Electronically delivered

October 18, 2021

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

RE: CCN: 245474
Cycle Start Date: September 2, 2021

Dear Administrator:

On September 24, 2021, we informed you that we may impose enforcement remedies.

On September 27, 2021, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 2, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 2, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 2, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of

payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 2, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Park View Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 2, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Susie Haben, Rapid Response
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 2, 2022 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING _____ B. WING _____	C 09/27/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/24/21 - 9/27/21, 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: H5474061C (MN00076926), with no deficiency cited. H5474061C (MN00077034), with no deficiency cited. However, as a result of the investigation a deficiency was cited at F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate 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	F 609		11/5/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/25/2021

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F 609	Continued From page 1 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 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 1 of 1 residents (R1), reviewed for resident to resident abuse. Findings include: R1's admission Minimum Data Set (MDS) dated 7/15/21, identified R1 was severely cognitively impaired; however, was free of communication impairments. He required supervision with mobility and was diagnosed with Lewy body dementia (progressive dementia which affected movement, thinking skills, mood, memory and	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:	

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F 609	Continued From page 2 behavior), behavioral disturbances, hallucinations (perception of things not really present), and delusional disorder (mental illness where a person cannot tell real from imagined). R2's quarterly MDS dated 7/22/21, identified R2 was unable to complete the cognitive assessment; however, staff assessment indicated R2 was severely cognitively impaired. R2's speech was unclear. He was sometimes understood and sometimes was able to understand others. He required supervision for ambulation; however, he required extensive physical assist of staff for the rest of his mobility and activities of daily living (ADLs). R2 was diagnosed with vascular dementia (lack of blood to the brain which affected reasoning, planning, judgement, and memory). A Common Entry Point (CEP) incident report was submitted to the SA on 9/21/21, which identified on 9/18/21, during the breakfast meal, R1 screamed at and threatened other residents while in the dining room. R1 took silverware from his breakfast tray and stated he was going to slice open his roommate's [R2] neck as he believed R2 slept with his wife. R2 was present in the dining room during R1's threats. After R1 was removed from the dining room to an adjacent area, per the report he continued to make "paraphrased" comments: "I hate this place; I can't do anything; I might as well shoot him [R2] with a gun. That might solve the issues here; Killing people here might make this place better." The report indicated "Many residents didn't want him around, was scared that [R2] was close and a few didn't want to eat in the dining center." R1 was sent to the emergency room (ER) via ambulance.	F 609	Regarding the cited resident: The report of the incident has previously been made to the SA. Actions taken to identify other potential residents having similar occurrences: Education regarding the definition of and the requirement for reporting verbal abuse was provided to all staff. Measures put in place to ensure deficient practice does not recur: Education regarding the definition of and the requirement for reporting verbal abuse was provided to all staff. 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 where state law provides for jurisdiction in the long-term care facilities) in accordance with State law through	

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F 609	Continued From page 3 During interview on 9/24/21, at 12:29 p.m. nursing assistant (NA)-A stated she worked 9/18/21 on the secured memory care unit and witnessed R1 as he threatened other residents and staff. She explained she entered the dining room and heard R1 as he stated he was going to take the knife in his hand and slit [R2's] throat as he thought R2 slept with his wife. "He scared me on [9/18/21]. He was charging me." "He was walking around and would not stop with the threat talking, and so we called the police." NA-A stated any type of verbal abuse was to be reported "right away." When interviewed on 9/24/21, at 1:33 p.m. NA-B stated she was present in the dining room on 9/18/21 when R1 entered it. When R1 witnessed R2 in the dining room being assisted to eat breakfast R1 grabbed a knife off of his breakfast tray and stated he was going to slit [R2's] throat as he commented "she" was good the night before and then that day she was sad. R1 made additional comments that [R2] always gets fed and why did staff not feed him. As R1 continued to make further comments directed at R2 and staff, he also attempted to propel his wheelchair toward R2. When staff attempted to move his wheelchair out of the dining room, R1 stood up: "We thought he would go after [R2]." NA-B explained, "I was scared. When he gets like that there is no redirection for him." "The residents were scared. I know they have dementia but they can hear and know what is going on." She stated verbal abuse was abuse that was reported "right away." When interviewed on 9/24/21, at 2:58 p.m. unit manager (RN)-A stated verbal abuse included "yelling at someone;" however, if no physical	F 609	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. Those responsible to maintain compliance will be: The Administrator is responsible for maintaining compliance. Completion date for certification purposes only is: 11/5/2021	

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F 609	Continued From page 4	F 609		

contact was made during the verbal abuse, the verbal abuse was not reported to the SA: "We get a lot of accusatory statements just as a nature of dementia. Sometimes they [the residents] make accusations...I cannot make that many VA's [reports to the SA]." RN-A explained if the interaction included emotional abuse then that was reported to the SA, in which emotional abuse may be identified if there was a negative reaction by one resident when another walked by them, altered body position, and/or guarding. RN-A explained it was not their decision for what was reported and what was not despite the ability to file a VA report with the SA. The DON and administrator filed the VA reports "to make sure it is up to state standards." RN-A indicated a VA report was not filed on 9/18/21, or after, by administration. RN-A explained staff contacted them on 9/18/21 after R1 returned from the ER that same day: "It is a serious matter. Even though we did not report, we did things about it."

During interview on 9/24/21, at 3:33 p.m. the DON stated abuse was "the willful attempt to hurt someone verbally, physically..." She explained a VA report was not submitted on 9/18/21 because "this was one sided...it was not a sparing back and forth." "If two residents are swearing at each other and they interact, separate them and lets file a VA." She indicated staff contacted her at 7:55 a.m. on 9/18/21 about R1's behaviors. She explained staff "were so focused on [R1], his behaviors, and attempts to find him a different setting: "[R1] is causing a lot of chaos right now on the unit. If we got him into another place I think things would settle down." She expressed, "hindsight is 20/20" and R1's behaviors on 9/18/21 did require reporting to the SA on 9/18/21.

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F 609	Continued From page 5 During interview on 9/27/21, at 12:50 p.m. the administrator stated he was made aware on 9/18/21, of R1's behaviors. He denied a VA report was submitted that day. He indicated R1's behaviors were verbally abusive in nature and verbal abuse was required to be submitted to the SA within two hours of the incident. 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 verbal abuse as "any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents...or within their hearing distance, regardless of age, ability to comprehend, or disability." An example of verbal abuse was identified as "threats of harm." Mental abuse "may occur through either verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation."	F 609		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18, 2021

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

Re: Event ID: 10NH11

Dear Administrator:

The above facility survey was completed on September 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,

Kamala Fiske-Downing

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00719	A. BUILDING: _____ B. WING _____	C 09/27/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/24/21 - 9/27/21, 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	2 000		

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

Electronically Signed | 10/25/21

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2 000	Continued From page 1 SUBSTANTIATED: H5474061C (MN00076926) and H5474061C (MN00077034); 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		