors, anxiety disorder, depression, and Parkinson's. An incident report was submitted by the director of nursing (DON) to the SA on 5/25/21, at 5:05 p.m. which identified R2 had alleged, "That guy keeps coming in my room and was rough with me. I'm scared." The report indicated after trained medication aide (TMA)-A had questioned nursing assistant (NA)-A on R2's behaviors after R2's comments that night, NA-A had stated, "I said something I wasn't supposed to say. I told her [R2] if you don't be quiet right now or I'll shut the door and turn off the lights." The report indicated the allegation incident had occurred on 5/20/21, at 1:30 a.m. A subsequent incident report was submitted by the administrator to the SA on 5/25/21, at 5:47 p.m. which identified R1 had alleged NA-A had told him to "shit himself and she [NA-A] would clean him up later." The report indicated the allegation incident had occurred on 5/20/21, at 11:00 pm. When interviewed on 5/27/21, at 12:54 p.m. staffing coordinator (SC)-A stated she and NA-B conversed on the evening of 5/24/21 regarding the allegations reported by R1 and R2. SC-A	F 609	both Resident #R1 and R2 and thoroughly investigated both allegations and shared the investigation with the state agency. Actions taken to identify other potential residents having similar occurrences: All residents on the Heritage Square Unit where the identified staff person worked were interviewed on 5/25/21 as part of the facility's investigation. Measures put in place to ensure deficient practice does not occur: All staff were re-educated on examples of abuse and neglect as well as abuse and neglect reporting requirements and process. The identified staff person was placed on administrative leave during the investigation and was terminated. Effective implementation of actions will be monitored by: The administrator will audit each facility reported incident for three months to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the state survey agency and adult protective services		

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F 609	Continued From page 3 explained she had updated the DON of these two allegations the morning of 5/25/21 when she (SC-A) had arrived to work. SC-A confirmed she is expected to update the DON and/or administrator "right away" when she is aware of abuse allegations and she acknowledged, "Telling a resident to poop their pants is not okay," and that it was "cruel punishment" to make someone scared of the dark; however, SC-A explained she had waited until 5/25/21 as "this had happened a few days ago" and felt it was okay to wait until the following morning. During interview on 5/27/21, at 3:40 p.m. the DON stated SC-A had initially reported R1 and R2's allegations to her on 5/25/21, during the "...morning/midmorning...probably before noon" hour time frame in which she had then spoken to the administrator "right away." The DON voiced, "If it truly happened [R1, R2's allegations] with NA-A, yes I would consider this abuse." When questioned on the time frames for having reported the allegations to the SA, the DON explained she had needed certain staff interviews to ensure all the required information was present before she filled out the SA incident report. Further, the DON explained her initial thought process had been "one employee against another employee" and during the morning of 5/25/21 she initially "did not have enough meat to say that this was truly a VA and who was involved in it. If I am going to suspend people, I need to know who I need to suspend." The DON stated the incident report had been reported to the SA within two hours of her awaited interview with TMA-A; however, she acknowledged, "We know that it was late reporting [based on SC-A's having reported it more than five hours prior to SA reporting]."	F 609	where state law provides for jurisdiction in the long-term care facilities) in accordance with State law through established procedures. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring /audits are recommended. The person responsible to maintain compliance will be: The administrator or designee is responsible for maintaining compliance. The completion date for certification purposes only is: 7/9/2021		

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F 609	Continued From page 4 When interviewed on 5/27/21, at 4:27 p.m. the administrator stated he expected any allegations of abuse or neglect to be reported to himself and the DON immediately and acknowledged the facility had two hours to report allegations of abuse to the SA. The administrator voiced he had been unsure as to the time frame he initially was updated by the DON on R1 and R2's abuse allegations; however, he acknowledged the SA had not been reported to within the required two hour time frame. He explained that he and the DON had needed to understand the situation as sometimes situations "...can be shades of gray" in relation to the staff involved and what the allegations may center around, and with this situation he and the DON initially had third and fourth hand information and felt additional staff interviews were needed in order to correctly complete the SA incident report. A Cassia Vulnerable Adult-MN policy, dated 11/21/18, identifies each employee is responsible to report suspected/alleged violations of resident abuse immediately (as soon as possible after discovery of the incident), but no later than 2 hours after the allegation is made, to the SA and all other agencies as required, if the events that cause the allegation involve abuse or result in serious bodily injury. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.	F 609			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2021

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

Re: Event ID: 7GY711

Dear Administrator:

The above facility survey was completed on May 27, 2021 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,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/27/2021
NAME OF PROVIDER OR SUPPLIER PARK VIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
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 5/27/21, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaints were found to be SUBSTANTIATED:	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/23/21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00719	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/27/2021
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2 000	Continued From page 1 H5474048C (MN00073218); however, no licensing orders were issued. H5474049C (MN00073220); however, no licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		